Health Systems Division
Integrated Health Programs

Hospital Services Administrative Rulebook

Chapter 410, Division 125

Effective January 1, 2017

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410-125-0000 – Determining When the Patient Has Medical Assistance

(1) The Medical Card gives the client's name as listed with the Oregon Health Plan (OHP) and their alpha-numeric prime number.

(2) Eligibility may change on a monthly basis. In some instances, eligibility will change during the month. Eligibility should be verified each time services are provided in order to assure that the client is eligible for date(s) of service. For ways to verify client eligibility see General Rules OAR 410120-1140.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 409.010, 414.065

410-125-0020 – Retroactive Eligibility

(1) The Division of Medical Assistance Programs (Division) may pay for services provided to an individual who does not have Medicaid coverage at the time services are provided if the individual is made retroactively eligible for medical assistance and eligibility is extended back to the date services were provided. Contact the local branch concerning possible retroactive eligibility. In some cases, the date of branch contact may be considered the date of application for eligibility.

(2) Authorization for payment may be given after the service is provided under limited circumstances. For prior authorization information see OAR 410-125-0124 (Hospital Services Program).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0030 – Hospital Hold

(1) A hospital hold is a process which allows an in-state general hospital or an out-of-state contiguous general hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the Oregon Health Plan due to inpatient hospitalization.

(2) The Division of Medical Assistance Programs (Division) will accept hospital holds for inpatient stays. Hospitals must either submit a DMAP 3261 or a hospital generated form to the Division within 24 hours of the admission time or the next working day. If a hospital uses its own form, the form must contain all the information found on the DMAP 3261.

Stat. Auth: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0040 – Title XIX/Title XXI Clients

(1) Title XIX /Title XXI clients are eligible for medical assistance through programs established by the Federal government and for which the State receives federal assistance. Most Title XIX/Title XXI clients are eligible for the Plus or Standard Benefit packages. See the General rules (chapter 410, division 120) for more information on eligibility, benefit package, and covered services. Most Title XIX/Title XXI clients are enrolled in a FCHP, a MHO and a DCO. Some Title XIX clients are Medicare Beneficiaries.

(2) The Division of Medical Assistance Programs (Division) contracts with Prepaid Health Plans (PHPs): Fully-Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), and Dental Care Organizations (DCOs), to provide certain medical, mental health and dental services on a prepaid basis.

(a) FCHPs provide a comprehensive package of health care benefits including hospital, physician, laboratory, X-ray and other diagnostic imaging, Medicheck (EPSDT), pharmacy, physical therapy, speech-language therapy, occupational therapy, case management, and other services;

(b) MHOs provide mental health services. They can be fully-capitated health plans, community mental health programs, private behavioral organizations or a combination thereof;

(c) DCOs provide dental care;

(d) If the client is enrolled in a Prepaid Health Plan, the name, address and phone number of the plan will appear on the Medical Care Identification. Always check with the plan listed if there is a question about coverage;

(e) PHP clients receive most of their primary care services through the PHP or upon referral from the PHP. In emergency situations, all services may be provided without prior authorization or referral. However, all claims for emergency services must be sent to the prepaid health plan. The hospital must work with the client's prepaid health plan to arrange for billing and payment for emergency and non-emergency services;

(f) The Division will not reimburse for services that can be provided by the client's PHP and are included in the PHP's contract as covered services. Reimbursement is between the service provider and the PHP.

(3) Medicare clients: Some Title XIX clients also have Medicare coverage. Most Medicare beneficiaries who are also eligible for Medicaid will have the full range of covered benefits for both Medicare and Medicaid. However, a few individuals who are Medicare eligible are eligible for only partial coverage through Medicaid. Refer to the General Rules Program (chapter 410, division 120) for information on eligibility.

Stat. Auth: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0041 – Non-Title XIX/XXI Clients

(1) State-funded clients are clients who have not qualified for medical assistance through a federal program but have access to medical benefits through state funded programs. There are two categories of clients who are in State-funded programs.

(2) Program General Assistance (GA) clients: Program GA clients are children in foster care, in Services to Children and Families (SCF) custody, who are not eligible for Title XIX/Title XXI programs. They have access to the full range of Medicaid covered services, but payment for services provided may be different from that for Title XIX/Title XXI clients. For additional reimbursement information see the Hospital Services Supplemental Information on the Division of Medical Assistance Programs (Division) web site.

(3) Program SF clients: Program SF clients are individuals who are receiving treatment in a state facility, such as Oregon State Hospital, or the Eastern Oregon Training Center. These clients may need to receive hospital care outside the state facility. They are entitled to the full range of Medicaid covered hospital services. These individuals will be referred by the state facility for services. They do not have Medical Care Identification cards. They are not enrolled in a Fully Capitated Health Plan. The state facility from which the client is transferred will contact the hospital regarding billing instructions for these clients.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0045 – Coverage and Limitations

In general, most medically appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the Division of Medical Assistance Programs' (Division) General Rules Program for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are:

(1) Prior authorization (PA): Some services require PA for the Oregon Health Plan (OHP) Plus Benefit Package check OAR 410-125-0080.

(2) Non-covered services:

(a) Services that are not medically appropriate, unproven medical efficacy or services that are the responsibility of another Department of Human Services (Department) or Oregon Health Authority (Authority) Division are not covered by the Division of Medical Assistance Programs;

(b) Service coverage is based on the Health Evidence Review Commission's (HERC) Prioritized List of Services and the client's benefit package;

(c) See the General Rules Program (chapter 410, division 120) and other program divisions in chapter 410 for a list of not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

(3) Limitations on hospital benefit days: Clients have no hospital benefit day limitations for treatment of covered services.

(4) Dental services: Clients have dental/denturist services identified as covered on the HERC Prioritized List (OAR 410-141-520).

(5) Services provided outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by Division as hospital services. The only exceptions to this are Maternity Case Management services and specific nursing or physician services provided during a ground or air ambulance transport.

(6) Dialysis services require a written physician prescription. The prescription must indicate the ICD-10 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules Program.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0047 – Limited Hospital Benefit for the OHP Standard Population

(1) The Oregon Health Plan (OHP) Standard population has a limited hospital benefit for urgent or emergent inpatient and outpatient services. Inpatient and outpatient hospital services are limited to the International Classification of Diseases 9th revision Clinical Modification (ICD-9 CM) Diagnoses codes listed on the 'Standard Population Limited Hospital Benefit Code List.'

(2) The limited hospital benefit includes the ICD-9 CM codes listed in the OHP Standard Population – Limited Hospital Benefit Code List. This rule incorporates by reference the OHP Standard Population – Limited Hospital Benefit Code List. This list includes diagnoses requiring prior authorization indicated by the letters for prior authorization (PA) next to the code number. The archived and the current list is available on the web site (www.oregon.gov/oha/healthplan/Pages/hospital.aspx), or contact the Division of Medical Assistance Programs (Division) for a hardcopy. The document dated:

(a) August 1, 2004, is effective for dates of service August 1, 2004 through August 31, 2004;

(b) September 1, 2004, is effective for dates of service September 30, 2004 through June 30, 2008; and

(c) July 1, 2008 is effective for dates of service July 1, 2008 forward;

(d) On or after January 1, 2012 the limited hospital benefit for the OHP Standard population will be enhanced to the OHP plus hospital benefit and will not be operative until the Division determines all necessary federal approvals have been obtained.

(3) The Division shall reimburse hospitals for inpatient (diagnostic and treatment) services, outpatient (diagnostic and treatment services) and emergency room (diagnostic and treatment) based on the following:

(a) For treatment, the diagnosis must be listed in the OHP Standard Population – Limited Hospital Benefit Code List;

(b) For treatment the diagnosis must be above the funding line on The Health Services Commission Prioritized List of Health Services (OAR 410-141-0520);

(c) The diagnosis (ICD-9) must pair with the treatment (CPT code); and

(d) Prior authorization (PA) must be obtained for codes indicated in the OHP Standard Population – Limited Hospital Benefit Code List. PA request should be directed to the Division and will follow the present (current) PA process. PAs must be processed as expeditiously as the client's health condition requires;

(e) Medically appropriate services required to make a definitive diagnosis are a covered benefit.

(4) Some non-diagnostic outpatient hospital services (e.g. speech, physical or occupational therapy, etc.) are not covered benefits for the OHP Standard population (see the individual program for coverage) in the hospital setting.

(5) For benefit implementation process and PA requirements for the client enrolled in a Fully Capitated Health Plan (FCHP) and/or Mental Health Organization (MHO), contact the client's FCHP or MHO. The FCHP and/or MHO may have different requirements than the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0050 – Client Copayments

Copayments may be required for certain services and/or benefit package(s). See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0080 – Inpatient Services

(1) Elective (not urgent or emergent) hospital admission:

(a) Coordinated Care Organization (CCO) and Mental Health Organization (MHO) clients: Contact the client's CCO, or MHO. The health plan may have different prior authorization (PA) requirements than the Division;

(b) Medicare clients: The Division does not require PA for inpatient services provided to clients with Medicare Part A or B coverage;

(c) Division clients: Oregon Health Plan (OHP) clients covered by the OHP Plus Benefit Package:

(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, rules OAR chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401;

(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service program rules, specifically OAR 410-130-0200, Table 130-0200-1.

(2) Transplant services:

(a) Complete rules for transplant services are in the Division's Transplant Services Program rules, OAR chapter 410, division 124;

(b) Clients are eligible for transplants covered by the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria.

(3) Out-of-State non-contiguous hospitals:

(a) All non-emergent and non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;

(b) Contact the Division's Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-State contiguous hospitals: The Division prior authorizes services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, following the same rules and procedures governing in-state providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Services program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA.

(b) For transfers to a skilled nursing facility, intermediate care facility, or swing bed, contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO clients, transfers require authorization and payment (for first 20 days) from the CCO;

(c) For transfers for the same or lesser level inpatient care to a general acute-care hospital, the Division shall cover transfers, including back transfers that are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or psychological benefit to the patient:

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;

(B) Payment for transfers not meeting these guidelines may be denied on the basis of post-payment review.

(d) Exceptions:

(A) Emergency transfers do not require PA;

(B) In-state or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;

(C) All non-urgent transfers to out-of-state, non-contiguous hospitals require PA.

(6) Dental procedures provided in a hospital setting:

(a) For prior authorization requirements, see the Division's Dental Services Program rules; specifically OAR 410-123-1260 and 410-123-1490;

(b) Emergency dental services do not require PA;

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, http://www.oregon.gov/OHA/healthplan/pages/dental.aspx);

(d) For clients enrolled in a CCO, contact the client's health plan.

(7) Long-term acute care (LTAC) hospital services authorization requirements:

(a) For an initial thirty-day stay:

(A) LTAC provider must, before admitting the client, submit a request for prior authorization to the Division;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Meet the clinical criteria outlined in the LTAC Hospital guide at: http:www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

(b) Extension of stay:

(A) Submit request for prior authorization to the Division;

(B) Include sufficient medical justification for the extended stay.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0085 – Outpatient Services

(1) Outpatient services that may require prior authorization (PA) include (see the individual program in the Authority's Health Systems Division (Division)) Oregon Administrative Rules:

(a) Physical Therapy (chapter 410, division 131);

(b) Occupational Therapy (chapter 410, division 131);

(c) Speech Therapy (chapter 410, division 129);

(d) Audiology (chapter 410, division 129);

(e) Hearing Aids (chapter 410, division 129);

(f) Dental Procedures (chapter 410, division 123);

(g) Drugs (chapter 410, division 121);

(h) Apnea monitors, services, and supplies (chapter 410, division 122);

(i) Home Parenteral/Enteral Therapy (chapter 410, division 148);

(j) Durable Medical Equipment and Medical supplies (chapter 410, division 122);

(k) Certain hospital services.

(2) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

(3) Outpatient surgical procedures:

(a) For Coordinated Care Organization (CCO) members: Contact the CCO. The CCO may have different PA requirements than the Division. Some services are not covered under CCO contracts and require PA from the Division, or the Division's Dental Services program analyst;

(b) For Medicare clients enrolled in a CCO: These services must be authorized by the CCO even if Medicare is the primary payer. Without this authorization, the provider may not be paid beyond any Medicare payments (see also OAR 410-125-0103);

(c) For fee-for-service clients on the OHP Plus benefit package:

(A) Surgical procedures listed in OAR 410-125-0080 require PA when performed in an outpatient or day surgery setting, unless they are urgent or emergent;

(B) Contact the Division for PA (unless indicated otherwise in OAR 410-125-0080).

(d) Out-of-State services: Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require PA unless specified in the Division's Hospital Services Program rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require PA. For clients enrolled in a CCO, contact the CCO for authorization. For clients not enrolled in a health plan, contact the Division's Provider Clinical Support Unit.

(4) Psychiatric Emergency Services (PES):

(a) Psychiatric emergency services as defined by OAR 309-023-0110 delivered in a PES facility as described in OAR 309-023-0120 shall be reimbursed for a maximum of 20 hours per admittance;

(b) Psychiatric emergency services shall be reimbursed with a bundled, hourly rate using a fee-for-service rate methodology that is based on rates paid for similar services, using similar providers at a similar level-of-care.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

410-125-0086 – Prior Authorization for FCHP/MHO Clients

Most non-emergent inpatient and outpatient services require prior authorization by a Fully Capitated Health Plan (FCHP) or a Mental Health Organization (MHO). Emergency hospital services must be covered by an FCHP or MHO without regard to prior authorization or the emergency care provider's contractual relationship with the FCHP or MHO. Emergency hospital services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. Once a client's condition is considered stabilized, or a medical screening examination has determined that the client's medical condition is not emergent, an FCHP or MHO may require prior authorization for hospital admission, follow-up care, or further treatment. Failure to obtain prior authorization from the FCHP or MHO may result in a denial of payment for services. Contact the client's FCHP or MHO for further information on prior authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0090 – Inpatient Rate Calculations: Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory and radiology services are based on the Division of Medical Assistance Programs' (Division) fee schedule;

(b) Retrospective cost-based reimbursement is made during the annual cost settlement period for all covered inpatient services, except for the hospitals that have payment contracts with managed care plans;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

(3) Type A, Type B, and Critical Access Hospitals are:

(a) Eligible for disproportionate share reimbursements, but must meet the same criteria as other hospitals. See OAR 410-125-0150 for eligibility criteria and reimbursement calculation;

(b) Type A, Type B, and Critical Access Hospitals do not receive cost outlier, capital, or medical education payments.

(4) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until Division determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient-covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory services which are based on the Division fee schedule;

(b) Retrospective cost-based reimbursement is made for all fee-for-service covered inpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0095 – Hospitals Providing Specialized Inpatient Services

(1) Some hospitals provide specific highly specialized inpatient services by arrangement with the Division of Medical Assistance Programs (Division).

(2) Reimbursement is made according to the terms of a contract between the Division and the hospital.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 2-1-10 (Stats)

410-125-0101 – Hospital-Based Nursing Facilities and Medicaid Swing Beds

To receive reimbursement for hospital-based long-term care nursing facility services or Medicaid swing beds, the hospital must enter into an agreement with Seniors and People with Disabilities (SPD). These services must be provided, billed, and accounted for separately from other hospital services and in accordance with SPD rules. Contact SPD client's branch office for further information.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0102 – Medically Needy Clients

(1) The QIO can give prior authorization for non-emergency inpatient services for clients who are in the Medically Needy Program but have not yet met their spend-down. Only Medically Needy Program clients under age 21 and pregnant women have coverage for inpatient services if enrolled in the Medically Needy Program.

(2) Prior authorization cannot be granted for outpatient services, which require prior authorization. However, you may contact the Division of Medical Assistance Programs (Division) Medical/ Dental Group once the client has been made eligible and request retroactive authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0103 – Medicare Clients

When Medicare is the primary payer, services provided in the inpatient or outpatient setting do not require prior authorization. However, if the Division of Medical Assistance Programs (Division) is the primary payer because the service is not covered by Medicare; the prior authorization requirements listed in Chapter 410 Division 125 would apply.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0115 – Non-Contiguous Area Out-of-State Hospitals

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with the Division of Medical Assistance Programs (Division) for specialized services, non-contiguous area out-of-state hospitals will receive Diagnostic Related Groups (DRG) reimbursement or billed charges whichever is less. The unit value for non-contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations from Other Hospitals, DRG Rate Methodology, OAR 410-125-0141 for the methodology used to calculate the unit value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0120 – Transportation To and From Medical Services

(1) Transportation to and from medical services, including hospital services, is a covered service. However, all non-emergency transports require prior authorization in order for the transportation provider to be paid.

(2) The transportation must be the least expensive obtainable under existing conditions and appropriate to the client's needs.

(3) Contact the Division of Medical Assistance Program (Division) -contracted regional Transportation Brokerage (Brokerage) for prior authorization for the transport or instruct the transportation provider to contact the Brokerage. Brokerage map and contact information is available at www.oregon.gov/oha/healthplan/Pages/medical-transportation.aspx.

(4) Hospitals must follow the after-hours procedures for the Brokerages and contact the appropriate after-hours providers for non-emergent transportation for hospital discharges.

(5) No prior authorization is required when the client's condition requires emergency transport.

(6) When a hospital sends a patient to another facility or provider during the course of an inpatient stay and the client is returned to the admitting hospital within 24 hours, the hospital must arrange for and pay for the transportation. See billing instructions contained in the Hospital Supplemental Information on the Division website for additional information.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0121 – Contiguous Area Out-of-State Hospitals

Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with the Division of Medical Assistance Programs (Division) for specialized services, contiguous area out-of-state hospitals will receive Diagnostic Related Group (DRG) reimbursement or billed charges whichever is less. The unit value for contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations for Other Hospitals, DRG Rate Methodology OAR 410-125-0141 for the methodology). Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0124 – Retroactive Authorization

Retroactive authorization for payment can be granted after the service is provided only in the following circumstances:

(1) The person was not yet eligible for Medicaid/CHIP at the time the services were provided. Payment can be made if the services are covered Medicaid/CHIP services and the client's eligibility is extended back to the date the hospital provided services. See: the Hospital Services Supplemental Information on the Division of Medical Assistance Programs (Division) website for additional billing information.

(2) If another insurer denied the claim because the service is not covered by that insurer, and the hospital did not seek prior authorization because it had good reason to believe the service was covered by the insurer. Payment can be made by the Division if the services are covered by Medicaid. See: the Hospital Services Supplemental Information on the Division's website for additional billing information.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0125 – Free-Standing Inpatient Psychiatric Facilities

Free-standing inpatient psychiatric facilities (institutions for mental diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the terms of an agreement between the Addictions and Mental Health, Seniors and People with Disabilities, and the hospital.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0140 – Prior Authorization Does Not Guarantee Payment

(1) Prior authorization (PA) is valid for the date range approved only as long as the client remains eligible for services. For example, a client may become ineligible after the PA has been granted but before the actual date of service, or a client's hospital benefit days may be used prior to the time the claim for the prior authorized service is submitted to the Division of Medical Assistance Programs (Division) for payment.

(2) All prior authorized treatment are subject to retrospective review. If the information provided to obtain PA cannot be validated in a retrospective review, payment shall be denied or recovered.

(3) Hospitals should develop their own internal monitoring system to determine if the admitting physician has received PA for the service from the Division.

(4) For the Plus Benefit Package PA information refer to the PA chart in the Hospital Services Program OAR 410-125-0080.

(5) Hospitals may also verify PA requirements by calling the Division’s Provider Services Unit or the RN Benefit Hotline (contact phone numbers are located on the Division’s website).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0141 – DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Division uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Division may modify the logic of the grouper program. The Division will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Division DRG weight tables can be found on the Division web site:

(a) Acute Care Hospitals larger than fifty beds are considered DRG hospitals and reimbursed using Medicare's MS-DRG grouper;

(b) Hospitals enrolled as long-term acute care (LTAC) are reimbursed using Medicare's MS-LTC DRG grouper.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, the Division establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, the Division uses the following methodology: Using the formula N = where Z = 1.15 (a 75 percent confidence level), S is the standard deviation, and R = 10 percent of the mean. The Division determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, the Division sets a relative weight using:

(A) Division non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the Division Title XIX caseload;

(c) When a test shows at the 90 percent confidence level that an externally derived weight is not representative of the average cost of services provided to the Division Title XIX population in that DRG, the weight derived from the Division Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by the Division. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty beds or enrolled as a long-term acute care (LTAC) hospital are reimbursed using the Diagnosis Related Grouper (DRG) as described in section (2). Effective for services on or after:

(a) August 15, 2005, the operating unit payment is 100 percent of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(b) May 1, 2009, the operating unit payment is 108.5 percent of the 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(c) Effective October 1, 2009 the operating unit payment is 100 percent of the most recent version of the Medicare base payment rates. The Division will revise the base payment rates each year in October when Medicare posts the rates.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital or LTAC hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out-of-state hospitals do not receive the capital amount).

(7) DRG Hospital Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients;

(b) For dates of service on and after March 1, 2004, the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold ($25,000 or 270 percent of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270 percent of the DRG or $25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50 percent), equals;

(vii) Cost Outlier Payment;

(E) Third party reimbursements are deducted from the Division calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and cost statement template, adjusted to reflect the Medicaid mix of services.

(8) LTAC Short Stay Outliers: Occurs when a covered length of stay is between one day and up to and including 5/6ths of the average length of stay for the LTC-DRG grouping. The Short Stay Outlier payment for the hospital will be the lesser of:

(a) Per Diem for Short Stay Outlier Calculation:

(A) MS-LTC DRG payment, divided by;

(B) Geometric Length of Stay (GLOS,) multiplied by;

(C) Actual length of stay, multiplied by;

(D) 120 percent equals;

(E) Per Diem payment;

(b) Full MS-LTC DRG payment.

(9) LTAC High Cost Outliers: Are an additional payment when the estimated cost of a claim exceeds the outlier threshold (LTC DRG payment plus a fixed loss amount):

(a) The fixed loss amount is published annually by Medicare;

(b) If the estimated cost of a claim is greater than the outlier threshold, an additional payment is added to the LTC DRG payment;

(c) The outlier payment is 80 percent of the difference between the estimated cost of the claim and the outlier threshold (LTC DRG payment plus the fixed loss amount);

(d) The estimated cost of the claim is calculated by multiplying the Division's allowable charge on the claim by the hospital's cost-to-charge ratio.

(10) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Division uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004, the Capital cost per discharge is 100 percent of the published Medicare capital rate for fiscal year 2004, see section (5). The capital cost is added to the Unit Value and paid per discharge;

(c) Effective October 1, 2009, the Capital cost per discharge is one 100 percent of the current year Medicare capital rate and updated every October thereafter, see section (5). The capital cost is added to the Unit Value and paid per discharge.

(11) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Division uses the Medicare definition and calculation of

direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct medical education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986, through June 30, 1987, are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;

(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;

(c) Direct medical education payment per discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85 percent. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity, and other relevant factors.

(C) Notwithstanding section (9) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006, and thereafter direct medical education payments will not be made to hospitals; and

(ii) On July 1, 2008, and thereafter direct medical education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

(12) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the state's fiscal year is the Division indirect medical education factor. This factor is used for the entire Oregon Fiscal Year;

(d) For dates of service on and after March 1, 2004, the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital-specific February 29, 2004, Unit Value, multiplied by the Indirect Factor, equals the Indirect Medical Education Payment;

(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital unit value, see (5)(c), multiplied by the indirect factor, equals the Indirect Medical Education Payment;

(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter;

(g) Notwithstanding section (10) of this rule, this subsection becomes effective for dates of service:

(A) On July 1, 2006, and thereafter Indirect Medical Education payment will not be made to hospitals; and

(B) On July 1, 2008, and thereafter Indirect Medical Education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0142 – Graduate Medical Education Reimbursement for Public Teaching Hospitals

(1) Graduate Medical Education (GME) payment is reimbursement made to an institution for the costs of an approved medical training program. The State makes GME payments to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. Funding for public teaching hospital GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans.

(2) For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (becomes base year).

(3) The GME payment is calculated as follows:

(a) Total Direct Medical Education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME.

(b) Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount -- other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

(c) The total net Title XIX GME is the sum of Title XIX IME and DME costs. The GME reimbursement is made quarterly. Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population. GME is rebased yearly.

(4) Total GME payments will not exceed that determined by using Medicare reimbursement. The Medicare upper limit will be determined from the most recent Medicare Cost Report and performed for all inpatient acute hospitals and separately for State operated inpatient acute hospitals in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the GME payment is made.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0146 – Supplemental Reimbursement for Public Academic Teaching University Medical Practitioners

(1) Effective for dates of service on or after November 17, 2005, physician and other practitioner services provided by practitioners affiliated with a public academic medical center that meets the following eligibility standards shall be eligible for a supplemental teaching practitioner's payment for these services provided to eligible Medicaid recipients and paid for directly on a fee-for-service basis, subject to subsections (3) and (4) of this rule. This supplemental payment shall be equal to the difference between the Medicare allowable and Medicaid reimbursement received.

(2) Eligible academic medical centers must be:

(a) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(b) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(3) Payments under this rule shall be made only to the eligible academic medical centers in accordance with the terms of an intergovernmental agreement between the eligible academic medical center and Division of Medical Assistance Programs (Division). Such payments may be made quarterly, but shall be at least paid annually, at the end of each federal fiscal year. Calculation of the payment amount will be based on the annual difference between the practitioners' Medicare allowable and the Medicaid allowable payments to eligible practitioners for the Medicaid claims paid during the most recently completed state fiscal year. Services included are physician and other practitioners' services with RVU weights and physician-administered drugs. The RVU rates used for the payment calculation are the Division’s fee established in rule for the date of service payment period.

(4) Allowable Medicaid payments including this supplemental payment remain subject to OAR 410-125-0220 (12) and 410-1300225. For purposes of this rule, the allowable Medicaid payments used to calculate the supplemental payment shall be limited to the services that are billed fee-for-service to the Division on the electronic 837P or the paper CMS-1500, and as to which the physician or practitioner is receiving no reimbursement from the eligible academic medical center and the cost of their service is not reported as a direct medical education cost on the Medicare and the Division’s cost report.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

410-125-0150 – Disproportionate Share

(1) The Disproportionate-share hospital (DSH) payment is an additional reimbursement made to hospitals that serve a disproportionate share of low-income patients with special needs.

(a) To receive DSH payments, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital that performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital that had discontinued or did not offer non-emergency obstetric services as of December 21, 1987. No hospital may qualify for disproportionate share payments unless the hospital has, at a minimum, a Medicaid utilization rate of 1 percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another State are also accounted for;

(b) Information on total inpatient days is taken from the most recent Medicare Cost Report. (2) A hospital's eligibility for DSH payments is determined at the beginning of each fiscal year. Hospitals that are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1.

(3) Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state:

(a) Criteria 1: One or more standard deviation above the mean

(A) The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) to total inpatient days is one or more standard deviations above the mean for all Oregon hospital;

(B) Information on total inpatient days is taken from the most recent audited Medicare Cost Report. The total paid Medicaid inpatient days is based on Division of Medical Assistance Programs' (Division) records for the same cost reporting period;

(C) Information on total paid Medicaid days is taken from Division reports of paid claims for the same fiscal period as the Medicare Cost Report.

(b) Criteria 2: A low-income utilization rate exceeding 25 percent

(A) The Low income utilization rate is the sum of percentages (3) (b) (A) (i) and (3) (b) (A) (ii) below:

(i) The Medicaid percentage: The total of Medicaid inpatient and outpatient revenues paid to the hospital for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus any cash subsidies received directly from State and local governments in the most recent Medicare cost reporting period. This amount is divided by the total amount of inpatient and outpatient revenues and cash subsidies of the hospital for patient services in the most recent Medicare cost reporting period. The result is expressed as a percentage;

(ii) The charity care percentage: The total hospital charges for inpatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage;

(iii) Charity care is provided to individuals who have no source of payment, including third party and personal resources.

(B) Charity care shall not include deductions from revenues or the amount by which inpatient charges are reduced due to contractual allowances and discounts to other third party payers, such as Fully-Capitated Health Plans (FCHPs), Medicare, Medicaid, etc.;

(C) The information used to calculate the low income utilization rate is taken from the following sources:

(i) The most recent Medicare Cost Reports;

(ii) The Division’s records of payments made during the same reporting period;

(iii) Hospital-provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period;

(iv) Hospital-provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period;

(v) Any other information that the Division, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

(D) The Division determines within 30 days of receipt of all required information if a hospital is eligible under the low income utilization rate criteria.

(d) Disproportionate-share payment calculations:

(A) All hospitals that have been deemed DSH hospitals will always qualify for DSH payments under criteria 1 or criteria 2. Hospital ranking is done on an annual basis for all hospitals. Once eligible hospitals are determined Division calculates the standard deviations for the hospitals to determine if they will be eligible under criteria 1 or criteria 2.

(B) Criteria 1: one or more deviations above the mean The quarterly DSH payment to hospitals eligible under criteria 1 is the sum of Diagnosis Related Groups (DRG) weights for paid Title XIX non-Medicare claims for the quarter multiplied by a percentage of the hospital-specific Unit Value; this determines the hospital's DSH payment for the current quarter. The Unit Value used for eligible Type A, Type B, and Critical Access Hospitals is set at the same rate as for out-of-state hospitals. The calculation is as follows:

(i) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5% to determine the DSH payment;

(ii) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. The amount is multiplied by 0.10 to determine the DSH payment.

(iii) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 0.25 to determine the DSH payment.

(C) Eligibility under Criteria 2 -- For hospitals eligible under Criteria 2 (low income utilization rate), the payment is the sum of DRG weights for claims paid by the Division in the quarter, multiplied by the hospital's disproportionate share adjustment percentage established under Section 1886(d)(5)(F)(iv) of the Social Security Act multiplied by the hospital's unit value;

(D) For out-of-state hospitals, the quarterly DSH payment is 5% of the out-of-state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals that have entered into agreements with the Division for payment are reimbursed according to the terms of the agreement or contract.

(d) Public Academic Medical Center Disproportionate Share adjustments:

(A) Public academic medical centers that meet the following eligibility standards shall be deemed eligible for additional DSH payments up to 100% of their cost for serving Medicaid fee for service clients and indigent and uninsured patients:

(i) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and

(ii) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(iii) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(B) 100% of the costs for hospitals qualifying for this DSH payment will be determined from the following sources:

(i) The most recent Medicare Cost Reports; or

(ii) The Division's record of payments made during the same reporting period; or

(iii) Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period; or

(iv) Any information which the Division, working in conjunction with representatives of Oregon hospitals, determines necessary to establish cost.

(e) Additional Disproportionate Adjustments:

(A) For all hospitals with a Medicaid utilization rate above one percent of all payer utilization, the DSH payment is the ratio of the hospital's low income shortfall to the low income shortfall for all eligible hospitals multiplied by the total Federal disproportionate share allotment remaining after disproportionate payments have been made.(B) The low income shortfall is the Medicaid costs for inpatient and outpatient hospitals services plus uncompensated care for the uninsured cost for inpatient and outpatient hospital services less total Medicaid and self-pay payments for inpatient and outpatient hospital services.

(f) Disproportionate-share payment schedule:

(A) Hospitals qualifying for DSH payments under section (3) (c) above will receive quarterly payments based on claims paid during the preceding quarter. Hospitals that were eligible during one fiscal year but are not eligible for

disproportionate share status during the next fiscal year will receive DSH payments based on claims paid in the quarter in which they were eligible. Hospitals qualifying for DSH payments under section (3) (e) above will receive quarterly payments of 25 percent of the amount determined under this section;

(B) Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, DSH payments to hospitals will not exceed 100 percent of the "basic limit" which is:

(i) The inpatient and outpatient costs for services to Medicaid patients, less the amounts paid by the State under the non-DSH payment provisions of the State plan, plus;

(ii) The inpatient and outpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who has no other resources to cover the costs of services delivered. The costs attributable to uninsured patients are determined through disclosures in the Medicare (HCFA-2552) cost report and state records on indigent care.

(C) The State has a contingency plan to assure that disproportionate share hospital payments will not exceed the State disproportionate share hospital allotment (allotment). A reduction in payments in proportion to payments received will be effected to meet the requirements of section 1923(f) of the Social Security Act. DSH payments are made quarterly. Before payments are made for the last quarter of the Federal fiscal year, payments for the first three quarters and the anticipated payment for the last quarter are cumulatively compared to the allotment.

(i) If the allotment will be exceeded, the DSH payments for the last quarter will be adjusted proportionately for each hospital qualifying for payments under section (3)(d).

(ii) If the allotment will still be exceeded after this adjustment, DSH payments to out-of-state hospitals will be adjusted in proportion to DSH payments received during the previous three quarters.

(iii) If this second adjustment still results in the allotment being exceeded, hospitals qualifying for payments under section (3)(c) (Criteria 1 and 2) will be adjusted by applying each hospital's proportional share of payments during the previous three quarters to total DSH payments to all hospitals for that period.

(D) Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to DSH

payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0155 – Upper Limits on Payment of Hospital Claims

(1) Supplemental payments:

(a) Private Hospital Supplemental Payments:

(A) From the private Upper Payment Limit (UPL) gap, payments shall be made to all private Diagnosis Related Groups (DRG) hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of the payment;

(B) This payment will be equal to one quarter of the gap amount divided by the total private DRG hospital Medicaid fee-for-service discharges from the quarter proceeding the month of payment;

(C) The supplemental payments for Private Hospitals will not exceed the UPL for inpatient hospital services.

(b) Non-State Government Owned Hospital Supplemental Payments:

(A) From the non-state government owned hospital upper payment limit gap, payments shall be made to all non-state government owned DRG hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of the payment;

(B) This payment will be equal to one quarter of the gap amount divided by the total non-state government owned DRG hospital Medicaid fee-for-service discharges from the quarter proceeding the month of payment;

(C) The supplemental payments for non-state government owned Hospitals will not exceed the UPL for inpatient hospital services.

(2) For Type A, Type B and Critical Access Hospitals, reimbursement shall be limited to the lesser of allowable costs or billed charges. This limitation shame be applied separately to inpatient and outpatient services.

(3) Payments will not exceed final approved plan:

(a) Total reimbursements to a state-operated facility made during the Division of Medical Assistance Program (Division) fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in the final approved plan;

(b) Total aggregate inpatient and outpatient reimbursements to all hospitals made during the Division's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in the final approved plan.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0162 – Hospital Transformation Performance Program

(1) The Hospital Transformation Performance Program (HTPP) is established by the Oregon Health Authority (Authority) to allow hospitals to earn incentive payments by meeting specific performance standards that advance health systems transformation, reduce hospital costs, and improve patient safety.

The total amount of funds available through the program is equal to the federal financial participation received from one-percentage point of the assessment. Hospitals that pay an assessment on their net patient revenue, as required by OAR 410-050-0870, are eligible to participate.

The performance standards shall be established by the Authority based on recommendations of the Hospital Performance Advisory Committee (Committee) and as approved by the Centers for Medicare and Medicaid Services (CMS). The Committee shall be appointed by the Authority director and comprise four hospital representatives, two Coordinated Care Organization (CCO) representatives, and three members with expertise in measuring health outcomes.

(2) To qualify for incentive payments, eligible hospitals must meet the performance standards and measures as determined by the Authority.

(3) The Authority will:

(a) Establish baselines and targets for performance measures;

(b) Post the data specs and formats, forms to be used, schedule and frequency of data submission, frequency of incentive distributions, and other technical information on the Authority's website once determined;

(c) Analyze performance data submitted by hospitals;

(d) Determine if hospitals achieve targeted goals or demonstrate sufficient improvement to qualify for incentive payments; and

(e) Distribute incentive payments to performing hospitals.

Stat. Auth.: ORS 414.746

Stats. Implemented: ORS 414.065

410-125-0165 – Transfers and Reimbursement

(1) When a patient is transferred between hospitals, the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the per diem inter-hospital transfer payment rate.

(2) The per diem inter-hospital transfer payment rate = the DRG payment divided by the geometric mean length of stay for the DRG. The geometric mean length of stay is reported in the DRG tables on the Division's website.

(3) Payment to the transferring hospital will not exceed the DRG payment.

(4) The final discharging hospital receives the full DRG payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0170 – Death Occurring on Day of Admission

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0175 – Hospitals Providing Specialized Outpatient Services

Some hospitals provide specific highly specialized outpatient services by arrangement with the Division of Medical Assistance Programs (Division). Reimbursement is made according to the terms of a written agreement or contract.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0180 – Public Rates

Rates billed to the Division of Medical Assistance Programs (Division) cannot exceed the facility's public billing rate.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0181 – Non-Contiguous and Contiguous Area Out-of-State Hospitals - Outpatient Services

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Division of Medical Assistance Programs (Division) regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services will be reimbursed under a Division fee schedule.

(2) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(3) Notwithstanding subsections (1) – (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained. Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Division regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(a) Clinical laboratory services will be reimbursed under a Division fee schedule;

(b) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(4) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

Stat. Auth.: ORS 413.042

Stats. Implemented: 414.065

410-125-0190 – Outpatient Rate Calculations: Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services which are based on the Division of Medical Assistance Programs (Division) fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

(3) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory, which are based on the Division fee schedule;

(b) Retrospective cost-based reimbursement is made for all fee-for-service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0195 – Outpatient Services In-State DRG Hospitals

(1) The National Drug Code (NDC) must be included on all claim formats for physician administered drug codes required by the Deficit Reduction Act of 2005.

(2) For discharges prior to January 1, 2012, In-State Diagnostic Related Grouper (DRG) hospital outpatient and emergency services are reimbursed under a cost-based methodology.

(a) Interim reimbursement:

(A) The interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges;

(B) The interim payment is the estimated percentage needed to achieve 100 percent of hospital cost in aggregate; and (C) This interim percentage is applied to all outpatient charges except for clinical laboratory services. Interim reimbursement for clinical laboratory services is calculated according to rates published in the Division of Medical Assistance Programs' (Division) fee schedule.

(b) Settlement reimbursement:

(A) For Medicaid- and Children's Health Insurance Program-eligible (Titles XIX and XXI of the Social Security Act) clients, an adjustment to 100 percent of outpatient costs is made during the cost settlement process;

(B) For General Assistance (GA) clients, outpatient hospital services are reimbursed at 50 percent of billed charges or 59 percent of costs, whichever is less.

(3) Effective for discharges on or after January 1, 2012:

(a) In-State DRG hospital outpatient and emergency services will be reimbursed in accordance with Code of Federal Regulations 42 Part 419 Prospective Payment System for Hospital Outpatient Department Services, using the Ambulatory Payment Classification (APC) Group methodology, and

(b) Payments will be based on rates determined by State Actuarial Services to be equivalent to 100 percent of Medicare outpatient payments for each DRG hospital.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0200 – Time Limitation for Submission of Claims

The Division of Medical Assistance Programs (Division) will accept a claim up to 12 months after the date of service. The date of discharge is the date of service for an inpatient hospital claim.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0201 – Independent ESRD Facilities

(1) Independent End Stage Renal Dialysis (ESRD) Facilities:

(a) ESRD facilities are reimbursed for Continuous Ambulatory Peritoneal Dialysis.

(b) (CAPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemodialysis:

(A) Composite at 80% of the Medicare allowed amount, except for Epoetin.

(B) Epoetin is reimbursed at 100% of the Medicare maximum allowed amount.

(2) Other dialysis related charges which are allowed by Medicare, are reimbursed at 80% of the Medicare maximum allowed amount. Allowable clinical laboratory charges are reimbursed according to the Division's fee schedule. Billed charges may not exceed the Medicare maximum allowable amount.

(3) The Division follows Medicare's criteria for coverage of Epoetin, Intradialytic Parenteral Nutrition services, and the frequency schedule for laboratory tests for ESRD services. When laboratory tests are performed at a frequency greater than specified by Medicare, the additional tests must be billed separately, and are covered by the Division only if the tests are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0210 – Third Party Resources and Reimbursement

(1) The Division of Medical Assistance Programs (Division) establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the Division's maximum allowable payment.

(2) The Division will not make any additional reimbursement when a third party pays an amount equal to or greater than the Division's reimbursement. The Division will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

(3) When Medicare is Primary:

(a) The Division calculates the reimbursement for these claims in the same manner as described in the Inpatient and Outpatient Rates Calculations sections above;

(b) Payment is the Division's allowable payment, less the Medicare payment, up to the amount of the deductible and/or coinsurance due. For clients who are Qualified Medicare Beneficiaries the Division does not make any reimbursement for a service that is not covered by Medicare. For clients who are Qualified Medicare/Medicaid Beneficiaries the Division's payment is the Division's allowable, less the Part A payment up to the amount of the deductible due for services by either Medicare or Medicaid.

(4) When Medicare is Secondary:

(a) An individual admitted to a hospital may have Medicare Part B, but not Part A. The Division calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations section above. Payment is the Division's allowable payment, less the Medicare Part B payment;

(b) An individual receiving services in the outpatient setting may have most services covered by Medicare Part B. The Division's payment is the Division's allowable payment, less the Part B payment, up to the amount of the coinsurance and deductible due. For services provided in the outpatient setting which are not covered by Medicare, (for example, Take Home Drugs), the Division payment is the Division's allowable payment as calculated in the Outpatient Rates Calculation section above;

(c) Most Medicare-Medicaid clients have Medicare Part A, Part B, and full Medicaid coverage. The Division refers to these clients as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. The Division refers to these clients as Qualified Medicare Beneficiaries (QMB). For QMB clients, the Division does not make reimbursement for a service that is a not covered service for Medicare.

(d) Clients who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services that are not covered by Medicare if those services are covered by the Division.

(5) For clients with Physician Care Organization (PCO) or Prepaid Health Plan (PHP) Coverage, Division payment is limited to those services that are not the responsibility of the PCO or PHP. Payment is made at Division rates.

(6) Other Insurance:

(a) The Division pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any third party payments;

(b) The Division will not make additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the Division reimbursement, or 100 percent of billed charges.

(7) Medically Needy with Spend-Down. Reimbursement is the Division’s maximum allowable payment for covered services less the amount of the spend-down due.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0220 – Services Billed on the Electronic 837I or on the Paper UB-04 and Other Claim Forms

(1) All inpatient and outpatient services provided by the hospital or hospital employees, unless otherwise specified below, are billed on the electronic 837I (837 Institutional) or on the paper CMS 1450 (UB-04) claim form.

(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper CMS 1450 (UB-04) along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost.

(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by the Division of Medical Assistance Programs (Division) through graduate medical education, for the hospitals that qualify (See OAR 410-125-0141) for payments and may not be billed on the electronic 837I or paper CMS 1450 (UB-04).

(4) Diagnostic and similar services provided by another provider or facility outside the hospital: When diagnostic or short-term services are provided to an inpatient by another provider or facility because the admitting hospital does not have the equipment or facilities to provide all services required and the patient is returned within 24 hours to the admitting hospital, the admitting hospital should add the following charges to the inpatient electronic 837I or paper CMS 1450 (UB-04) claim:

(a) Charges from the other provider or hospital under the appropriate Revenue Code. The admitting hospital is responsible for reimbursing the other provider or hospital. The Division will not reimburse the other provider or hospital; and

(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. The Division will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper CMS 1450 (UB-04).

(5) Orthotics, prosthetics, durable medical equipment and implants:

(a) When a provider of orthotic or prosthetic devices provides services or materials to an inpatient through an agreement or arrangement with the hospital, the cost of those services will be billed by the hospital on the electronic 837I or the paper CMS 1450 (UB-04), along with all other inpatient services. The hospital is responsible for reimbursing the provider. The Division will not reimburse the provider;

(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the durable medical equipment supplier or by the hospital if the hospital is the supplier.

(6) Pharmaceutical and home parenteral/enteral services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB04, except home parenteral and enteral services and medications provided to patients who are in nursing homes:

(a) Home parenteral and enteral services, including home hyperalimentation, Home IV antibiotics, home IV analgesics, home enteral therapy, home IV chemotherapy, home IV hydrational fluids, and other home IV drugs, require prior authorization and must be billed on the Pharmacy Invoice Form in accordance with the rules in the Home Enteral/Parenteral Program rules (chapter 410, division 148);

(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services Program rules (chapter 410, division 121).

(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper CMS 1450 (UB-04). For hospital dentistry requirements refer to the Dental Service Program rules (chapter 410, division 123).

(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper CMS 1450 (UB-04) as described in these rules and instructions and will be reimbursed at the hospital's interim rate.

(9) Maternity case management:

(a) Hospital clinics may serve as maternity case managers for pregnant clients. The Medical-Surgical Program rules (chapter 410, division 130) contain information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-04); and

(b) Providers must bill using Revenue Code 569.

(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Division’s Home Health Care Services Program rules (chapter 410, division 127).

(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to the Division for a provider number as an air or ground ambulance provider. If costs for staff and equipment are reported on the Medicare Cost Report, these costs must be identifiable. The Division will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge

ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation Program rules (chapter 410, division 136).

(12) Supervising physicians providing services in a teaching setting:

(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper CMS 1450 (UB-04) with other inpatient or outpatient charges only when:

(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and

(B) The hospital does not report these services as a direct medical education cost on the Medicare and the Division's cost report.

(b) The services of supervising faculty physicians are not to be billed to the Division on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper CMS 1450 (UB-04)if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and the Division's cost report; and

(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (chapter 410, division 130) or additional information on billing on the electronic 837P or the paper CMS-1500.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0221 – Payment in Full

The payment made by Medicaid towards any inpatient or outpatient services, including cost outlier, disproportionate share, and capital payments, constitutes payment in full for the service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0360 – Definitions and Billing Requirements

(1) Total days on an inpatient claim must equal the number of accommodation days. Do not count the day of discharge when calculating the number of accommodation days.

(2) Inpatient services are reimbursed based on the admission date and discharge diagnosis.

(3) Inpatient services are services to patients who typically are admitted to the hospital before midnight and listed on the following day's census, with the following exceptions:

(a) A patient admitted and transferred to another acute care hospital on the same day is considered an inpatient;

(b) A patient who expires on the day of admission is an inpatient; and

(c) Births.

(4) Outpatient services:

(a) Outpatient services are services to patients who are treated and released the same day;

(b) Outpatient services also include services provided prior to midnight and continuing into the next day if the patient was admitted for ambulatory surgery, admitted to a birthing center, a treatment or observation room, or a short term stay bed;

(c) Outpatient observation services are services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation shall be reimbursed. An outpatient observation stay that exceeds 48 hours shall be billed as inpatient; and

(d) Outpatient observation services do not include the following:

(A) Services provided for the convenience of the patient, patient's family or physician but that are not medically necessary;

(B) Standard recovery period; and

(C) Routine preparation services and recovery for diagnostic services provided in a hospital outpatient department.

(5) Outpatient and inpatient services provided on the same day: If a patient receives services in the emergency room or in any outpatient setting and is admitted to an acute

care bed in the same hospital on the same day, combine the emergency room and other outpatient charges related to that admission with the inpatient charges. Bill on a single UB-04 for both inpatient and outpatient services provided under these circumstances:

(a) If on the day of discharge, the client uses outpatient services at the same hospital, these shall be billed on the UB-04 along with other inpatient charges, regardless of the type of service provided or the diagnosis of the client. Prescription medications provided to a patient being discharged from the hospital may be billed separately as outpatient Take Home Drugs if the patient receives more than a three-day supply;

(b) Inpatient and outpatient services provided to a client on the same day by two different hospitals shall be reimbursed separately. Each hospital shall bill for the services provided by that hospital;

(c) Inpatient and psychiatric emergency services (PES) as defined in OAR 309-023-0110 provided to the patient on the same day, whether in the same hospital or two different hospitals, shall be reimbursed separately.

(6) Outpatient procedures that result in an inpatient admission: If, during the course of an outpatient procedure, an emergency develops requiring an inpatient stay, place a "1" in the Type of Admission field. The principal diagnosis should be the condition or complication that caused the admission. Bill charges for the outpatient and inpatient services together.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

410-125-0400 – Discharge

(1) A discharge from a hospital is the formal release of a patient to home, to another facility such as an intermediate care facility or nursing home, to a home health care agency, or to another provider of health care services.

(2) For services beginning January 1, 1993, and later, the transfer of a patient from acute care to a distinct part physical rehabilitation unit (i.e., a unit exempt from the Medicare Prospective Payment System) within the same hospital will be considered a discharge. The admission to the rehabilitation unit is billed separately. All other transfers occurring within a hospital, including transfers to Medicare PPS-exempt psychiatric units, will not be considered discharges, and all charges for services must be submitted on a single UB-04 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another acute care hospital, to a long-term acute care hospital, to a skilled nursing facility, or an intermediate care facility. When a physician sends a patient directly to another hospital for further inpatient care, the discharge should be billed as a transfer, regardless of the mode of transportation.

(4) When the Division receives claims from two hospitals for the same patient, and the date of discharge from one hospital is the same as the date of admission to the other, the Division will assume that a transfer has occurred. The Division will change the discharge status code on the first claim to 02 (Transferred to Another Acute Care Facility), automatically generating an adjustment if the claim has already been adjudicated, unless discharge status on the claim is already 02 (Transfer) or 07 (Discharge AMA). If it is believed that the Division made an error in assigning Discharge Status code 02 to a claim, the hospital may submit an Adjustment Request along with supporting documentation from the medical record.

(5) A transfer between units within a hospital is not a transfer for billing purposes, except in the case of transfers to distinct part physical rehabilitation units. Note that transfers in the other direction from rehabilitative care to acute care are not considered discharges from the rehabilitation unit unless the stay in the acute setting exceeds seven days. Stays of seven days or less in the acute care setting may not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0401 – Definitions: Emergent, Urgent, and Elective Admissions

(1) EMERGENT ADMISSION -- an admission which occurs after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) Placing their health or the health of an unborn child in serious jeopardy;

(b) Serious impairment of bodily functions; or

(c) Serious dysfunction of any bodily organ or part. "Immediate medical attention" is defined as medical attention which could not be delayed by 24 hours.

(2) URGENT ADMISSION -- an admission which occurs for evaluation or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychological suffering by the patient. An urgent admission is defined as one which could not have been delayed for a period of 72 hours.

(3) ELECTIVE ADMISSION -- an admission which is or could have been scheduled in advance and for which a delay of 72 hours or more in the delivery of medical treatment or diagnosis would not have substantially affected the health of the patient. See Prior Authorization section of the Hospital Services Program administrative rules for requirements.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0410 – Readmission

(1) A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status, and both admissions must be combined into a single billing. The Division of Medical Assistance Programs (Division) will make one payment for the combined service. Examples of planned readmissions include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

(2) A patient whose discharge and readmission to the hospital is within thirty (30) days for the same or related diagnosis must be combined into a single billing. Division shall make one payment for the amount appropriate for the combined service.

(3) This rule does not apply to:

(a) Readmissions for an unrelated diagnosis;

(b) Readmissions occurring more than 30 days after the date of discharge;

(c) Readmissions for a diagnosis that may require episodic (a series) acute care hospitalizations to stabilize the medical condition such as, but not limited to: diabetes, asthma, or chronic obstructive pulmonary disease. See billing instructions in the Hospital Supplemental guide on the Division’s website for additional information.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0450 – Provider Preventable Conditions

(1) Health Care-Acquired Conditions (HCAC):

(a) Formally known as Medicare's list of "hospital acquired conditions" (HAC) that apply to inpatient hospital settings with dates of admission on or after January 1, 2011 except those hospitals exempt from the reporting requirements.

(b) For inpatient hospital admissions on or after July 1, 2012, all in-state, contiguous and non-contiguous hospitals must report health care-acquired conditions.

(A) A HCAC is a condition that is reasonably preventable and was not present or identified at the hospital admission.

(B) A "present on admission" (POA) indicator is a status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that developed during an outpatient encounter. This includes, but is not limited to the emergency department, observation, and outpatient surgery.

(C) The Division of Medical Assistance Program (Division) shall use the most recent list of conditions identified as non-payable by Medicare. The Division may revise through addition or deletion the selected conditions at any time during the fiscal year.

(D) Diagnosis-related groups (DRG) and percentage paid hospitals must submit a POA indicator for the principal diagnosis and every secondary diagnosis code. A valid POA indicator must be included all inpatient hospital claims. Claims without a valid POA indicator shall be denied.

(E) Critical Access Hospitals (CAH) must implement the POA reporting requirements by September 1, 2013.

(F) For a complete list of HCACs and billing instructions please see the hospital supplemental guide.

(2) Other Provider-Preventable Conditions (OPPC):

(a) Applies to any health care setting, including but not limited to inpatient and outpatient hospital settings.

(b) Effective July 1, 2012 the Agency shall no longer cover the following conditions identified by the National Coverage Determinations (NCD):

(A) Wrong surgical or other invasive procedure performed on a patient;

(B) Surgical or other invasive procedure performed on the wrong body part;

(C) Surgical or other invasive procedure performed on the wrong patient.

(c) To protect the access to care the Division requires:

(A) No reduction in payment for a Provider Preventable Conditions (PPC) will be imposed on a provider when an identified PPC for a client existed prior to the initiation of treatment for that client by that provider.

(B) Reductions in provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Division reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

(3) For clients with both Medicare and Medicaid (duals) the agency may not act as secondary payer for Medicare non-payment of HCAC.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0550 – X-Ray or EKG Procedures Furnished in Emergency Room

The Division of Medical Assistance Programs (Division) pays for only one interpretation of an x-ray or EKG procedure furnished to an emergency room patient, and that is for the interpretation and report that directly contributed to the diagnosis and treatment of the patient. A second interpretation of an x-ray or EKG is considered to be for quality control purposes only, and is not reimbursable. Payment will be made for a second interpretation only under unusual circumstances, such as questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

Stat. Auth.: ORS 413.042

Stats. Implemented : ORS 414.065

410-125-0600 – Non-Contiguous Out-of-State Hospital Services

(1) Non-contiguous out-of-state hospitals are those hospitals located more than 75 miles from the Oregon border.

(2) The hospital must be enrolled as a provider with Oregon Medical Assistance Programs to receive payment. Contact the Division of Medical Assistance Programs (Division) for information on enrollment.

(3) Billings are sent to the Division.

(4) When the service provided is emergent or urgent, no prior authorization is required. The claim should be sent to the Division along with documentation supporting the emergent or urgent requirement for treatment.

(5) In a non-emergency situation, prior authorization is required for all services. Contact the Division.

(6) Claims must be billed on the electronic 837I or on a paper CMS 1450 (UB-04), unless other arrangements are made for billing through the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0620 – Special Reports and Exams and Medical Records

Refer to the Division of Medical Assistance Programs' Administrative Exams and Reports Billing Program rules (chapter 410, division 150) for information and instructions on billing for administrative exams and reports.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0640 Third Party Payers – Other Resources, Client Responsibility and Liability

(1) Medicare: Do not send claims to the Division of Medical Assistance Programs (Division) until they have been billed to and adjudicated by Medicare:

(a) Exception: Take home drugs and other services, which are not covered by Medicare, may be billed directly to the Division without billing Medicare first;

(b) See: billing instructions in the Hospital Services Supplemental Information on the Division's website for additional information on billing Medicare claims.

(2) Other Insurance. With the exception of services described in the General Rules Program, bill all other insurance first before billing the Division. Report the payments made by the other insurers.

(3) Motor vehicle accident fund:

(a) Enter 01 (Auto Accident) in the Occurrence Code Block and give the date of the accident;

(b) For all other clients, bill all other resources before billing the Division. Do not bill the Motor Vehicle Accident Fund.

(4) Employment Related Injuries: Enter 04 (Employment Related Accident) in the Occurrence Code Block and give the date of the injury.

(5) Liability:

(a) Liability refers to insurance that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages;

(b) The provider may bill the insurer for liability prior to billing the Division. The provider may not bill both the Division and the insurer;

(c) The provider may bill the Division after receiving a payment denial from the insurer; however, the Division billing must be within 12 months of date of service. Payment accepted from the Division is payment in full;

(d) The provider may bill the Division without billing the liability insurer. However, payment accepted from the Division is payment in full. The payment made by the Division may not later be returned in order to pursue payment from the liability

insurer. When the provider bills the Division, the provider agrees not to place any lien against the client's liability settlement;

(e) The provider has 12 months from the date of service to bill the Division. No payment will be made by the Division under any circumstances once the one year limit has passed if no billing has been received within that time.

(6) Adoption agreements. Adopting parents and/or an adoption agency may be considered a prior resource. In some instances, the Division makes reimbursement to hospitals and other providers for services provided to a mother whose baby is to be adopted. The Division may also make reimbursement for services provided to the infant. Some adoption agreements, however, stipulate that the adoptive parents will make payment for part or all of the medical costs for the mother and/or the child. In these instances, the adoptive parent(s) and/or agency are a third party resource and should be billed before billing the Division for this service.

(7) Veteran's Administration benefits:

(a) Some clients have limited benefits through the Veterans' Administration. Hospitals must bill the Veterans' Administration for VA covered services before billing the Division;

(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.

(8) Trust funds. Some individuals will have trust funds that will pay for medical expenses. Occasionally a special trust fund will be set up to pay for extraordinary medical expenses, such as a transplant. These, and other trusts which pay medical expenses, are considered a prior resource. Bill the trust fund prior to billing the Division for services that are covered by the trust fund.

(9) Billing the client. A provider may bill the client or any financially responsible relative or representative of that individual only as allowed in OAR 410-120-1280.

(10) The hospital may not bill the client under the following circumstances:

(a) For services which are covered by the Division;

(b) For services for which the Division has made payment;

(c) For services billed to the Division for which no payment is made because third party reimbursement exceeds the Division maximum allowed amount;

(d) For any deductible, coinsurance or co-pay amount;

(e) For services for which the Division has denied payment to the hospital as a result of one of the following:

(A) The hospital failed to supply the correct information to the Division to allow processing of the claim in a timely manner as described in these rules and the General Rules Program;

(B) The hospital failed to obtain prior authorization as described in these rules;

(C) The service provided by the hospital was determined by or the Division not to be medically appropriate; or

(D) The service provided by the hospital was determined by the QIO not to be medically appropriate, necessary, or reasonable.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0641 – Medicare

(1) A Medicare/Medicaid claim can automatically be sent to the Division of Medical Assistance Programs (Division) after adjudicated by Medicare. This saves the effort of a second submission, as well as ensuring a more accurate and speedier payment by the Division. Medicare will automatically transmit the correct Medicare payment, coinsurance, and deductible information to the Division.

(2) Hard copy billings sent to Medicare can also be automatically sent to the Division. Refer to the Hospital Services Program Supplemental Information for specific billing instructions.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0720 – Adjustment Requests

(1) Most overpayment and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a Centers for Medicare and Medicaid Services, CMS 1450 (UB-04) for processing. All overpayments must be reported. Overpayments will be taken from future payments.

(2) Much of the information required on the Adjustment Request Form is printed on the paper Remittance Advice or the electronic 835. Documentation may be submitted to support the request. Attach a copy of the claim and paper Remittance Advice or the electronic 835 to the Adjustment Request (DMAP 1036). Adjustment requests must be submitted in writing to the Division of Medical Assistance Programs (Division).

(3) Complete adjustment instructions can be found in Hospital Services Program Supplemental Information.

Stat Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-1020 – Filing of Cost Statement

(1) The hospital must file an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital with Division of Medical Assistance Programs (Division):

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with the Division, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the Division 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., Diagnosis-Related Groups (DRG) payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(2) Twelve months after the hospital's fiscal year end, the Division will send the hospital a computer printout listing all transactions between the hospital and the Division during that auditing period. The Calculation of Reasonable Cost statement (DMAP 42) is due within 90 days of receipt by the hospital of the computer printout. Failure to file within 90 days may result in a 20 percent reduction in the payment rate:

(a) Hospitals without an agreement with Medicare may be subject to a field audit;

(b) Hospitals without an agreement with Medicare are required to submit a financial statement giving details of all assets, liabilities, income, and expenses, audited by a Certified Public Accountant.

(3) Improperly completed or incomplete Calculation of Reasonable Cost statements will be returned to the hospital for proper completion. The statement is not considered to be filed until it is received in a correct and complete form.

(4) If a hospital knowingly, or has reason to know, files a cost statement containing false information, such action constitutes cause for termination of its agreement with the Division. Hospitals filing false reports may also be referred to prosecution under applicable statutes.

(5) Each Calculation of Reasonable Cost statement submitted to the Division must be signed by the individual who normally signs the hospital's Medicare reports, federal income tax return, and other reports. If the hospital has someone, other than an

employee prepare the cost statement, that individual will also sign the statement and indicate his or her status with the hospital.

(6) Notwithstanding subsection (1) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained. The hospital must file with the Division, an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital:

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with the Division, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the DMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(7) Inpatient rehabilitation facilities are exempt from filing an annual calculation of reasonable Cost (DMAP 42) and not cost settled.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-1040 – Accounting and Record Keeping

(1) All records for a given fiscal period must be kept for three years after the Medicare audit for that period has been finalized.

(2) Each hospital is required to make its financial records available for auditing within the state of Oregon at a location specified by the provider.

(3) All hospital records are subject to inspection and review by the Division of Medical Assistance Programs (Division) personnel and Department of Health and Human Services personnel during the period the records are required to be held.

(4) All expenses must be documented in detail as a part of the record. All capital expenditures requiring approval under the Certificate of Need process, and not having such approval, will be disallowed.

(5) Hospitals without a Medicare agreement must use the Hospital Administrative Services (HAS) system of reporting.

(6) Record keeping and reporting must be based on date of service, not date of payment. Billings for patients determined by the Division to be eligible for Title XIX or Program 5 must be included as accruals, even those billings not yet paid.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-1060 – Fiscal Audits

(1) Year-end fiscal audits will include retrospective examination and verification of claims and the determination of allowable charges and costs of hospital services provided to the Division of Medical Assistance Programs' (Division) clients.

(2) The principal source document for the fiscal audit of Title XIX/Title XXI and General Assistance patient billings and payments for a given fiscal period is the Division's data processing printout. This printout includes all transactions for the audit period. Using gross totals from this printout and applying other information from Division records, information received from the hospital, and other sources, the Division will compile detailed schedules of adjustments and revise the gross totals. A revised Calculation of Reasonable Cost Statement (DMAP 42) will be prepared using revised totals and information from the Medicare report.

(3) Cost Settlements: The Division will send the hospital a letter stating the amount of underpayment or overpayment calculated by the Division for the fiscal year examined. The letter will also state the hospital's inpatient/outpatient interim reimbursement rate for the period from the effective date of the change until the next fiscal year's audit is completed. Payment of the cost-settlement amount is due and payable within 30 days from the date of the letter.

(4) The Division, at its discretion, may grant a (30) thirty-day extension for the purpose of reviewing the cost settlement upon a written request by the hospital. If a (30) thirty-day extension is granted, payment of the cost settlement amount is due within sixty (60) days from the date of the letter. If the provider chooses to appeal the decision or rate, a written request for an administrative review, or contested case must be received by the Division within (30) thirty-days of the date of the letter notifying the hospital of the settlement amount and interim rate, or within sixty (60) days if the Division has granted a thirty (30) day extension, notwithstanding the time limits in OAR 410-120-1580(3) or 410-120-1660(1). Upon receipt of the request, the Division will attempt to resolve any differences informally with the provider before scheduling the administrative review or hearing.

(5) Under extraordinary circumstances, the Division, at its discretion, may negotiate a repayment schedule with a hospital. The hospital may be required to submit additional information to support the hospital's request for a repayment schedule. The hospital will be required to pay interest associated with extended payments granted by the Division.

(6) The revised Calculation of Reasonable Cost, copies of adjustment schedules, and a copy of the printout are available to the hospital upon request. For Type A rural hospitals the Calculation of Reasonable Cost Statement will reflect the difference between payment at 100% of costs and payment for dates-of-services on or after January 1, 2006 under the fee schedule for clinical laboratory services provided by the hospital. An adjustment to the Cost Settlement will be made to reimburse a Type A hospital at 100% of costs for laboratory and radiology services provided to Medical

Assistance Program clients during the period the hospital was designated a Type A hospital. Settlements to Type B and Critical Access hospitals will be made within the legislative appropriation.

(7) The adjusted Professional Component Cost-to-Charge ratio(s) will be applied to all corresponding revenue code charges as listed on the Hospital Claim Detail Reports for cost settlements finalized on or after October 1, 1999.

(8) Hospital Based Rural Health Clinics shall be subject to the rules in the Hospital Services for the Oregon Health Plan Guide for Type A and B Hospitals. Hospital Based Rural Health Clinics cost settlements for dates of service from January 1, 2001 shall be finalized to cost.

(9) No interim settlements will be made. No settlements will be made until after receipt and review of the audited Medicare cost report.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-1070 – Type A and Type B Hospitals

(1) Type A and Type B hospitals must submit the following information to the Division of Medical Assistance Programs (Division):

(a) The aggregate percent increase in patient charges and the effective date of the increase within 30 days following the end of their fiscal year for increases in the preceding year. Aggregate percent increase in patient charges is defined as the percent increase in patient revenues due to charge increases; and

(b) The amount of payment received by the hospital, from each Division-contracted managed care plan and third-party payers, for inpatient and outpatient hospital services provided to managed care members, within the hospital's fiscal year.

(2) When a hospital is contracted with a Prepaid Health Plan (PHP), within thirty (30) days of the Division’s request, the hospital will supply to the Division the following information:

(a) The name of the contracting PHP; and

(b) The dates for which the contract will be effective; and

(c) The contracted services and reimbursement rates.

(3) The hospital and PHP must coordinate payment information to verify and return the PHP payment data file sent by the Division within ninety (90) days from date the data file is received by the hospital.

(4) Failure to supply the requested information within timelines stated may result in a discretionary sanction or fine (see OAR 410-120-1440). No sanction or fine will be imposed if the Division determines, at its sole discretion, that the hospital was unable to coordinate payment information with the PHP through no fault of the hospital’s own.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-1080 – Documentation

(1) Federal regulations require Medicaid providers to maintain records that fully support the extent of services for which payment has been requested, and that such records be furnished to the Division upon request (**42 CFR 431.107**).

(2) When requested by the Division or its medical review contractor, hospitals must submit sufficient medical documentation to verify the emergency nature, medical necessity, quality and appropriateness of treatment, and appropriateness of the length of stay for inpatient and outpatient hospital services. The Division may request sufficient information to evaluate the accuracy and appropriateness of ICD-10-CM Coding for the claim. In addition, the Division may request an itemized billing for all services provided. The Division will specify in its request what documentation is required

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

410-125-2000 – Access to Records

(1) Providers must furnish requested medical and financial documentation within 30 calendar days from the date of request. Failure to comply within 30 calendar days shall result in recovery of payment(s) made by the Division for services being reviewed.

(2) The Division conducts post payment review of admissions and claim records. The Division may request records from a hospital or may request access to records while at the hospital.

(3) The hospital has 30 days to provide the Division with copies of records. In some cases, there may be a more urgent need to review records.

(4) The Medical Payment Recovery Unit (MPRU) conducts recovery activities for the Division involving third party liability resources. MPRU may request records from the hospital. This unit has the same right to medical and financial information as the Division.

Stat. Auth.: 413-042

Stats. Implemented: ORS 414.065

410-125-2020 – Post Payment Review

(1) All services provided by a hospital in the inpatient or outpatient setting are subject to post-payment review by the Division. Both emergency and non-emergency services may be reviewed. Claims for services may be reviewed to determine:

(a) The medical necessity of the admission or outpatient services provided;

(b) The appropriateness of the length of stay;

(c) The appropriateness of the plan of care;

(d) The accuracy of the ICD-10 coding and DRG assignment;

(e) The appropriateness of the setting selected for service delivery;

(f) The quality of care of the services provided;

(g) The nature of any service coded as emergent;

(h) The accuracy of the billing;

(i) The care furnished is appropriately documented.

(2) If the Division determines that a hospital service was not within Division coverage parameters, the hospital and attending physician shall be notified in writing and will have twenty days to provide additional written documentation to support the medical necessity of the admission and/or procedure(s).

(3) If the recommendation for denial is upheld by the Division, the hospital and/or practitioner may request a reconsideration of the denial within 30 days of the receipt of the denial.

(4) If the reconsidered decision is to uphold the denial, payment to all providers of service shall be recovered.

(5) The hospital and/or practitioner may appeal any final decision through the Division administrative appeals process.

(6) No payment shall be made by the Division for inpatient services if the Division or Medicare has determined the service is not medically necessary and/or appropriate.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-2030 – Recovery of Payments

(1) Payments made by the Division of Medical Assistance Programs (Division) shall be recovered for:

(a) Services identified by the provider as emergent or urgent, but determined on retrospective review not to have been emergent or urgent. Payment shall also be recovered from the admitting and/or performing physician;

(b) Services determined by the Division that the readmission to the same hospital was the result of a premature discharge;

(c) Services were billed but not provided;

(d) Services provided at an inappropriate level of care, which includes the setting selected for service delivery;

(e) The Division non-covered services;

(f) Services, which were covered by a third party payer or other resources; or

(g) Services denied by a third party payer as not medically necessary.

(2) Payment to a physician and other providers of service for inpatient non-urgent or non-emergent services requiring prior authorization is subject to recovery by the Division if recovery is made from the hospital.

(3) If review by the Division results in a denial, the hospital may appeal any final decision through the Division Administrative Appeals process. See Administrative Hearings (chapter 410, division 120).

(4) As part of the Utilization Review Program, the Division shall develop and maintain a data system profiling the patterns of practice of institutions and practitioners. As a result of these profiles, the Division may initiate focused reviews. Any practitioner or hospital subject to a focused review shall be notified in advance of the review.

(5) All providers having a pattern of inappropriate utilization or inappropriate quality of care according to the current standards of the medical community and/or abuse of the Division rules or procedures shall be subject to corrective action. Actions taken shall be those determined appropriate by the Division, or sanctions established under the Oregon Revised Statues (ORS) or Oregon administrative rule and/or referral to a State or Federal authority, licensing body or regulatory agency for appropriate action.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-2040 – Provider Appeals - Administrative Review

(1) A provider may request an administrative review regarding the decision(s) by the Division of Medical Assistance Programs (Division) that affect the services they provide or have provided. See General Rules Program (chapter 410, division 120).

(2) A requests for an administrative review must be submitted in writing to the Medicaid Administrator, 500 Summer Street NE, E49, Salem, OR 97301-1079.

(3) The request must be received within 30 days of the date of notification of the payment decision or notification of change in reimbursement.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-2060 – Provider Appeals - Hearing Request

If the hospital disagrees with the Division calculation of reasonable costs for outpatient services or inpatient services, the outpatient interim rate, Diagnosis-Related Groups (DRG) based prospective payment for inpatient services, the calculation of the hospital's unit value, or any other hospital reimbursement methodologies or payments, a written request for an appeal may be made to the Division in accordance with the General Rules Program (chapter 410, division 120). A hearing request must be received not later than 30 days following the date of the notice of action. At the time of appeal, the hospital must submit any data the hospital wants the Division to consider in support of the appeal. The appeal will be conducted as described in the General Rules Program.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-2080 – Administrative Errors

(1) If a hospital has been given incorrect information by Division of Medical Assistance Programs, or Children, Adults, and Families Programs, or Seniors and People with Disabilities/staff, and services were provided on the basis of this information and payment has been denied as a result, the hospital may submit a request for payment as an administrative error.

(2) Include the following:

(a) An explanation of the problem;

(b) Any documents supporting the request for payment;

(c) A copy of any paper remittance advice or electronic 835 printouts received on this claim;

(d) A copy of the original claim.

(3) Send the request: Division of Medical Assistance Programs, Provider Inquiry, Administrative Errors, 500 Summer Street NE, E-44, Salem, OR 97301-1077.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065