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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
03/22/2024 11:42 AM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Clarify Language, Add Definitions, Update References and Repeal Obsolete Rules.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 04/21/2024 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

410-120-0000 Updating Definitions, including care coordination, 'Licensed practitioner of the healing arts" (LPHA), to align language and content with CCO contract agreements for HRSN benefits.
410-120-1280 Cleaning up language around 340B entities, and clarifying confusing language.
410-120-0045 Clean up confusing language in Section (9) for Out Stationed Outreach Worker (OSOW)
410-120-1195 No Text. Repeal the rule when no longer needed for anyone wo was on OSIP-MN Medically Needy Program as of January 21, 2003
410-120-1340 Rate increases for OHP providers
410-120-1870 No Text. Repeal Rule, we no longer require Client Premium Payments

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Suggestions from members and providers to improve clarity of rules, and federal guidelines for rate changes.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

Removing outdated rules will remove confusion. Improving clarity in the rules allows more community members access to understanding the rules. Updating rates allows providers to be paid the correct rate for services that help the community.

FISCAL AND ECONOMIC IMPACT:

410-120-1340 updating the rates increases payments to providers for services. No other fiscal impact.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) No impact.

(2)

(a) No cost on small businesses

(b) No changes or costs

(c) Not changes or costs

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Impacted small businesses were engaged by the External Relations Division, and invited to comment and participate in the RAC.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-120-0000, 410-120-0045, 410-120-1195, 410-120-1280, 410-120-1340, 410-120-1870

AMEND: 410-120-0000

RULE SUMMARY: Updating Definitions, including care coordination, 'Licensed practitioner of the healing arts" (LPHA), to align language and content with CCO contract agreements for HRSN benefits.

CHANGES TO RULE:

410-120-0000
Acronyms and Definitions ¶

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program, (i) OAR 410-141-3500 Acronyms and Definitions, (ii) 410-200-0015 General Definitions, and (iii) any appropriate governing acronyms and definitions in the Oregon Department of Human Services (Department) administrative rules set found in chapters 411, 413, or 461 or contact the Division.¶
(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.¶
(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a Coordinated Care Organization (CCO) member, refer to OAR 410-141-3500.¶
(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶
(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶
(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶
(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice

price of the item, supply, or equipment plus any shipping or postage for the item.¶
(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶
(8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the Oregon Health Plan (OHP) 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.¶
(10) "Adults and Youths Discharged from an Institution for Mental Disease (IMD)" means Members who have been discharged from an IMD (as such term is defined in 42 CFR 435.1010) within the last 365 calendar days. Eligibility for HRSN Services shall expire on the 366th calendar day after discharge from an IMD.¶
(11) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 365 calendar days, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections, or tribal correctional ~~facilities, or immigration detention~~ facilities. Eligibility for HRSN Services shall expire on the 366th calendar day after release from a carceral facility.¶
(12) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
(13) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶
(14) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
(15) "Affiliation" means for provider requesting enrollment or revalidation as an Oregon Medicaid provider any of the following:¶
(a) Five (5) percent or greater direct or indirect ownership interest that an individual or entity has in another organization;¶
(b) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization;¶
(c) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization, either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization; includes sole proprietorships;¶
(d) An interest in which an individual is acting as an officer or director of a corporation; or¶
(e) Any payment assignment relationship under 42 CFR 447.10(g).¶
(16) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.¶
(17) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶
(18) "All-Inclusive Rate" or "Bundled Rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.¶
(19) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, Area Agencies on Aging (AAAs), and federally recognized American Indian tribes).¶
(20) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with a Managed Care Entity (MCE), including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶
(21) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
(22) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).¶
(23) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶

(24) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.¶
(25) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).¶
(26) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
(27) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
(28) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶
(29) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.¶
(30) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages.¶
(31) "At Risk of Homelessness" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.¶
(32) "Atypical Provider" means an entity able to enroll as a Billing Provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
(33) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(34) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.¶
(35) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.¶
(36) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
(37) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(38) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
(39) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶
(40) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(41) "Benefit Package" means the package of covered health care services for which the client is eligible.¶
(42) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.¶
(43) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶
(44) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶
(45) "By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care shall facilitate evaluation.¶

(46) "Care Coordination" means the act and responsibility of CCOs to deliberately organize a members service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member.¶
(47) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.¶
(~~47~~8) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.¶
(~~48~~9) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
(~~49~~50) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.¶
(5~~0~~1) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(5~~1~~2) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
(5~~2~~3) "Citizenship Waived Medical (CWM) Benefit Package" means the coverage and limitations defined in OAR 410-134-0005(2) for individuals who met the eligibility requirements in OAR 410-200-0240(1).-The CWM Benefits Package ended on June 30, 2023.-See OARs 410-134-0005 and 410-200-0240.¶
(5~~3~~4) "Citizenship Waived Medical Plus (CWX) Benefit Package" means coverage and limitations described in OAR 410-134-0005(2) for CWM individuals who were pregnant or in their post-partum period and meet the eligibility requirements defined in OAR 410-200-0240(2). The CWM Benefits Package which was previously referred to as "CWX", ended on June 20, 2023.-See OARs 410-134-0005 and 410-200-0240.¶
(5~~4~~5) "Claimant" means an individual who has requested a hearing.¶
(5~~5~~6) "Client" means an individual found eligible to receive OHP health services.¶
(5~~6~~7) "Climate-Related Supports" means climate-related devices and services provided to HRSN Eligible Members in their own home or non-institutional, non-congregate primary residence and for whom such equipment and support are Clinically Appropriate as a component of health services treatment or prevention. HRSN Eligible Members are eligible for new climate-related devices only every thirty-six (36) months.-¶
(a) Clinically Appropriate climate-related devices for Member homes, non-institutional, non-congregate primary residence include:-¶
(i) Air conditioners for individuals at health risk due to significant heat;¶
(ii) Heaters for individuals at increased health risk due to significant cold;¶
(iii) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;¶
(iv) Mini refrigeration units as needed for individuals for medication storage; and¶
(v) Portable power supplies (PPSs) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs (PSPS) that may compromise their ability to use medically necessary devices.¶
(b) Climate-Related Support services include, as may be needed by the Member, the provision and service delivery of the climate-related devices identified above and device maintenance.-For air conditioners, Climate-Related Support services shall also include installation as needed by the Member. Ensuring safe utilization may also include an attestation from the member that they can safely and legally install the device in their primary, non-institutional place of residence.¶
(5~~7~~8) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶
(5~~8~~9) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(~~59~~60) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
(6~~0~~1) "Clinically Appropriate" means having at least one HRSN Clinical Risk Factor and at least one HRSN Social Risk Factor, each of which must be applicable to the HRSN Service for which the Member is authorized. For example, to determine if a Member should be authorized to receive Climate-Related Supports, the member must, in addition to belonging to an HRSN Covered Population, have at least one HRSN Climate Device Clinical Risk Factor and one HRSN Climate Device Social Risk Factor. HRSN Services are not Clinically Appropriate if they are solely for the convenience or preference of the Member.¶
(6~~1~~2) "Closed Loop Referral" means the process of exchanging information between and among an MCE, the

Oregon Health Authority (which may include its Fee For Service (FFS) Program), a Member, HRSN Service Providers, and other similar organizations, to make referrals and communicate about the status of referrals for a Member.¶
(6~~2~~3) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶
(6~~3~~4) "Community Health Worker" means an individual who:¶
(a) Has expertise or experience in public health;¶
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
(f) Provides health education and information that is culturally appropriate to the individuals being served;¶
(g) Assists community residents in receiving the care they require;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(6~~4~~5) "Community Information Exchange" and "CIE" each means a software application that is utilized by a network of collaborative partners using technology systems to exchange information for the purpose of connecting individuals to the services and supports they need. CIE functionality must include Closed Loop Referrals, a shared resource directory, and documentation of consent to the use of technology by the Member or other individual being connected to services.¶
(6~~5~~6) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶
(6~~6~~7) "Community Partner" means an individual affiliated with an organization contracted, trained, and certified by the Oregon Health Authority's Community Partner Outreach Program to provide free assistance to people applying for health coverage in Oregon that includes but is not limited to:-¶
(a) Helping with health coverage application;¶
(b) Helping with enrolling in health insurance plans;-¶
(c) Assisting with health coverage renewal assistance;¶
(d) Helping with Healthcare System Navigation defined in OAR 410-120-0000; and¶
(e) Outreach and engagement related to subsections (a) through (d) of this rule.-¶
(6~~7~~8) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
(6~~8~~9) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission (HERC), constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
(~~69~~70) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:¶
(a) A client or member or their representative;¶
(b) A member of an MCE after resolution of the MCE's appeal process;¶
(c) An MCE member's provider; or¶
(d) An MCE.¶
(7~~0~~1) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
(7~~1~~2) "Contiguous Area Provider" means a provider practicing in a contiguous area.¶
(7~~2~~3) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.¶
(7~~3~~4) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).¶

(745) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered.¶
(756) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.¶
(767) "Cover All Kids (CAK)" meaning defined in OAR 410-200-0015.¶
(778) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules. Covered services include:¶
(a) Services described in the Prioritized List of Health Services above the funding line set by the legislature;¶
(b) Ancillary Services OAR 410-120-0000 (22);¶
(c) Diagnostic Services OAR 410-120-0000 (82);¶
(d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and¶
(e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 Division 151.¶
(789) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
(7980) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.¶
(801) "Credible Allegation of Fraud" means an allegation for fraud, which has been verified by the Authority or delegate, from any source, including but not limited to: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have the indicia of reliability and the Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.¶
(812) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.¶
(823) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.¶
(834) "Deactivation" means an action prohibiting a provider's participation where the Authority assigned provider number is terminated as the result of inactivity, as evidenced by failure to submit claims for eighteen (18) months, or relocation, as evidenced by returned/undeliverable mail by the United States Postal Service or any other mail carrier.¶
(845) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶
(856) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶
(867) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶
(878) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶
(889) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶
(890) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶
(901) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶
(912) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.¶
(923) "Dentally Appropriate"¶
(a) means dental services, items or dental supplies that are:¶
(A) Recommended by a licensed health provider practicing within the scope of their license; and¶
(B) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶

(C) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and¶
(D) The most cost effective of the alternative levels or types of health services, items or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement.¶
(b) All covered services must be dentally appropriate for the member or client but not all medically appropriate services are covered services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410, Division 151.¶
(934) "Oregon Department of Human Services (Department or ODHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.¶
(945) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(956) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶
(967) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(978) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶
(989) "Dietitian" means an individual licensed by the Board of Licensed Dietitians to provide nutrition services as outlined in the Standards of Practice in the OR Administrative Rules, Chapter 834, Division 60 (OAR 834-060-0000).¶
(99100) "Division" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶
(1001) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom-built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶
(1012) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means the program requiring specific coverage for children and young adults, as described in chapter 410 Division 151.¶
(1023) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶
(1034) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.¶
(1045) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.¶
(1056) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.¶
(1067) "Emergency Health Benefit Funding" means funding for the health benefits defined in 410-134-0004(2)(a-j), included in the Healthier Oregon benefits package that is in part funded with state funding and matched with federal funds (42 CFR 440.255).¶
(1078) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity 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 placing the health of the individual (or with respect to the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.¶
(1089) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical

service is available.¶
(1109) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.¶
(1101) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings.¶
(1112) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result, or has resulted, in an overpayment.¶
(1123) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.¶
(1134) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:¶
(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;¶
(b) Is qualified to participate in 340B discount purchasing as an HTC;¶
(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has an identification number that is listed in the HTC directory on the CDC website;¶
(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and¶
(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.¶
(1145) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.¶
(1156) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.¶
(1167) "For Cause Termination" means a mandatory or discretionary termination by the Authority as is outlined in OAR 410-120-1400.¶
(1178) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶
(1189) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.¶
(1192) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶
(1201) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶
(1212) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶
(1223) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and

screenings for clients within their scope of practice, licensure, or certification.¶
(1234) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. The Division uses HCPCS codes; however, the Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.¶
(1245) "Healthcare System Navigation" means the process by which a Community Partner supports individuals who are in need of health care by:¶
(a) Assisting with application for or renewal of Oregon Health Plan (OHP); ¶
(b) Assisting with the management of the application process for OHP;¶
(c) Assisting with accessing available benefits;¶
(d) Identifying and removing barriers to care;¶
(e) Providing the information needed to build the knowledge and confidence necessary for utilizing benefits; or¶
(f) Promoting the establishment of healthcare services and continuity of care.¶
(1256) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.¶
(1267) "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶
(1278) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.¶
(1289) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.¶
(1293) "Healthier Oregon" means the medical assistance benefit package that is equal to the OHP Plus benefit package defined in OAR 410-120-1210. The Healthier Oregon is for individuals;¶
(a) Who do not meet the citizenship and non-citizen status requirements defined in OAR 410-200-0215 and 461-120-0110; and¶
(b) Who do meet the financial and other non-financial eligibility requirements for a Health Systems Division (HSD) Medical Program (see OAR Chapter 410 Division 200) or an Oregon Supplemental Income Program Medical (OSIPM) Program (see OAR Chapter 461).¶
~~(130) "Health-Related Social Needs" and "HRSN" each means the unmet climate-related needs that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.¶~~
(131) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.¶
(132) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.¶
(133) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.¶
(134) "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.¶
(135) "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(136) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(137) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement

and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.¶
(138) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short-term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.¶
(139) "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for the Division.¶
(140) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶
(141) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.¶
(142) "Health-Related Social Needs" and "HRSN" each means the unmet climate-related needs that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.¶
(143) "HRSN Climate Device Clinical Risk Factor" means any one the climate device-specific clinical risk factors detailed in the CMS approved HRSN services protocol.¶
(1434) "HRSN Climate Device Social Risk Factor" "HRSN Climate Device Social Risk Factor" means an individual who resides in their own home or non-institutional~~, non-congregate~~ primary residence ~~who has a need that will be aided by one of the following devices:~~and for whom an air conditioner~~s~~, heater~~s~~, air filtration device~~s~~, portable power suppl~~ies~~y (PPS~~s~~), and/or mini refrigeration unit~~s~~ is Clinically appropriate as a component of health services, treatment, or prevention.¶
(1445) "HRSN Clinical Risk Factor" is the generic term for any one, or combination, or all of the following:¶
(a) HRSN Climate Device Clinical Risk Factor;¶
(b) HRSN Housing Clinical Risk Factor;¶
(c) HRSN Nutrition Clinical Risk Factor.¶
(1456) "HRSN Connector" means any person or entity, including HRSN Service Providers and other similar social service organizations, that assists Members in documenting the information necessary to make an HRSN Request to an MCE for an HRSN Eligibility Screening and HRSN Service authorization.¶
(1467) "HRSN Covered Populations" means Members, except for individuals receiving the BRG service package defined in OAR 410-135-0030, who belong to one or more of the following populations, as further specified in the HRSN Guidance Document: ¶
(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD);¶
(b) Adults and Youth Released from Incarceration;¶
(c) Individuals currently or previously involved in Oregon's Child Welfare system;¶
(d) Individuals Transitioning to Dual Medicaid and Medicare Status;¶
(e) Individuals who meet the definitions of either "HUD Homeless" or "At Risk of Homelessness," as such terms are defined by HUD in 24 CFR □ 91.5.¶
(1478) "HRSN Eligibility Screening" means the process by which an MCE determines whether an individual:¶
(a) is enrolled in Medicaid;¶
(b) belongs to a Covered Population;¶
(c) has at least one HRSN Clinical Risk applicable to the HRSN Services for which they are being screened;¶
(d) has at least one HRSN Social Risk applicable to the HRSN Services for which they are being screened;¶
(e) is not receiving the same or substantially similar service from a state or federally funded program that would be received from the MCE if authorized to receive the HRSN Services; and¶
(f) meets any other additional required eligibility criteria that may apply in connection with the specific HRSN Services that may be needed.¶
(1489) "HRSN Eligible" means a Member, except for individuals receiving the BRG service package defined in OAR 410-135-0030, who meets all of the following criteria: ¶
(a) Belongs to at least one of the HRSN Covered Populations;¶
(b) Has at least one HRSN Clinical Risk Factor applicable to the HRSN Services for which they are being screened;¶
(c) Has at least one HRSN Social Risk Factor applicable to the HRSN Services for which they are being screened; and ¶

(d) Meets any additional eligibility criteria and requirements that may apply in connection with the specific HRSN Services.¶
(14~~9~~50) "HRSN Fee Schedule" means the Oregon Health Authority¶
(15~~0~~1) "HRSN Outreach and Engagement Services" means the activities performed by HRSN Service Providers or Contractor for the purpose of identifying OHP enrolled individuals presumed eligible for HRSN Climate-Related Services.¶
(a) At a minimum, HRSN Outreach and Engagement Services must include ¶
(A) Contacting and engaging Members who belong to one or more HRSN Covered Populations who are presumed to be eligible for HRSN Climate-Related Services; and¶
(B) Determining whether the Member is enrolled in the FFS Program or a CCO and, if a CCO, which one.¶
(b) HRSN Outreach and Engagement activities may also include:¶
(A) transmitting to the Member's CCO or to OHA's FFS Program (or its designated third-party contractor) the partial or complete HRSN Request Form, or information contained within, for HRSN eligibility determination and HRSN Service authorization, and/or ¶
(B) providing HRSN Eligible Members who may have a need for medical, peer, social, educational, legal, or other related services with information and logistical support necessary to connect them with the needed resource and services.¶
(15~~1~~2) "HRSN Request" means a request from an HRSN Connector organization or individual made to an MCE for the purpose of requesting that the MCE perform an HRSN Eligibility Screening. An HRSN Request is comprised of, at minimum, the name and contact information of the individual being recommended and identification of the anticipated HRSN ~~s~~Service need. An HRSN Request may also include confirmation of OHP Medicaid enrollment or confirmation the individual is a Member enrolled in the MCE's CCO (or both), as well as any other information regarding the individual's potential HRSN Eligibility. The MCE's CCO will be required to document its attempts to collect the information needed to determine eligibility.¶
(15~~2~~3) "HRSN Self-Attestation" means a written attestation made by the Member or Member Representative that they satisfy the applicable requirements necessary to establish the Member is HRSN Eligible to receive one or more HRSN Services.¶
(15~~3~~4) "HRSN Service Provider" means a private or public social service organization, community organization, or other similar individual or entity that provides HRSN Services.¶
(15~~4~~5) "HRSN Service Vendor" means any individual or entity that is contracted or procured by an MCE or an HRSN Service Provider to deliver or provide HRSN Services directly to an HRSN Eligible Member who has been approved to receive HRSN Services. Examples of HRSN Service Vendors include, without limitation, entities or individuals that deliver air conditioners, heaters, air filtration devices, Portable Power Supply (PPSs) or mini refrigeration units to the homes or non-institutional primary residences of Members, or in the case of air conditioners, additionally help to install.¶
(15~~5~~6) "HRSN Services" means Climate-Related Supports, and associated HRSN Outreach and Engagement, that address a Member's Health-Related Social Needs.¶
(15~~6~~7) "HRSN Social Risk Factor" means the need(s) of a Member related to a Health-Related Social Needs service. The HRSN Social Risk Factors are specific to each of the HRSN Services, which are Climate-Related Supports, Housing, and Nutrition.¶
(15~~7~~8) "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.¶
(15~~8~~9) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶
(15~~9~~60) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶
(16~~0~~1) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.¶
(16~~1~~2) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service.¶
(16~~2~~3) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶
(16~~3~~4) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶

(1645) "Individuals Involved with Child Welfare" means Members who are currently, or have previously been, involved in Oregon's Child Welfare System including members who are currently or have previously been: ¶
(a) In ~~foster~~"resource care" (formerly called foster care)/substitute care; ¶
(b) Receiving adoption or guardianship assistance or family preservation services; or ¶
(c) The subject of an open child welfare case in any court. ¶
~~(d) This definition is more fully described in the HRSN Guidance Document. ¶~~
(165~~5~~6) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to dual status with Medicare and Medicaid coverage. Members shall be included in HRSN Covered Population for the ninety (90) calendar days ~~(3 months)~~ preceding the date Medicare coverage is to take effect and ~~the nine (9) month~~270 calendar days after it takes effect. Eligibility for services must be determined within ~~nine (9) months~~270 calendar days after transition to dual status.¶
(166~~7~~) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)¶
(167~~8~~) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶
(168~~9~~) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.¶
(1~~69~~70) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶
(170~~1~~) "Joint Fair Hearing Request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.¶
(171~~2~~) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).¶
(172~~3~~) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.¶
(173~~4~~) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶
(174~~5~~) "Licensed practitioner of the healing arts" (LPHA) means any health practitioner who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.¶
(176) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.¶
(175~~7~~) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.¶
(176~~8~~) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:¶
(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;¶
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and

defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶
(1779) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶
(1780) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(17981) "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the provider, whether the provider is an individual, institution, organization or agency.¶
(1802) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶
(1813) "Meaningful access" means client or member-centered access reflecting the following statute and standards:¶
(a) Pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the corresponding Federal Regulation at 45 CFR Part 92 and The Americans with Disabilities Act (ADA), providers' telemedicine or telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have Limited English Proficiency (LEP) including providing access to auxiliary aids and services as described in 45 CFR Part 92;¶
(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards; and¶
(c) As applicable to the client or member, Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx;¶
(d) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring.¶
(1824) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶
(1835) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.¶
(1846) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan, or Healthier Oregon, or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).¶
(1857) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).¶
(1868) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶
(1879) "Medical Transportation" means transportation to or from covered medical services.¶
(18890) "Medically Appropriate"¶
(a) Means health services, items, or medical supplies that are:¶
(A) Recommended by a licensed health provider practicing within the scope of their license; and¶
(B) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶
(C) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and¶
(D) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment.¶
(b) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151. ¶

(1~~8~~91) "Medically Necessary" means:¶
(a) Health services and items that are required to address one or more of the following:¶
(A) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could result in health impairments or a disability; or¶
(B) The client's or member's ability to achieve age-appropriate growth and development; or¶
(C) The client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(D) The client's or member's ability to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice, when they are receiving Long Term Services or Supports (as defined in these rules);¶
(b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.¶
(19~~0~~2) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:¶
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and¶
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;¶
(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.¶
(19~~1~~3) "Medical Nutrition Therapy means" an evidence-based application of the Nutrition Care Process provided by licensed dietitians; focused on prevention, delay or management of diseases and conditions; and involving an in-depth assessment, periodic reassessment and intervention(s). (OAR 834-020-0000)¶
(19~~2~~4) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
(19~~3~~5) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.¶
(19~~4~~6) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.¶
(19~~5~~7) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages shall display less than 11 digits, but the number assumes leading zeroes.¶
(19~~6~~8) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.¶
(19~~7~~9) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
(~~198~~200) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.¶
(~~199~~201) "Non-Billing Provider" also referred to as non-payable, means a provider who is issued a provider number for purposes of rendering, ordering, referring, prescribing, data collection, encounters, or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶
(20~~0~~2) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:¶
(a) OAR 410-120-1200 Excluded Services and Limitations; and¶
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶
(c) OAR 410-141-3820 OHP Benefit Package of Covered Services;¶
(d) OAR 410-141-0520 Prioritized List of Health Services; and¶
(e) Any other applicable Division administrative rules.¶
(20~~1~~3) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site,

usually a hospital, where appropriate emergency medical care is available.¶
(2024) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.¶
(2035) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.¶
(2046) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.¶
(2057) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶
(2068) "Nursing Services" means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.¶
(2079) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶
(2108) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶
(20911) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.¶
(2102) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.¶
(2113) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued.¶
(2124) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.¶
(2135) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.¶
(2146) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶
(2157) "Oregon Health Authority (Authority)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.¶
(2168) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.¶
(2179) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon:¶
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;¶
(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.¶
(21820) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125.¶
(2219) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.¶
(2202) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.¶
(2213) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.¶
(2224) Ownership interest' means the possession of equity in the capital, the stock, or the profits of the disclosing entity. A person with an ownership or control interest is a person or corporation that:¶
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;¶
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;¶
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;¶
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing

entity;¶
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or¶
(f) Is a partner in a disclosing entity that is organized as a partnership.¶
(2235) "Participating provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(2246) "Payable Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims directly to the Authority for payment.¶
(2257) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.¶
(2268) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.¶
(2279) "Peer Support Specialist" means an individual providing services to another individual who shares a similar life experience such as (i) addiction to addiction, (ii) mental health condition to mental health condition, or (iii) family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be a self-identified individual:¶
(a) Currently or formerly receiving addictions or mental health services;¶
(b) In recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;¶
(c) In recovery from problem gambling.¶
(22830) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶
(22931) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and shall assist the patient in achieving the goals.¶
(2302) "Person-Centered Service Plan" and "PCSP" each means the HRSN-related component of the care plan that is developed in consultation with the Member upon authorization of Climate-Related Supports. The PCSP must be reviewed and revised upon reassessment of need at least every twelve (12) months, when the Member's circumstances or needs change significantly, or at the request of the Member.¶
(2313) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and considering the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(2324) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶
(2335) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(2346) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.¶
(2357) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶
(2368) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.¶
(2379) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶
(23840) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.¶
(23941) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶
(2402) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶

(2413) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(2424) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶
(2435) "Practitioner" or "Practitioner of the Healing Arts" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶
(2446) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO)¶
(2457) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶
(2468) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶
(2479) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.¶
(2485) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶
(2495) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.¶
(2502) "Provider" means an individual, facility, institution, corporate entity, or other organization enrolled or not enrolled that provides or supplies health services or items, also termed a rendering provider or participating provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶
(2513) "Provider Organization" means a group practice, facility, or organization that is:¶
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or¶
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or¶
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and¶
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;¶
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)¶
(2524) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶
(2535) "Public Health Clinic" means a clinic operated by a county government.¶
(2546) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.¶
(2557) "Public Safety Power Shutoff (PSPS)" means the temporary shutdown of electricity for the purpose of protecting communities in high fire-risk areas when experiencing extreme weather events, which could cause the electrical system to spark wildfires. The decision to implement a PSPS is usually made by the utility provider of the affected service area.¶
(2568) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶
(2579) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶
(25860) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶
(25961) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.¶

(260~~0~~2) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.¶
(261~~4~~3) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶
(262~~2~~4) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶
(263~~3~~5) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.¶
(264~~4~~6) "Reduction of Services" means situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested 20 physical therapy visits and the Division denies the individual's coverage of 20 visits, covering instead only 10 visits-this is considered a denial of a service and could be appealed.¶
(265~~5~~7) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.¶
(266~~6~~8) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.¶
(267~~7~~9) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶
(268~~8~~70) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶
(269~~9~~71) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶
(270~~2~~2) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.¶
(271~~4~~3) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶
(272~~2~~4) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶
(273~~3~~5) "Sanction" means an action against providers taken by the Authority in cases of misuse or abuse of Oregon Health Authority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.¶
(274~~4~~6) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.¶
(275~~5~~7) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶
(276~~6~~8) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.¶
(277~~7~~9) "Service location" means the location of a provider when services are rendered.¶
(278~~8~~0) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.¶
(279~~9~~81) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(280~~0~~2) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(281~~4~~3) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in

individuals or groups of individuals.¶
(28~~2~~4) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶
(28~~3~~5) "Supplemental Health Benefit State Funding" means funding for the health benefits included in the Healthier Oregon benefits package described in OAR 410-134-0004(3)(a-m). ¶
(284~~6~~) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization may meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.¶
(28~~5~~7) "Subrogation" means right of the state to stand in place of the client in the collection of Third Party Resources (TPR).¶
(28~~6~~8) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶
(28~~7~~9) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.¶
(2~~88~~90) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(2~~8~~91) "Suspension" means a temporary sanction prohibiting a provider's participation in the medical assistance programs by suspending the provider's Authority-assigned provider number for a specified period of time for one or more of the reasons in OAR 410-120-1400. No payments, Title XIX, or State Funds shall be made for services provided while the provider is suspended.¶
(29~~0~~2) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.¶
(29~~1~~3) "Telecommunication technologies" means the use of devices and services for telemedicine or telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.¶
(29~~2~~4) "Telehealth" includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration.¶
(29~~3~~5) "Telemedicine" means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member's healthcare.¶
(294~~6~~) "Termination" means a sanction prohibiting a provider's participation in the Authority's programs by canceling the provider's Authority-assigned provider number and provider agreement for one or more of the reasons in OAR 410-120-1400 and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. No payments, Title XIX, or state funds shall be made for services provided after the date of termination. Termination is permanent unless:¶
(a) The exceptions to mandatory exclusion are met; or¶
(b) Otherwise stated by the Authority at the time of termination.¶
(29~~5~~7) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶
(29~~6~~8) "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, birth doula, or other similar health workers not regulated or certified by the State of Oregon.¶
(29~~7~~9) "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon. OAR 950-060-0010(19)¶
(~~298~~300) "Transportation" means medical transportation.¶
(~~299~~301) "Trauma informed approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and

providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.¶
(30~~0~~2) "Trauma Informed Services" means those services provided using a trauma informed approach.¶
(30~~1~~3) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶
(30~~2~~4) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶
(30~~3~~5) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.¶
(304~~6~~) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III-Older Americans Act, and Title XIX of the Social Security Act.¶
(30~~5~~7) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶
(30~~6~~8) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶
(30~~7~~9) "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.¶
(3~~1~~08) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:¶
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;¶
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.¶
(3~~09~~11) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.¶
(31~~0~~2) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶
(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and¶
(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).¶
(31~~1~~3) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who may be eligible for the service at the time of the service, and the document contains:¶
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶
(31~~2~~4) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(31~~3~~5) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.
Statutory/Other Authority: ORS 413.042, 414.231, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.025

AMEND: 410-120-0045

RULE SUMMARY: Clean up confusing language in Section (9).

CHANGES TO RULE:

410-120-0045
Applications for Medical Assistance at Provider locations ¶

(1) The Oregon Health Authority (Authority) allows Division enrolled providers the opportunity to assist patients applying for public and private health coverage offered through the Authority and the Oregon Health Insurance Exchange (OHIX). To apply for this opportunity, providers fill out and submit form OHA 3128, Application Assistance by Provider Staff; this is an addendum to the provider's agreement to provide Medicaid reimbursed services. Once the provider is determined certified by the Authority to provide application assistance, providers shall receive an approval letter, requirements for assister certification, training requirements, and other information.¶
(2) For purposes of this rule, the provider's practice shall be referred to as a site. Sites can be, but are not limited to, the following:¶
(a) Hospitals;¶
(b) Federally qualified health centers/rural health clinics (FQHC/RHCs);¶
(c) County health departments;¶
(d) Substance Use Disorder adult and adolescent treatment and recovery centers;¶
(e) Tribal health clinics;¶
(f) Family Planning clinics;¶
(g) Other primary care clinics as approved by the Authority.¶
(3) The site may sign the Application Assistance by Provider Staff (OHA 3128) addendum indicating the site's willingness to provide on-site application assistance. The addendum outlines site and application assister standards as well as conflict of interest protections. The site shall require employees that ~~wi~~shall be assisting to participate in mandatory training sessions for application assistance certification. Employees must pass tests before initiating application assistance service. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Authority. For purposes of this rule, certified staff shall be referred to as "application assisters."¶
(4) Application assisters shall utilize authorized methods to provide enrollment assistance. Regardless of which form of application is used, the application assister shall write the date the application was started and the assister's assigned assister identification number in the appropriate space on the application. Application assisters shall maintain copies of all eligibility verification documents and all records related to enrollment assistance, including the required, current OHA-provided Consent Form for six years, whether in paper, electronic, or other forms in a secure and locked location. Assistance will support patients potentially eligible for public and private health coverage offered through the Authority and OHIX. Sites are not under an obligation to provide application assistance to individuals other than those for whom they are providing service. Once written on the application, the date can never be changed, altered, or backdated.¶
(5) The application assister shall encourage applicants to provide accurate and truthful information, assist in completing the application and enrollment process, and shall assure that the information contained on the application is complete. The application assister shall not attempt to pre-determine applicant eligibility or make any assurances regarding the eligibility for public or private health coverage offered through the Authority and OHIX.¶
(6) The application assister shall provide information to applicants about public medical programs and private insurance products so each applicant can make an informed choice when enrolling into a health insurance product. Language interpreters or interpreter services or referrals must be provided if requested by applicants including linguistically and culturally appropriate materials:¶
(a) The information given to the applicant shall, at a minimum, include an explanation of the significance of the date of request on the application and a review of public medical programs and private insurance products that are available, provide unbiased health coverage choices and information provided by the Authority or OHIX during the enrollment process, answer questions, and assist in filling out online or paper application forms. The information provided at these sessions may include, but is not limited to, the following:¶
(A) General eligibility criteria for public and private coverage accessible through the Authority and OHIX;¶
(B) Health plan choices, criteria, and how to enroll in public medical programs or OHIX private insurance product choices.¶
(b) The application assister shall make copies of the original eligibility verification documentation required to accompany the application, but not uploaded to ONE applicant portal.¶

(7) Providers, staff, contracted employees, and volunteers are subject to all applicable provisions under General Rules OAR chapter 410, division 120, and Application Assistance by Provider Staff addendum (OH~~A~~P 3128):¶
(a) The application assister shall treat all information they obtain for public medical programs and private insurance as confidential and privileged communications. The application assister may not disclose such information without the written consent of the individual, ~~his or he~~their delegated authority, attorney, or responsible parent of a minor child or child's guardian. Nothing prohibits the disclosure of information in summaries, statistical or other form, that does not identify particular individuals;¶
(b) The Authority and sites shall share information as necessary to effectively serve public medical programs and OHIX eligible or potentially eligible individuals;¶
(c) Personally identifiable health information about applicants and recipients shall be subject to the transaction, security, and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the administrative rules there under. Sites shall cooperate with the Authority in the adoption of policies and procedures for maintaining the privacy and security of records and for conducting transactions pursuant to HIPAA requirements.¶
(8) The Authority shall be responsible for the following:¶
(a) The Authority shall provide training to application assisters on public medical programs and private insurance products, eligibility and enrollment, application procedures, and documentation requirements. The Authority shall set dates and times for these additional training classes as needed, following changes in policy or procedure;¶
(b) The Authority shall make available public medical programs application forms online and in hard copy (in English, translated languages, and alternative formats), health insurance coverage options, assister identification number instructions, reporting guidance, and other necessary forms;¶
(c) The Authority shall process all applications in accordance with Authority and OHIX standards;¶
(d) The Authority shall process completed applications that have satisfactory verification information within the time requirements set forth in the Authority and OHIX policy. In the event of a change in policy, the time for completion of processing shall be changed to the new time requirements.¶
(9) The Authority shall provide all necessary forms and applications as referenced above at no cost to the site. There are no monetary provisions in this rule for any payment for the performance of work by the site, except for those costs provided under OAR 410-147-0400 and 410-146-0460, because there is compensation for Out Stationed Outreach Worker (OSOW) activities outlined in OAR 410-147-0400. The rules for FQHC's and RHC's are in OAR 410-146-0460 for Indian Health Care Providers (IHCPs). However, the parties acknowledge the exchange and receipt of other valuable considerations in the spirit of cooperation to the benefit of all by collaborating and authorizing the performance of the work. The Authority does not guarantee a particular volume of business under these rules.¶
(10) The provider may terminate enrollment at any time as outlined in OAR 410-120-1260(15).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.041

REPEAL: 410-120-1195

RULE SUMMARY: Repeal the rule when no longer needed for anyone wo was on OSIP-MN Medically Needy Program as of January 21, 2003.

CHANGES TO RULE:

~~410-120-1195~~
~~SB 5548 Population~~
~~Effective for services rendered on or after January 1, 2004.¶~~
~~(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by the Authority with specific health-related conditions as outlined in the Joint Ways and Means budget note accompanying Senate Bill 5548 (2003) shall be referred to as SB 5548 clients.¶~~
~~(2) SB 5548 clients are eligible for a State-funded, limited, prescription drug benefit for covered drugs described in subsection (3) of this rule.¶~~
~~(3) Eligibility for and access to covered drugs for SB 5548 clients:¶~~
~~(a) SB 5548 clients must have been participating in the former OSIP-MN Medically Needy Program as of January 31, 2003, and as of that date had a medical diagnosis of HIV or organ transplant status;¶~~
~~(b) SB 5548 clients receiving anti-retroviral and other prescriptions necessary for the direct support of HIV symptoms:¶~~
~~(A) Must agree to participate in the Authority's CareAssist Program in order to obtain access to this limited prescription drug benefit; and¶~~
~~(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at http://www.oregon.gov/oha/(pharmacy/CAREAssist/Pages/providers.aspx;¶~~
~~(c) SB 5548 clients receiving prescriptions necessary for the direct support of organ transplants are limited:¶~~
~~(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infective or other prescriptions necessary for the direct support of organ transplants;¶~~
~~(B) Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.¶~~
~~(4) Reimbursement for covered prescription drugs is limited by the terms and conditions described in this rule. This limited drug benefit provides State-funded reimbursement to pharmacies choosing to participate according to the terms and conditions of this rule:¶~~
~~(a) The Authority will send SB 5548 clients a letter from the Authority, instead of a Medical Care Identification, which will document their eligibility for this limited drug benefit;¶~~
~~(b) Retail pharmacies choosing to participate will be reimbursed for covered prescription drugs for the direct support of organ transplants described in subsection (3)(c) of this rule based upon Oregon Medicaid reimbursement levels as specified in the Division's Pharmaceutical Services Program administrative rules 410-121-0155 and 410-121-0160.¶~~
~~(c) The Authority pharmacy benefits manager, will process retail pharmacy drug benefit reimbursement claims for SB 5548 clients;¶~~
~~(d) Mail order reimbursement will be subject to the Authority contract rates;¶~~
~~(e) Prescription drugs through the CareAssist program will be subject to the Authority contract rates;¶~~
~~(f) Reimbursement for this limited drug benefit is not subject to the following rules:¶~~
~~(A) 410-120-1230, Client Copayments;¶~~
~~(B) 410-121-0300, Federal Upper Limit (FUL) for prescription drugs.~~
~~Statutory/Other Authority: ORS 413.042~~
~~Statutes/Other Implemented: ORS 414.025, 414.065~~

AMEND: 410-120-1280

RULE SUMMARY: Cleaning up language around 340B entities, and clarifying confusing language.

CHANGES TO RULE:

410-120-1280
Billing ¶

(1) A provider enrolled with the Authority or providing services to a client in a~~n~~ Managed Care Entity (MCE) under the Oregon Health Plan (OHP) may not seek payment from the client for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by the Authority under this rule.¶
(2) Identification of eligibility and third-party liability (TPL). The provider shall:¶
(a) Verify the client's eligibility for medical assistance and benefit package prior to rendering service pursuant to OAR 410-120-1140;¶
(b) Make "reasonable efforts" to identify third-party resources as described in section (10)(b) of this rule; and¶
(c) Ask the client at the point of service and verify prior to billing if the client has medical assistance, is applying for medical assistance, enrolled with an MCE or has other third-party liability.¶
(3) If a provider's patient is a medical assistance recipient, the provider must:¶
(a) Comply with the provisions in sections (10) through (12) of this rule regarding third-party resources;¶
(b) Submit a claim to the Authority or MCE, if no third-party resources are available or the provider has complied with section (2)(a) of this rule;¶
(c) Delay any billing or collection action against the patient for ninety (90) calendar days from submitting the claim to the Authority or MCE, except as authorized in section (4) of this rule;¶
(d) If no payment is received from the Authority or MCE within ninety (90) calendar days from the date ~~the claim~~a valid claim (OAR 410-120-0000) was submitted:¶
(A) Verify the patient's eligibility for the date of service;¶
(B) If the patient was not eligible for medical assistance on the date of service, proceed with the provider's normal billing and collection process; or¶
(C) If the patient was eligible for medical assistance on the date of service, and the provider does not have a completed agreement to pay form (OHP 3165, 3166, 4109), the provider is not allowed to bill the client, collect payment from the client, or assign an unpaid claim to a collection agency or similar entity pursuant to ORS 414.066, except as authorized by section (5) of this rule.¶
(4) For Medicaid covered services, the provider must not:¶
(a) Bill the Authority more than the provider's Usual Charge (OAR 410-120-0000~~(254)~~) or the reimbursement specified in the applicable Authority program rules;¶
(b) Bill the client for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Authority;¶
(c) Bill the client for services or treatments that have been denied due to provider error, except as authorized under section (5) of this rule. Examples of provider error could be things such as required documentation not submitted for a prior authorization, or a prior authorization not submitted, or an error in the information or billing codes the provider listed on the claim.¶
(5) Providers may only bill a client or a financially responsible relative or representative of that client in the following situations: ¶
(a) The client did not inform the provider of their Oregon Health plan I.D., MCE I.D. card, or third-party insurance card, or gave a name that did not match OHP I.D. at the time of or after a service was provided; therefore, the provider ~~may not~~is now unable to bill the appropriate payer for reasons including but not limited to the lack of prior authorization, or because the time limit to submit the claim for payment to the appropriate payor has passed. The provider shall verify eligibility of the client at the time of service pursuant to OAR 410-120-1140 and prior to billing or collection pursuant to OAR 410-120-1280, and document each attempt~~s~~ to obtain coverage information prior to billing the client;¶
(b) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service;¶
(c) A third-party payer made payments directly to the client for services provided.;¶
(d) Citizenship Waived Medical (CWM) Benefits Package recipients prior to June 30, 2023, that received services that are not part of the CWM emergency only benefits, must have signed the provider-completed Agreement to Pay OHP form 3165, 3166 or 4109. CWM Benefits Package coverage, limitations, and billing guidance found in OAR 410-134-0005.¶
(e) The client has requested a continuation of benefits during the contested case hearing process, and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service on or

after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the agreement to pay form OHP 3165 pursuant to section (5)(h) of this rule before providing these services to the client;¶
(f) The client has requested to privately pay for services denied as not meeting the prior authorization, HERC or other criteria. ~~Refer to~~The provider shall provide to the client all required information for a non-covered service~~s~~ in this rule section (5)(h);¶
(g) The client has requested to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all the following:¶
(A) The requested service is a covered service~~,~~ and the appropriate payer (the Authority, MCE, or third-party payer) ~~may~~would pay the provider in full for the covered service; and¶
(B) The estimated total cost of the covered service, including all related charges~~,~~ and the amount that the appropriate payer (Authority ~~or~~, MCE~~) may pay for the~~, or third-party) pays the provider for the covered service, and that the provider ~~may~~shall not bill the client for an amount greater than the amount the appropriate payer ~~may~~ pays; and¶
(C) That the client knowingly and voluntarily agrees to pay for the covered service; and¶
(D) The provider shall document~~s~~ in writing~~, signed by the client or the client's representative~~ the date and time in the client's medical record, indicating that:¶
(i) The provider gave the client or the client's authorized representative the information described in section (5)(g)(A-C) of this rule; and¶
(ii) The client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and¶
(iii) The client agreed to privately pay for the covered service by signing an agreement to pay form (OHP 3165, 3166, 4109) ; and¶
(iv) The provider ~~assures they have~~shall give~~n~~ a~~ll~~ copy of the ~~information described above; and¶~~
~~(iv) The provider must give a copy of the signed agreement to the client~~signed and dated agreement to pay form (OHP 3165, 3166, 4109) to the client and keep a copy of the form in the client's medical record. A provider ~~may~~shall not submit a claim for payment for covered services to the Authority ~~or to~~, the client's MCE, or a third-party payer that is subject to the agreement.¶
(h) ~~N~~The service is a non-covered service~~s~~ by the Authority, or MCE (non-covered services include services denied under prior authorization. Refer to OAR 410-120-0000 for a definition of non-covered services). Before providing the non-covered service, the ~~client must sign~~provider shall provide to the client of all of the following: ¶
(A) The information in this rule OAR 410-120-1280 (5)(g)(A-C) for the non-covered service; and¶
(B) the provider shall document in writing in the clients record that:¶
(C) The provider gave the client the information described in OAR 410-120-1280 (5)(g)(A-C); and ¶
(D) the client must sign and date the provider-completed ~~A~~agreement to ~~P~~pay form (OHP 3165, 3166, or 4109) or a facsimile containing all of the information and elements of the 3165 or 3166 as shown in Table 3165, 3166, or 4109 of this rule~~.~~; ¶
(i) The completed agreement to pay form (OHP 3165, 3166, 4109) or facsimile is valid only if the estimated fee for the service or good does not change and the service is scheduled within thirty (30) days of the client's signature. The completed agreement to pay form (OHP 3165, 3166, 4109) is not transferrable to a different service or good. The agreement to pay form (OHP 3165, 3166, 4109) is not valid when this form is used by the provider as a generic agreement by the client to pay for unspecified non-covered services.¶
(ii) For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy.¶
(iii) Providers must make a copy of the completed agreement to pay form (OHP 3165, 3166 or 4109 ~~form~~) or facsimile available to the Authority or MCE upon request.¶
(i) For clients agreeing to pay for services under this rule section (5) who are limited English proficient, who are deaf, or hard of hearing, the provider shall provide translation or interpretation services in advance of the client or a financially responsible relative or representative of that client, signing the agreement to pay form (OHP 3165, 3166, 4109). This includes but is not limited to providing the following without limitation:¶
(A) Written documents in appropriate languages; and ¶
(B) Interpreter services consistent with OAR 410-120-0001.¶
(6) Code set requirements:¶
(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions, and payments. Code Set has the meaning set forth in 45 CFR 162.103, and it includes the codes and the descriptors of the codes~~. Federal Code Set requirements are mandatory~~, code guidelines, and parentheticals related to the code. Federal Code Set requirements are mandatory as part of the National Correct Coding Initiative (NCCI), and the Authority lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;¶

(b) The Authority shall adhere to the Code Set requirements in 45 CFR 162.1000-162.1011;¶
(c) Periodically, the Authority shall update its provider rules and tables to conform to national codes. In the event of an alleged variation between an Authority-listed code and a national code, the Authority shall apply the national code in effect on the date of request or date of service. Providers billing the Authority shall use codes in the appropriate sequency and highest degree of specificity, append the appropriate modifiers, and indicate the appropriate and most specific place of services;¶
(d) Only codes with limitations or requiring prior authorization are noted in OAR. National Code Set issuance alone may not be construed as coverage or a covered service by the Authority;¶
(e) The Authority adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology - CPT) and on the CMS website (Healthcare Common Procedural Coding System - HCPCS). This code adoption may not be construed as coverage or as a covered service by the Authority.¶
(7) Claims:¶
(a) Upon submission of a claim to the Authority for payment, the provider agrees that it has complied with all Division program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;¶
(b) A provider enrolled with the Division shall bill using the Authority assigned provider number, or the National Provider Identification (NPI) number ~~if the NPI is available~~, pursuant to OAR 410-120-1260;¶
(c) The provider may not bill the Division more than the provider's usual charge (see Definitions) or the reimbursement specified in the applicable Division program rules;¶
(d) Claims shall be submitted on the appropriate form as described in the individual Division program rules or electronically in a manner authorized in OAR Chapter 943, Division 120;¶
(e) Medicare shall send crossover claims to the Authority or contracted health plan after adjudication by Medicare. When billing Medicare as the primary payer, claims for all Medicaid/Medicare members shall include all applicable payer information (with Medicare as primary and Medicaid as secondary) so that Medicare can automatically transmit the correct Medicare payment, coinsurance, and deductible information to the Authority or MCE;¶
(f) Claims must be for services provided within the provider's licensure or certification as required by OAR Chapter 410 Division120 and program specific rules;¶
(g) Unless otherwise specified, claims shall be submitted after:¶
(A) Delivery of service; or¶
(B) Dispensing, shipment or mailing of the item.¶
(h) The provider shall submit true and accurate information when billing the Division. Use of a billing provider does not do away with the performing provider's responsibility for the truth and accuracy of submitted information;¶
(i) A claim is considered a valid claim only if it contains all data required for processing. See the appropriate provider rules and supplemental information for specific instructions and requirements;¶
(j) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:¶
(A) Any false claim for payment;¶
(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;¶
(C) Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exception of (10)(c)(A-D) of this rule. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Division. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate Third Party Liability (TPL) Explanation Code;¶
(D) Any claim for furnishing specific care, items, or services that has not been provided.¶
(k) If an overpayment has been made by the Authority, the provider is required to do one of the following:¶
(A) Adjust the original claim to show the overpayment as a credit in the appropriate field:¶
(i) Submit an Individual Adjustment Request (OHP 1036); or¶
(ii) Adjust the claim on the Provider Web Portal at https://www.or-medicaid.gov;¶
(B) Refund the amount of the overpayment on any claim;¶
(C) Void the claim via the Provider Web Portal if the Division overpaid due to an erroneous billing;¶
(D) If the overpayment occurred because of a payment from a third-party payer refer to section (10)(f) of this rule.¶
(L) ~~A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued improper billing practices and has had an opportunity for a contested case hearing shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of the violation~~340B covered entities that bill Fee for Service (FFS) or a Coordinated Care Organization (CCO) shall follow OHA's 340B policy in order to avoid "duplicate discounts".¶
(8) Diagnosis code requirement:¶

(a) A primary diagnosis code is required on all claims, using the ICD-10-CM diagnosis code set, unless specifically excluded in individual Division program rules;¶
(b) The primary diagnosis code shall be the code that most accurately describes the client's condition;¶
(c) All diagnosis codes are required to the highest degree of specificity;¶
(d) Hospitals shall follow national coding guidelines and bill using the seventh digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.¶
(9) Procedure code requirement:¶
(a) For claims requiring a procedure code the provider shall bill as instructed in the appropriate Division program rules and shall use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;¶
(b) For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim ~~must~~shall be supported by the client's medical record and shall be the code that most accurately describes the services provided. All Providers, including Hospitals, shall follow national coding guidelines;¶
(c) When there is no appropriate descriptive procedure code to bill the Division, the provider shall use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;¶
(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider shall bill the Division using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.¶
(10) Third-Party Liability (TPL):¶
(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division shall be the payer of last resort;¶
(b) Providers shall make reasonable efforts to obtain payment first from other resources. For the purposes of this rule, "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:¶
(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;¶
(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing;¶
(C) Asking the Medicaid recipient at the point of service or prior to billing if they have other health insurance;¶
(D) If the provider identifies from the client or other source third-party insurance that is unknown to the state or that is different from what is reported in one of the Division verification systems, the provider shall report the coverage to the Health Insurance Group (HIG) using the secure online form at www.reporttpl.org.¶
(c) Except as noted in section (10)(d)(A)-(E) of this rule, when third-party coverage is known to the provider prior to billing the Division, the provider shall:¶
(A) Bill all third-party insurance the client is covered by, which could include Personal Insurance Protection (PIP) or Workers Compensation if the claim is related to a personal injury; and¶
(B) Except for pharmacy claims billed through the Division's point-of-sale system, the provider shall wait 30 days from submission date of a clean claim and have not received payment from the third party; and¶
(C) Comply with the insurer's billing and authorization requirements; and¶
(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.¶
(d) In accordance with federal regulations, the provider shall bill the TPL prior to billing the Division, except under the following circumstances:¶
(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);¶
(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;¶
(C) The covered health services are prenatal and preventive pediatric services;¶
(D) Services are covered by a third-party insurer through an absent parent where the medical coverage is administratively or court ordered;¶
(E) When a negligent third party caused an injury or illness to a client, a provider may choose to bill the Liability Insurance (see Definitions), bill the liable third party, place a lien on a tort settlement or judgement, or bill the Division. The provider may not both place a lien against a settlement and bill the Division:¶
(i) The provider may withdraw their lien and bill the Division within 12 months of the date of service; however, the provider shall accept the Division payment as payment in full;¶
(ii) The provider may not return the payment made by the Division in order to place a lien or to accept payment from a liability settlement, judgement, liability insurer, or other source.¶
(F) In the circumstances outlined in section (10)(d)(A)-(E) of this rule, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall process the claim and, if applicable, pay the

Division's allowable rate for these services and seek reimbursement from the liable third-party insurance plan;¶
(G) In making the decision to bill the Division, the provider shall be cognizant of the possibility that the third-party payer may reimburse the service at a higher rate than the Division and that once the Division makes payment, no additional billing to the third party is permitted by the provider.¶
(e) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation shall be on file in the provider's records indicating this is a non-covered service for purposes of Third-Party Resources. See the individual provider rules for further information on services that shall be billed to Medicare first;¶
(f) In the case of known third-party coverage, a provider may bill the Division if payment from the third-party coverage is not received within 30 days. If a payment is received from the third-party coverage after receiving the Division payment, the provider shall do the following within 30 days of receiving the payment:¶
(A) Submit an Individual Adjustment Request (OHP 1036) that shows the amount of the third-party payment as a credit in the appropriate field; or¶
(B) Submit a claim adjustment online at https://www.or-medicaid.gov/ProdPortal/ that shows the amount of the third-party payment as a credit in the appropriate field; or¶
(C) Refund the amount paid by the Division. The amount refunded shall be the lesser of the third-party payment or the amount paid by the Division. The check to repay the Division shall include the reason the payment is being made and either:¶
(i) An Individual Adjustment Request that identifies the original claim, name and number of the client, date of service, and items or services for which the repayment is made; or¶
(ii) A copy of the Remittance Advice showing the original Division payment.¶
(D) Failure to submit the Individual Adjustment Requests within 30 days of receipt of the third-party payment or to refund the Division payment is considered concealment of material facts and is grounds for recovery and sanction;¶
(E) Any provider who accepts payment from a client or client's representative and is subsequently paid for the service by the Division shall reimburse the client or their representative the full amount of their payment.¶
(g) If the third-party coverage is not known by the Division or the provider at the time the Division makes payment, a provider may not return the Division payment in order to bill the third-party coverage if the third-party coverage becomes known after the Division payment;¶
(h) The Division may make a claim against any third-party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursuing alternate resources includes but is not limited to requesting the provider to bill the third party and to refund the Division in accordance with this rule;¶
(i) For services provided to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment, except as noted in OAR 410-141-3565, and the provider shall honor that request. Claims submitted to Medicare shall include the Medicaid information necessary to enable electronic crossover to the Authority or contracted health plan. Under federal regulation, a provider may not charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;¶
(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals shall be timely pursued, and Medicare denial must be obtained prior to submitting the claim for payment to the Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.¶
(11) Full use of alternate resources:¶
(a) The Division shall generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;¶
(b) Except as provided in section (12) of this rule, alternate resources may be available:¶
(A) Under a federal or state worker's compensation law or plan;¶
(B) For items or services furnished by reason of membership in a prepayment plan;¶
(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity such as:¶
(i) Armed Forces Retirees and Dependents Act (CHAMPVA);¶
(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); or¶
(iii) Medicare Parts A and B.¶
(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or¶
(E) Through other reasonably available resources.¶
(12) Exceptions:¶
(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 410-146-0020, Indian Health Services facilities and Tribal facilities operating under Public

Law 93, Section 638 agreement are payers of last resort and are not considered an alternate resource or TPL;¶
(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service-related conditions and as such are not considered an alternate or TPL.¶
(13) Table 120-1280 - TPR codes.¶
(14) Table - OHP Client Agreement to Pay for Health Services, OHP 3165, 3166 or 4109.¶
[ED. NOTE: To view attachments referenced in rule text, click here for PDF copy.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.066

AMEND: 410-120-1340

RULE SUMMARY: redline for the rate increases for OHP providers that are in OAR 410-120-1340.

CHANGES TO RULE:

410-120-1340
Payment ¶

(1) The Division shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.¶
(2) Division reimbursement for services may be subject to review prior to reimbursement.¶
(3) The Division sets fee-for-service (FFS) payment rates for the billed services or items. The FFS payment rates are the Division's maximum allowable rates for billed services or items.¶
(4) The Division reimburses providers for billed services or items at the lesser of:¶
(a) The amount billed;¶
(b) The Division's FFS payment rate in effect on the date of service; or¶
(c) The rate specified in the individual program provider rules.¶
(5) The amount billed may not exceed the provider's "usual charge" (see definitions 410-120-0000).¶
(6) The Division's maximum allowable rate setting process uses the following methodology for:¶
(a) Relative Value Unit (RVU) weight-based rates. The Division updates all CPT/HCPCS codes assigned an RVU weight effective January 1 of each year, based on the annual RVU updates published in the Federal Register:¶
(A) The Division applies RVU weights as follows:¶
(i) The Non-Facility Total RVU weight, to professional services not typically performed in a facility;¶
(ii) The Facility Total RVU weight, to professional services typically performed in a facility.¶
(B) The Division applies the following conversion factors:¶
(i) $40.79 for labor and delivery codes (59400-59622);¶
(ii) $38.76 for neonatal intensive care and pediatric intensive care professional service codes (99468-99480);¶
(iii) $28.50 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider types and specialties ("Oregon Primary Care Providers and Procedure Codes") is available at http://www.oregon.gov/OHA/HSD/OHP/Pages/Providers.aspx;¶
(iv) $~~25.48~~7.11 for all remaining RVU weight-based CPT/HCPCS codes.¶
(C) The Division calculates rates using statewide Geographic Practice Cost Indices (GPCIs) as follows:¶
(i) (Work RVU) X (Work GPCI-) + (Practice Expense RVU) X (Practice GPCI-) + (Malpractice RVU) X (Malpractice GPCI-). The formula used to create the statewide GPCI is (3*(Portland GPCI) + 33* (Rest of State GPCI))/36 = GPCI.¶
(ii) The sum in paragraph (C)(i) is multiplied by the applicable conversion factor in section (B) to calculate the rate;¶
(b) Non-RVU-weight-based rates:¶
(A) $2~~0.78~~1.12 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;¶
(B) Clinical lab codes are ~~7~~80 percent of the Medicare clinical lab fee schedule effective on the date of service;¶
(C) All approved Ambulatory Surgical Center procedures are 80 percent of the Medicare fee schedule effective on the date of service;¶
(D) Physician-administered drugs billed under a HCPCS code are 100 percent of the Medicare rate. The Medicare rate is equal to Average Sales Price (ASP) plus six percent;¶
(c) When no ASP rate is available, the rate is based upon the Wholesale Acquisition Cost (WAC) provided by First Data Bank;¶
(d) If no WAC is available, then the rate is the Acquisition Cost. These rates may change periodically based on drug costs;¶
(e) All procedures used for vision materials and supplies are contracted rates that include acquisition cost plus shipping and handling;¶
(f) Individual provider rules may specify rates for particular services or items.¶
(7) The Division reimburses inpatient hospital services under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.¶
(8) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services program rules (chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.¶

(9) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.¶
(10) For services provided by out-of-state institutions and facilities such as skilled nursing care facilities, psychiatric facilities and rehabilitative care facilities, the Division sets rates that are:¶
(a) Consistent with the rate for similar services provided in Oregon; and¶
(b) The lesser of the rate paid to the most similar licensed Oregon facility or the rate paid by the other state's Medicaid program; or¶
(c) Consistent with the rate established by APD for out-of-state nursing facilities.¶
(11) The Division may not make payment on the following claims:¶
(a) Assigned, sold or otherwise transferred claims; or¶
(b) Claims where the billing provider, billing agent, or billing service receives a percentage of the amount billed, amount collected or payment authorized. This includes, but is not limited to, claims transferred to a collection agency or individual who advances money to a provider for accounts receivable.¶
(12) Nursing facility payments:¶
(a) The Division may not make a separate payment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate (OAR 411-070-0085).¶
(b) The following services are not in the all-inclusive rate and may be reimbursed separately:¶
(A) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services program administrative rules (chapter 410, division 148);¶
(B) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);¶
(C) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);¶
(D) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);¶
(E) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);¶
(F) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);¶
(G) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).¶
(13) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.¶
(14) For payment for Division clients with Medicare and full Medicaid:¶
(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;¶
(b) The Division pays the allowable rate for covered services that are not covered by Medicare.¶
(15) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.¶
(16) The Division payments including contracted Managed Care Entity (MCE) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down. For the Division, payment in full includes:¶
(a) Zero payments for claims when a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and¶
(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.¶
(17) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742, 414.743

REPEAL: 410-120-1870

RULE SUMMARY: Repeal Rule, we no longer require Client Premium Payments.

CHANGES TO RULE:

~~410-120-1870~~
~~Client Premium Payments~~
~~(1) All non-exempt clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120.¶~~
~~(2) Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.~~
~~Statutory/Other Authority: ORS 413.042~~
~~Statutes/Other Implemented: ORS 411.408, 414.025, 414.065~~