410-120-1280
Billing

(1) A provider, regardless of enrollment with the Authority, ~~enrolled with the Authority or providing services to a client in an MCE under the Oregon Health Plan (OHP)~~ may not seek payment from a medical assistance recipient~~the client~~ for any services covered by Medicaid fee-for-service or through contracted MCE's~~health care plans~~ except as authorized by the Authority under this rule.~~:~~

(2) Identification of eligibility and third party liability: The provider must:

(a) Verify the client's eligibility for medical assistance and benefit package prior to rendering service pursuant 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 (3)(a) of this rule;

(c) Delay any billing or collection action against the patient for 90 calendar days from submitting the claim to the Authority or MCE, except for non covered services as authorized in section (5)(g) of this rule;

(d) If no payment is received from the Authority or MCE within 90 calendar days from the date the claim 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, 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)(f) of this rule.

(4~~2~~) For Medicaid covered services, the provider ~~may~~ must not:

(a) B~~b~~ill the Authority~~Division~~ more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Authority~~Division~~ program rules;

(b~~a~~) Bill~~A~~ the client ~~may not be billed~~ 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~~Division~~;

(cb) Bill theA client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(2) For Medicaid covered services, 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.

(53) Providers mayshall only bill a client or a financially responsible relative or representative of that client in the following situations:

(a) For any applicable coinsurance, copayments, and deductibles expressly authorized in OAR chapter 410, divisions 120 and 141, or any other AuthorityDivision program rules;

(b) The client did not inform the provider of their Oregon Health plan I.D orHP coverage, enrollment in an MCE I.D card, or third party insurance cardcoverage or gave a name that did not match OHP I.D at the time of or after a service was provided; therefore, the provider could not bill the appropriate payer for reasons including but not limited to the lack of prior authorization or the time limit to submit the claim for payment has passed. The provider must verify eligibility 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 attempts to obtain coverage information prior to billing the client;

(c) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service;

(d) A third party payer made payments directly to the client for services provided;

(e) The client has the limited Citizen Alien Waived Emergency Medical benefit package. CAWEM clients have the benefit package identifier of CWM. Clients receiving CAWEM benefits may be billed for services that are scheduled or routine care and not part of the CAWEM emergency only benefits. (See OAR 410-120-1210 for coverage.) The provider must document that the client was informed in advance that the service or item would not be covered by the Division. An OHP 3165 is not required for these for these pre-scheduled, routine services;

(f) 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 OHP 3165 pursuant to section (3)(h) of this rule before providing these services;

(g) The client has requested In exceptional circumstances, a client may decide to privately pay for a covered service. In this exceptional situation, the provider may bill the client if the provider informs the client in advance of all of the following:

(A) The requested service is a covered service, and the appropriate payer (the Division, MCE, or third party payer) would pay the provider in full for the covered service; and

(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer (OHA or CCO) would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and

(C) That the client knowingly and voluntarily agrees to pay for the covered service;

(D) The provider documents in writing, signed by the client or the client's representative, indicating that the provider gave the client the information described in section (3)(g)(A-C); that the client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and that the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above. The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Division or to the client's MCE or third party payer that is subject to the agreement.

(h) Non-covered services~~A provider may bill a client for services that are not covered~~ by the Division, MCE (see definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165 or 3166) ~~or a facsimile containing all of the information and elements of the OHP 3165 or 3166 as shown in Table 3165 and 3166 of this rule~~. The completed OHP 3165, 3166 ~~or facsimile~~ is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. Providers must make a copy of the completed OHP 3165, 3166 form~~or facsimile~~ available to the Division or MCE upon request.

(6~~4~~) Code s~~S~~et 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, and the Division 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 Division shall adhere to the Code Set requirements in 45 CFR 162.1000–162.1011;

(c) Periodically, the Division shall update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service;

(d) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone may not be construed as coverage or a covered service by the Division;

(e) The Division 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 Division.

(7~~5~~) Claims:

(a) Upon submission of a claim to the Division 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 must 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 must 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 will send crossover claims to the Authority or contracted health plan after adjudication by Medicare. When billing~~This requires claims sent to~~ Medicare as the~~for~~ primary payer~~ment~~ claims for all ~~to include the applicable information for all dually eligible~~ Medicaid/Medicare members must~~so that~~ include all applicable payer information (with Medicare as primary and Medicaid as secondary) so that Medicare ~~claims~~ can automatically ~~cross-over electronically to the Authority or to contracted health care plans. Medicare shall automatically~~ transmit the correct Medicare payment, coinsurance, and deductible information to the Division or MCE~~the contracted health plan~~;

(f) Claims must be for services provided within the provider's licensure or certification;

(g) Unless otherwise specified, claims must be submitted after:

(A) Delivery of service; or

(B) Dispensing, shipment or mailing of the item.

(h) The provider must submit true and accurate information when billing the Division. Use of a billing provider does not abrogate 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~~data is entered on or attached to the claim form~~. 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~~8~~)(c)(A-D) below. 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 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 Division, 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; or

(B) Refund the amount of the overpayment on any claim; or

(C) Void the claim via the Pprovider Wweb Pportal if the Division overpaid due toreason for the overpayment was an erroneous billing;

(D) If the overpayment occurred because of a payment from a third party payer refer to (108)(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.

(86) 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 must 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 must follow national coding guidelines and bill using the 7th digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.

(97) Procedure code requirement:

(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division program rules and must 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 be the code that most accurately describes the services provided. Hospitals must follow national coding guidelines;

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider must 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 must 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.

(108) 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 must 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 must 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~~8~~)(d)(A through E) below, when third party coverage is known to the provider prior to billing the Division, the provider must:

(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 must 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 must 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 definition), 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 must 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~~8~~)(d)(A) through (E) above, 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 must 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 must 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 one of 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 410-141-3420, and the provider must 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 must 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~~9~~) 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 (10) 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~~0~~) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, 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.

(131) Table 120-1280 – TPR codes.

(142) Table – OHP Client Agreement to Pay for Health Services, OHP 3165.

[NOTE: Tables referenced are not included in rule text. Click here for PDF copy of tables.]

[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy.]

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065,414.066
History:
DMAP 62-2017, amend filed 12/28/2017, effective 01/01/2018
DMAP 53-2016, f. 8-26-16, cert. ef. 9-1-16

410-120-1855
Client's Rights and Responsibilities

(1) Division of Medical Assistance Programs (Division) clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, substance use disorder or family planning services without getting a referral from a Primary Care Practitioner (PCP) or other provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the Division client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive Division covered services that meet generally accepted standards of practice and are medically appropriate;

(l) To obtain covered preventive services;

(m) To receive a referral to specialty providers for medically appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, substance use disorder or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 — Patient Self-Determination Act;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with the Division and receive a response as defined in OAR 410-120-1860 and 410120-1865;

(t) To request an Administrative Hearing with the Oregon Health Authority (Authority);

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of Authority privacy practices.

(2) Division clients shall have the following responsibilities:

(a) To treat the providers and clinic's staff with respect;

(b) To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use emergency services appropriately;

(g) To give accurate information, name that matches the Oregon Health I.D card for inclusion in the clinical or billing record;

(h) To help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the provider that his or her health care is covered with the Division before services are received and to show the provider their Oregon Health I.D.;

(n) To tell the Department or Authority worker of a change of address or phone number;

(o) To tell the Department or Authority worker if the Division client becomes pregnant and to notify the Department worker of the birth of the Division client's child;

(p) To tell the Department or Authority worker if any family members move in or out of the household;

(q) To tell the Department or Authority worker and provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(r) To pay for non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist the Division in pursuing any TPR available and to pay the Division the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the Division; and

(v) To sign an authorization for release of medical information so that the Authority can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065