Secretary of State Website Division 120 MEDICAL ASSISTANCE PROGRAMS

Contents

410-120-0000

Billing Agent or Billing Service

(35) "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.

Billing Provider

(36) "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.

Contested Case Hearing

(57) "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.

Credible Allegation of Fraud

(X) '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.

Commented [TAM1]: Recommend including this definition in Sec. 0000. Will ensure consistent application of the term throughout Div 120.
The CCO Contract includes this term – but it has previously been defined only in the provider audit rule.

Complex Rehab Technology

(X) Complex Rehab Technology

Commented [KN2]: Comment from David Knight 07/21/23 "Can we add definition of CRT (Complex Rehab Technology)? This is an important definition that separates customized assistive technology from "off the shelf" (DME) assistive technology. It is widely used by Medicaid and Medicare throughout the country."

Covered Services

(64) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:

(a) Ancillary services (OAR 410-120-0000(22));

(b) Diagnostic services necessary to determine the existence, nature, or extent of the client or member's disease, disorder, disability or condition;

(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k;

(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic~~s~~ and Treatment (EPSDT). ~~as specified in the Oregon Health Plan 1115 Demonstration Project (waiver).~~

Deactivation

(X) "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.

Commented [TAM3]: Recommend adding to reflect changes in HSD Provider Enrollment Unit processes.
The provider enrollment forms now use this term – but it is not currently defined in the OARs.

Dentally Appropriate – with changes recommended by Ellen Tausig-Conaty

(77) "Dentally Appropriate"

(a) means health services, items, or dental supplies that are:

(A~~a~~) Recommended by a licensed health provider practicing within the scope of their license; and

(Bb) 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

(Cc) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and

(Dd) 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.;

(be) 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.

Durable Medical Equipment

(84) "Durable Medical Equipment , ~~Prosthetics, Orthotics and Medical Supplies~~ (DMEPOS)" means equipment and appliances that can stand repeated use and is primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removeable. 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. items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.~~

Managing Employee

(X) "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.

Medical Services

(147) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

Medical Transportation

(148) "Medical Transportation" means transportation to or from covered medical services.

Commented [GRVA4]: Should this DME ?

Commented [KN5]: Suggestion from Kelly Jamison 07/21/23 DME Meeting

Commented [KN6]: Comment from Tamara Bakewell "I think the DMEPOS acronym needs to be removed as well, right?"

Commented [KN7R6]: This makes sense to me! Will check with the DME Meeting

Commented [KN8]: Comment from Catherine Sweeney "Can we change to "can serve a medical and/or functional purpose?
We have had denials because the DME did not "resolve" a medical condition"

Commented [KN9]: Comment from Tina Treasure "This reads as a double negative."

Commented [KN10R9]: Comment from Kelly that we are using the direct definition from Medicaid/Federal Definition. Plan to check in with DOJ if there is no way to still be federally compliant, while resolving the double negative.

Commented [KN11]: Suggestion from Gloria Stubbs

Commented [JK12]: In the DME rules 410-122-0010 we have broken these out into two different definitions to match federal Medicaid regulations at 42 CFR 440.70 as they have different definitions. One for DME and one for medical supplies. If you intend to combine them in one definition I recommend adding the definition of medical supplies as indicated below to match federal definition.
"Durable Medical Equipment" means equipment and appliances that are primarily used to serve a medical purpose, generally not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.
"Medical supplies" means health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual that are required to address an individual medical disability, illness, or injury."

Commented [BRM13]: This definition does not appear to align with the definition that is in the DME rules. Specifically, 410-122-0010(4). Is the intent here to change this definition and then to change the definition in the DME rules? Shouldn't the rules align?

Commented [TAM14]: Recommend including CFR language for managing employee. Providers enrolling with OHA must now disclose specific information to OHA re: ownership and control.
The provider enrollment forms now use this term – but it is not currently defined in the OARs.

Medically Appropriate

(149) "Medically Appropriate" means health services, items, or medical supplies that are:

(a) Recommended by a licensed health provider practicing within the scope of their license;

(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;

(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;

(d) The most cost effective of the alternative, equally effective 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;~~ with deference on this issue to the opinion of the treating professional.

(e) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

(f) For Early and Periodic Screening, Diagnosis and Treatment (EPSDT), see chapter 410 Division 151.

Additional Edits to Medically Appropriate from Ellen Taussig Conaty

(149~~7~~) "Medically Appropriate"

(a) means health services, items, or medical supplies that are:

(A)~~a)~~ R~~r~~ecommended by a licensed health provider practicing within the scope of their license; and

(B~~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~~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~~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~~e~~) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

(c~~f~~) For Early and Periodic Screening, Diagnosis and Treatment (EPSDT), see chapter 410 Division 151.

Commented [TAM15]: OHA OPI supports keeping the term 'medically appropriate'. But would not recommend HSD adopt the edits in (d) to removed 'in the division's judgement' and about 'deference'. The division's judgement is necessary for management of the OHP program where OHA must decide what level of services Medicaid rules allow the OHP to pay for. The deference edit duplicates (a).

- The OARs also need to protect members from providers who charge OHP for medically inappropriate services and goods (e.g. Ivermectin prescribed by OR MD's to treat COVID).
- There is a risk of patient harm (e.g. from tx that is medically inappropriate).

Commented [KN16]: Suggestion from OLC to remove: "Eliminate all language in the rules that references 'not

Commented [LS(17R16]: As we discussed with Jesse, removing this language contradicts federal requirements.

Commented [DK18R16]: The word "convenience" is not clearly defined as it relates to Medical Equipment. Is

Commented [LS(19]: In the draft EPSDT definition, we are using this language, which is (we think) more

Commented [KN20]: Comment to try to find a better word than "deference"

Commented [LS(21R20]: As we discussed with Jesse, deference to the physician contradicts federal requiremer

Commented [JK22R20]: I agree with Liz. Had similar discussion with Jesse about this.

Commented [DK23R20]: If deference is not given to the treating medical professional then we are saying that the

Commented [KN24]: The tracked changes reflect suggested text from the OLC

Commented [KN25]: Comment from JSA: "check with Jessica- However response could be- changes to medica

Commented [LS(26R25]: Our proposed edits are included here. Adding (f) is the most important as it direct

Commented [KN27]: Suggestion to remove this entire subsection

Commented [DK28R27]: Agreed this is extremely redundant and confusing.

Commented [KN29R27]: Melissa Mumey: 07/27/23 I would support this. We struggle with notices ONLY citing

Commented [LJ30]: If we can legally delete the "Medically Appropriate" section from existence, I'd

Commented [DK31R30]: I agree. This definition is not widely used by other states and It causes a lot of problem

Commented [LS(32]: @Nita when we met with you and Jesse, this is the wording we agreed on. This directs folks t

Medicheck for Children and Teens

~~(153) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under the age of 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.~~

Medically Necessary

(150) "Medically Necessary" means health services and items that are required by a client or member 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 results in health impairments or a disability;

(b) The ability for a client or member to achieve age-appropriate growth and development;

(c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

(d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules 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;

(e) 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.

(f) For Early and Periodic Screening, Diagnosis and Treatment (EPSDT), see chapter 410 Division 151.

Additional Edits to Medically Necessary from Ellen Taussig Conaty

(15~~048~~) "Medically Necessary" means

(a) health services and items that are required ~~by a client or member~~ 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~~s~~ in health impairments or a disability; or

(B~~b~~) The client's or member's ability ~~for a client or member~~ to achieve age-appropriate growth and development; or

Commented [LS(33]: EPSDT changes remove this definition entirely. This language hasn't been used since like the 80s.

Commented [KN34]: Comment from OLC: Change the definition of "medically necessary" in OAR 410-120-0000(148) to include deference to the client's treating professional's opinion regarding the medical necessity of the requested service/treatment/DME.

Commented [LJ35R34]: Agreed with OLC. Maybe add a statement such as "Recommended by the consumer's licensed health provider practicing within the scope of their license."

Commented [KN36]: Comment from Kelly Jamison before retiring, about the Prioritized List and coverage, and how it is part of why we have both the Medically Necessary and Medically Appropriate definitions.

Commented [MM37R36]: I don't think Kelly's comment was relayed enough to understand; however, I'm not sure that I agree with completely removing (e), as suggested below. Possibly shortening to only read, "A medically necessary service must also be medically appropriate." It is more of a statement than an option, so it could be worked into the main definition?. Per 410-141-3820(1)(b) a service must be medically necessary **AND** appropriate. There are only a few places in the rules that identify that services must be medically necessary and appropriate. If one of those citations isn't cited in a denial, it would be nice to have this maintained in definition somehow so that whenever medically necessary is cited, the def. refers to medically appropriate.

Commented [KN38]: Suggestion to remove this entire subsection

Commented [LJ39R38]: Agreed on removal. Causes too much confusion & wrongful denial opportunities

Commented [LS(40]: See comment above.

We are also adding this to the definition of Dentally Appropriate.

Commented [KN41]: Sub section added per E

Commented [TAM42]: I think Ellen's edits are great.

(Cc) The client's or member's ability ~~for a client or member~~ to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

(Dd) The client's or member's ability ~~opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules~~ 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).~~;~~

(be) 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.

(cf) For Early and Periodic Screening, Diagnosis and Treatment (EPSDT), see chapter 410 Division 151.

Non Billing Provider

(158) "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).

Commented [TAM43]: General recommendation that OHA review the provider types – some of these may no longer be applicable due to changes in how OHA manages provider enrollment.

Ownership Interest

(X) '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.

Commented [TAM44]: Recommend including CFR language for ownership interest. Providers enrolling with OHA must now disclose specific information to OHA re: ownership and control.
The provider enrollment forms now use this term – but it is not currently defined in the OARs.

Participating Provider

(X) "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.

Commented [TAM45]: Definition from Ch 410 Div 141. Recommend including in general rule for consistency.

Alternative:

"Participating provider" has the meaning as provided for in OAR 410-141-3500.

Payable Provider

(X) "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.

Commented [KN46]: Ask Jesse or Allison about this

Commented [KN47R46]: Recommendation from Todd (provider Enrollment) Previously called "non billing" Not a provider rendering any services, but they are still enrolled and still required to follow requirements as an Enrolled provider

Provider

(208) "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.

Reduction of Services

(X) "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.

Commented [KN48]: Added per Jesse Anderson (Email from Thu 6/22/2023 7:57 AM)

Commented [TAM49R48]: I like this clarification. Very helpful for members.

Rendering Provider

(223) "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.

Commented [KN50]: I do not see any edits! Should I remove this?

Sanction

(229) "Sanction" means an action against providers taken by the Authority in cases of ~~fraud,~~ misuse~~,~~ or abuse of ~~Division~~ Authority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.

Service Location

(X) "Service location" means the location of a provider when services are rendered.

Commented [MTJ51]: Recommend adding this term to eliminate providers from out of state renting office space in Oregon to get an Oregon location when they are not providing service at that location.

Suspension

(244) “Suspension” means a temporary sanction prohibiting a provider's participation in the medical assistance programs by ~~deactivation~~ suspending~~of~~ the provider's Authority-assigned ~~billing~~ provider number for a specified period of time or 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~~during the~~ suspended~~sion~~. ~~The number shall be reactivated automatically after the suspension period has elapsed.~~

Commented [KN52]: Jesse, please review this text suggestion

Commented [KN53]: I like the clarification! Considering how to define “suspension” without using the word Suspension. It’s a temporary shut off, not a permanent deactivation.

Termination

(246) “Termination” means a sanction prohibiting a provider's participation in the ~~Division's~~Authority~~'s~~ programs by canceling the provider's Authority-assigned ~~billing~~ provider number and provider agreement 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 after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Authority at the time of termination.

Commented [TAM54]: Is this CFR still active/correct?

Commented [KN55R54]: I think this needs to be updated

410-120-0011

410-120-0011
Effect of COVID-19 Emergency Authorities on Administrative Rules

Summary: The entire rule is repealed due to the Public Health Emergency ending

~~(1) Under authority of the President's declaration of a national emergency related to COVID-19:~~

~~(a) On March 25, 2020 the Centers for Medicare and Medicaid Services (CMS) approved temporary modifications and waivers requested by the Authority under Section 1135 of the Social Security Act to certain Medicaid, CHIP, and HIPAA requirements (March 25 State Specific Waiver, posted at https://govstatus.egov.com/OR-OHA-COVID-19).~~

~~(b) On March 13, 2020, CMS issued a blanket 1135 waiver, applicable to all fifty of the United States, of certain requirements set forth in Titles XVIII, XIX, and XXI of the Social Security Act (March 13 Blanket Waiver, described at https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf).~~

~~(c) On March 26, 2020, CMS issued a letter to the Oregon Association of Hospitals and Health Systems, waiving certain federal requirements applicable to hospitals and other providers (March 26 Provider Waiver, posted at https://static1.squarespace.com/static/5e712c5039792019ff647a40/t/5e7ed359d5037c1157b16618/1585369947488/OR-Oregon+Waiver+Approval+3-26-2020.pdf).~~

~~(d) On or before March 30, 2020, CMS issued a number of COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (CMS Blanket Provider Waivers, posted at https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers).~~

~~(2) In this rule, "COVID-19 Emergency Authorities" means the March 25 State Specific Waiver, the March 13 Blanket Waiver, the March 26 Provider Waiver, the CMS Blanket Provider Waivers, and all emergency orders or declarations relating to COVID-19 by the Governor of the State of Oregon or by the Authority (posted at https://govstatus.egov.com/OR-OHA-COVID-19, tab on "OHA Guidance and Emergency Rules"). In the event of termination or withdrawal of any of the COVID-19 Emergency Authorities in effect on the date this rule is adopted, the term "COVID-19 Emergency Authorities" means only those waivers, emergency orders or declarations described in the previous sentence that remain in effect.~~

~~(3) The purpose of this rule is to ensure medical assistance programs provide all appropriate and necessary services, providers are able to operate and deliver services effectively and efficiently, and the medical assistance programs are administered effectively and efficiently, all in accordance with the COVID-19 Emergency Authorities with the goal of reducing adverse impacts from COVID-19.~~

~~(4) In order to accomplish the purposes identified above, and consistent with the COVID-19 Emergency Authorities, all rules in this chapter inconsistent with the COVID-19 Emergency Authorities are hereby suspended. OHA shall issue guidance concerning any rule in this chapter 410 that is inconsistent with the COVID-19 Emergency Authorities and is deemed to be suspended pursuant to this paragraph.~~

~~(5) In addition to issuing the guidance described in section (4) of this rule, the Authority may do any of, or any combination of, the following:~~

~~(a) Issue guidance on how an existing rule in this chapter is to be interpreted and applied;~~

~~(b) Suspend one or more existing rules in this chapter, in accordance with normal administrative procedures or by the Governor's rule suspension authority; or~~

~~(c) Adopt one or more temporary rules in this chapter, in accordance with normal administrative procedures.~~

~~(6) OHA shall post any guidance issued under this rule at https://govstatus.egov.com/OR-OHA-COVID-19, tab on "OHA Guidance and Emergency Rules."~~

Statutory/Other Authority: ORS 409.050
Statutes/Other Implemented: ORS 414.065

410-120-1140

410-120-1140
Verification of Eligibility and Coverage

Summary: Remove outdated reference to form 1086

(1) To ensure Division reimbursement of services, providers are responsible to verify the following before rendering services:

(a) Client eligibility: That the person is an eligible Oregon Health Plan (OHP) client on the date(s) services are rendered; and

(b) Benefit coverage: That the person is enrolled in an OHP benefit package that covers the services they plan to render. See OAR 410-120-1210 for services covered under each Division benefit package.

(2) Providers who do not verify eligibility and benefit coverage with the Division before serving a person shall assume full financial responsibility in serving that person.

(3) The following types of client identification (ID) only list the client's name, Oregon Medicaid ID number (prime number), and the date the ID was issued. They do not guarantee client eligibility or benefit coverage:

(a) The standard ID (called the Oregon Health ID, formerly the DHS Medical Care ID) printed on perforated paper the size of a business card;

(b) Replacement IDs (printed on regular printer paper in case of misplaced originals).

(4) When a person presents a standard or replacement ID, providers must verify client eligibility and benefit coverage through one of the following (For instructions see the Division General Rules Supplemental Information available on the web at http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-General-Rules.aspx:

(a) The Division's Medicaid Management Information System (MMIS) Provider Web portal;

(b) The Automated Voice Response (AVR) telephone system;

(c) Batch or real-time electronic data interchange (EDI) eligibility inquiry (270) and response (271) transactions;

(5) The client may also present ~~one of~~ the ~~following~~ Temporary Oregon Health ID~~s; both are full-page forms~~:

~~(a) DMAP form 1086: This document guarantees eligibility and benefit coverage for seven days from the beginning dates of coverage entered in Part 1 of the form. This temporary ID is issued only if the client needs immediate care but their eligibility and coverage information is not yet available for verification as described in part (4) of this rule. Providers must honor the Temporary Oregon Health ID when presented within seven (7) days of the beginning date of coverage entered on the form;~~

~~(b)~~ OHP 3263A: Approval Notice for Hospital Presumptive Eligibility for Medical Coverage: This ID is issued for those who are "presumed" eligible based on certain information and authorizes benefit coverage only on a temporary basis. The OHP 3263A informs the client of the exact date by which the Division must receive their full Medicaid application so that they may be evaluated for ongoing eligibility.

410-120-1180

410-120-1180
Medical Assistance Benefits: Out-of-State Services

Summary: Clarify Out of State Pharmacy Services

(1) A provider located in a state other than Oregon whose services are rendered in that state shall be licensed and otherwise certified by the proper agencies in the state of residence as qualified to render the services. Certain cities within 75 miles of the Oregon border may be closer for Oregon residents than major cities in Oregon, and therefore, these areas are considered contiguous areas, and providers are treated as providing in-state services.

(2) Out-of-state providers must enroll with the Authority as described in OARs 943-120-0320 and 410-120-1260, Provider Enrollment. Out-of-state providers must provide services and bill in compliance with these rules and the OARs for the appropriate type of services provided.

(3) Payment rates for out-of-state providers are established in the individual provider rules through contracts or service agreements and in accordance with OAR chapter 943, division 120 and OAR 410-120-1340, Payment.

(4) For enrolled non-contiguous, out-of-state providers, the Division reimburses for covered services under any of the following conditions:

(a) For clients enrolled in an MCE:

(A) The service is authorized by an MCE, and payment to the out-of-state provider is the responsibility of the MCE;

(B) If a client has coverage through an MCE, the request for non-emergency services must be referred to the MCE. Payment for these services is the responsibility of the MCE;

(C) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-state provider is cost effective, as determined by the MCE.

(D) MCE must provide all Members with the option to utilize mail order pharmacy services. MCE may use an out-of-state mail order provider when necessary to meet the needs of the Member, as long as the pharmacy has signed a participating provider agreement or subcontract with ~~is in~~ the MCE ~~provider network~~, is licensed to operate in state they reside, and ~~they~~ adheres ~~with~~ to out-of-state services and other applicable Division rules. ~~necessary to meet the needs of the~~ Member.

(b) For clients not enrolled in an MCE:

(A) The service to a Division client is emergent as defined in 410-120-0000;

(B) A delay in the provision of services until the client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;

(C) The Division authorized payment for the service in advance of the provision of services or is otherwise authorized in accordance with payment authorization requirements in the individual provider rules or in the General Rules;

(D) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage;

(E) The client is traveling and unable to use an in-state pharmacy;

Commented [SG56]: Recommend using full description in (a) for reference to MCE throughout the remainder of the rule.

Commented [TM57]: recommend moving this part/statement to avoid confusion - the pharmacy must follow all the division rules appliable to pharmacy services and payment, not just those rules "necessary to meet the needs of the member.

Commented [TM58]: What does "in the MCE provider network" mean? Does this mean the pharmacy is enrolled as an encounter only (i.e. participating provider) provider? does this mean the pharmacy has signed a contract or provider agreement with the MCE?

edits suggested for clarity - but pharmacy policy team may need to clarify what the exact requirement is.

Commented [KN59]: Language added by brandon per question raised in email from Dee on 01/27/23

(F) The pharmacy is out-of-state and mail order; the primary insurance TPL policy requires the use of the pharmacy;

(G) The pharmacy is out-of-state and mail order and provides one or more pharmaceutical products that are only available through a limited distribution network.

(5) The Authority may give prior authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled provider under the following conditions:

(a) The service is billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage; or

(b) The Division covers the service or item under the specific client's benefit package; and

(c) The service or item is not available in the State of Oregon, or provision of the service or item by an out-of-state provider is cost effective, as determined by the Division; and

(d) The service or item is deemed medically appropriate and is recommended by a referring Oregon physician.

(6) Laboratory analysis of specimens sent to out-of-state independent or hospital-based laboratories is a covered service and does not require PA. The laboratory must meet the same certification requirements as Oregon laboratories and must bill in accordance with Division rules.

~~(7) The Division makes no reimbursement for services provided to a client outside the territorial limits of the United States. For purposes of this provision, the United States includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.~~

(7) Reimbursement and services outside the territorial limits of the United states:

(a) For purposes of this provision, the United States includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa;

(b) The division will not provide any payments for items or services to any financial institution or entity located outside of the United States pursuant to 1902(a)(80) of the Social Security Act.

(A) This provision also prohibits payments to telemedicine providers and pharmacies located outside of the United States;

(B) This does not preclude providers from providing covered items and/or services to Medicaid beneficiaries provided that reimbursement is made to a financial institution or entities located within the United States.

(8) The Division shall reimburse within limits described in these General Rules and in individual provider rules all services provided by enrolled providers to children:

(a) Who the Division has placed in foster care;

(b) Who the Department has placed in a subsidized adoption outside the State of Oregon; or

(c) Who are in the custody of the Department and traveling with the consent of the Department.

Commented [KN60]: Pramela Reddi "You are in compliance with CMS in that you have put the SSA section 1902(a)(80) requirement in the State Plan. To the extent requirements in the State Plan should also be in rule, yes, you should develop a rule that addresses the payment issue in SSA section 1902(a)(80)."

Commented [KN61]: Pramela Reddi "You are in compliance with CMS in that you have put the SSA section 1902(a)(80) requirement in the State Plan. To the extent requirements in the State Plan should also be in rule, yes, you should develop a rule that addresses the payment issue in SSA section 1902(a)(80)."

(9) The Division does not require authorization of non-emergency services for the children covered by section (8) except as specified in the individual provider rules.

(10) Payment rates for out-of-state providers are established in the individual provider rules through contracts or service agreements and in accordance with OAR 943-120-0350 and 410-120-1340, Payment.

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

410-120-1200

410-120-1200
Excluded Services and Limitations

Summary: Remove language for "significantly improve" in section (2)(a)

(1) Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in Oregon Administrative Rule (OAR) 410-141-3830 and the individual program chapter 410 OARs, including chapter 410 Division 151 for Early and Periodic Screening, Diagnosis and Treatment (EPSDT). If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

(2) The Health Systems Division (Division) shall make no payment for any expense incurred for services or items that meet any of the following: ~~services or items that are:~~

~~(a) Not expected to significantly improve the basic health status of the client as determined by Division staff or its contracted entities; for example, the Division's medical director, medical consultants, dental consultants, or Quality Improvement Organizations (QIO);~~

(a~~b~~) Determined not medically or dentally appropriate by Division staff or authorized representatives, including the Division's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

(b~~c~~) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within their scope of practice or licensure;

(c~~d~~) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the client. Examples include exams for employment or insurance purposes;

(d~~e~~) Provided by friends or relatives of eligible clients or members of his or her household, except when the friend, relative or household member:

(A) Is a health professional acting in a professional capacity; or

Commented [KN62]: Joli Schroader-ODDS- I'm not sure if you have heard about the concerns expressed by parents of minors who are currently being paid to provide care to their children and want to continue to do so after the PHE. ODDS is looking at all OARs and statutes and federal regulations to see where it is allowed or not allowed. I found this OAR and wondered if it would apply to K Plan meaning that by OAR we do not allow relatives or household members to provide services. If you think it would apply to K Plan that is ok. I'm not sure if it would need to be amended at this point. Just gathering information for Lilia.

Commented [KN63]: Added per EPSDT group

Commented [LJ64]: Medically Appropriate vs Medical Necessity debate comes in to play again. If my prescribing physician &/or PT shows medical necessity, then how does Division staff have authority to determine if it's medically appropriate for me when they don't know me or my health matters?

Commented [LJ65]: Would this be another "aid or assist" spot?

(B) Is directly employed by the client under the Department of Human Services (Department) Aging and People with Disabilities division (APD) Home and Community Based Services or the APD administrative rules, OAR 411-034-0000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) Is directly employed by the client under the Department Child Welfare administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor client (under the age of 18) must not be legally responsible for the client in order to be a provider of personal care services;

(ef) For services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Division's administrative rules (i.e., inpatient hospitalizations);

(fg) Needed for purchase, repair, or replacement of materials or equipment caused by adverse actions of adult clients age 21 and over to personally owned goods or equipment or to items or equipment that the Division rented or purchased;

(hg) Related to a non-covered service, some exceptions are identified in the individual provider rules. If the Division determines the provision of a service related to a non-covered service is cost effective, the related medical service may, at the discretion of the Division and with Division prior authorization (PA), be covered;

(hi) Considered experimental or investigational, that deviates from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(ij) Identified in the appropriate program rules including the Division's Hospital Services program administrative rules, Revenue Codes Section, as non-covered services;

(jk) Requested by or for a client whom the Division has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(kl) For copying or preparing records or documents, except those Administrative Medical Reports requested by the branch offices or the Division for casework planning or eligibility determinations;

(Lm) Whose primary intent is to improve appearances, exceptions subject to the HERC coverage and guidelines;

(mn) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

(no) For the purpose of establishing or reestablishing fertility or pregnancy;

(op) Items or services that are for the convenience of the client and are not medically or dentally appropriate;

(pq) The collection, processing, and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled;

Commented [LJ66]: Who & how is this determined? Things that could appear as "intentional" could very easily be circumstance or accidental.

Commented [LJ67]: This seems like yet another way of trying to justify "least costly" options as the only option. That's not always true. IE: Group 3 & Group 4 PWCs…the 3s are cheaper than the 4s & on paper they both appear to be the same exact chair but for that consumer one may be a better fit over the other when trying to meet their medical necessity needs.

Commented [LJ68]: Who & how is this determined? Things that could appear as "convenient" could very easily be a medical necessity.

(~~r~~q) Educational or training classes that are not intended to improve a medical condition;

(~~q~~r~~s~~) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;

(~~r~~s~~t~~) Post-mortem exams or burial costs;

(~~s~~t~~u~~) Radial keratotomies;

(~~t~~u~~v~~) Recreational therapy;

(~~u~~v~~w~~) Telephone calls except for:

(A) Tobacco cessation counseling as described in OAR 410-130-0190;

(B) Maternity case management as described in OAR 410-130-0595;

(C) Telemedicine as described in OAR 410-120-1990; and

(D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and substance use disorder procedure code and reimbursement rates published by the Addiction and Mental Health division.

(~~v~~w~~x~~) Services that have no standard code set as established according to 45 CFR 162.1000 to 162.1011, unless the Division has assigned a procedure code to a service authorized in rule;

(~~w~~x~~y~~) Whole blood (Whole blood is available at no cost from the Red Cross). The processing, storage, and costs of administering whole blood are covered;

(~~x~~y~~z~~) Immunizations prescribed for foreign travel;

(~~y~~z~~aa~~) Services that are requested or ordered but not provided to the client, unless specified otherwise in individual program rules;

(~~z~~aa~~bb~~) Missed appointments, an appointment that the client fails to keep. Refer to OAR 410-120-1280;

(~~aa~~bb~~cc~~) Transportation to meet a client's personal choice of a provider;

(~~bb~~cc~~dd~~) Alcoholics Anonymous (AA) and other self-help programs;

(~~cc~~dd~~ee~~) Medicare Part D covered prescription drugs or classes of drugs and any cost sharing for those drugs for Medicare-Medicaid Fully Dual Eligible clients, even if the Fully Dual Eligible client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for benefit package;

(~~dd~~ee~~ff~~) Services provided outside of the United States. Refer to OAR 410-120-1180.

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

Commented [LJ69]: This should be covered. We talk about community access & inclusiveness, yet we won't help fund a method of implementing it. Centers for Independent Living could be a massive resource in assisting PWD with community access & inclusiveness through recreational therapy opportunities but we don't fund it for OHP members.

Commented [KN70]: Comment from Jesse "The General rules has exclusion language that will need to be changed for 10/1/23. OAR 410-120-1200 (z) Immunizations prescribed for foreign travel;"

410-120-1260

410-120-1260
Provider Enrollment

Summary: Need to include use of the agreement to pay form as the written documentation.

(1) This rule applies to providers requesting enrollmente~~d~~, currently enrolled, and previously enrolled with ~~or seeking to enroll with~~ the Oregon Health Authority (Authority), Health Systems Division (Division).

(2) Providers signing the Provider Enrollment Agreement constitute agreement to comply with all applicable ~~Division~~ Authority provider rules, Oregon Department of Human Services (ODHS) provider rules, and federal and state laws and regulations applicable to Medicaid payments.

(3) Authority review of a provider application for enrollment, material change in a provider's enrollment information, and any documentation received in response to an Authority re-validation request is based on a categorical risk level of limited, moderate, or high. If a provider falls within more than one risk level described in 42 CFR 455.450, the highest level of review is conducted by Authority. Authority will assign a risk level which meets or exceeds federal requirement and reserves the right to adjust provider risk level at any time when:

(a) Authority imposes a payment suspension, in accordance with OAR 410-120-1400, on a provider based on credible allegation of fraud, waste or abuse;

(b) The provider has an existing Medicaid overpayment which, including all outstanding depts and interest, is $1,500 or greater and all of the following:

(i) Is more than 30 calendar days old;

(ii) Has not been repaid at the time the application for enrollment is filed;

(iii) Is not currently being appealed; and

(iv) Is not part of an Authority approved extended repayment schedule for the entire outstanding overpayment.

(c) The provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid program within the previous 10 years; or

(d) Authority or CMS in the previous six (6) months lifted a temporary moratorium for the particular provider type, in compliance with 42 CFR 455.470 and 42 CFR 424.570, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six (6) months from the date the moratorium was lifted.

Commented [KN71]: Suggestion to integrate HSD process changes due to changes to unit work and evolving CMS requirements for provider enrollment. There are several minor and several larger changes in the proposed updates.

See email from Allison on 03/09/23

Commented [TM72R71]: Examples of the proposed key updates:
1. adding several terms and provisions due to HSD team updated processes: deactivation, for-cause, not-for-cause, ownership interest, managing employee, credible allegation of fraud, affiliation, and agent.
2. revise several existing terms for clarity: suspension and termination; NPI requirements when provider has more than one;
3. update (3) to clarify application process for new and revalidation and the documentation/data currently required from providers with those applications;
4. add language to address OHA provider FPBC screening and on-site site visits process;
5. clarify requirement that providers grant prompt access to DOJ MFCU and maintain confidence of any information shared in an investigation of FWA;
6. clarify OHA notice to providers for enrollment deactivation, suspension, termination, re-validation due etc.

Commented [TAM73]: Language added to comply with 42 CFR 455.450 and update rule to reflect HSD provider enrollment current processes/procedures.

Commented [TAM74]: Requesting guidance from rule coordinators regarding whether website links should be included in rules. What is OHA's policy on including and how these are represented?

What format for links is easiest and requires fewest changes in future?

https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx

Commented [TAM75]: Recommend this be updated to align with HSD's current processes for screening and enrollment of high risk providers.

(4) Authority, CMS, its agents, or its designated contractors may, in accordance with 42 CFR 455.432, conduct pre- and post-enrollment on-site visits and unannounced inspections of any and all provider locations at any time, for all provider types.

(5) Providers enrolled by the ~~Division~~ Authority include:

(a) A non-~~payable~~ billing provider, meaning a provider who is issued a provider number for purposes of screening, data collection or non-claims-use such as, but not limited to:

(A) Ordering or referring providers, required by 42 CFR 455.410, whose only relationship with the ~~Division~~ Authority is to order, refer, or prescribe services for ~~Division~~ Authority members~~clients~~;

(B) A billing agent or billing service submitting claims or providing other business services on behalf of a provider but not receiving payment in the name of or on behalf of the provider;

(C) An encounter only provider contracted with and credentialed by a MCE, as required by OAR 410-141-3510.~~PHP or CCO.~~

(b) A payable provider, meaning a provider who is issued a provider number for submitting health care claims for reimbursement from the ~~Division~~Authority. A payable provider may be:

(A) The rendering provider;

(B) An individual, agent, business, corporation, clinic, group, institution, or other entity that in connection with the submission of claims or encounters receives or directs the payment on behalf of a rendering provider.

(~~4~~6) When a~~n~~ payable provider ~~entity~~ is receiving or directing payment on behalf of the rendering provider, the ~~billing~~ payable provider must:

(a) Meet one of the following standards ~~as applicable~~:

(A) Have a relationship with the rendering provider described in 42 CFR 447.10(g) and have the authority to submit the rendering provider enrollment application and supporting documentation on behalf of the rendering provider; and

(B) Is a contracted billing agent or billing service enrolled with the ~~Division~~ Authority to provide services with the submission of claims and to receive or direct payment in the name of the rendering provider pursuant to 42 CFR 447.10(f).

(b) Maintain and ~~make available~~provide to the ~~Division~~ Authority upon request records indicating the billing provider's relationship with the rendering provider. This includes:

(A) Identifying all rendering providers for whom they bill or receive or direct payments at the time of enrollment;

(B) Notifying the ~~Division~~ Authority within 30 days using Authority forms of a change to the rendering provider's enrollment record such as name, date of birth, address, ~~Division~~ Authority assigned provider numbers, National Provider Identification Numbers (NPI~~s~~), Social Security Number (SSN), or the Employer Identification Number (EIN); and~~.~~

Commented [TAM76]: Language added to address Agency process for conducting pre and post provider enrollment site visits.

Commented [TAM77]: HSD provider enrollment feedback – they do not believe that HSD enrolls any of these providers. Is this (B) still applicable to OHA current practices/process or could this (B) be removed?

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Commented [TAM78]: Term 'CCO' updated to align with OAR 410-141. All MCE providers must enroll, not just CCO providers.

(C) The authorization to direct payment, signed by the rendering provider.

(c) Prior to submission of any claims or receipt or direction of any payment from the ~~Division~~Authority , obtain signed confirmation from the rendering provider that the billing entity or provider is authorized by the rendering provider to submit claims or receive or direct payment on behalf of the rendering provider. This authorization, and any limitations or termination of such authorization, must be signed by the rendering provider and maintained in the provider's files for at least ~~five~~ seven (7) years following the submission of claims or receipt or direction of funds from the ~~Division~~Authority.

(~~5~~8) T~~In order t~~o facilitate timely claims and encounter processing and ~~claims~~ payment consistent with applicable privacy and security requirements for providers:

(a) The ~~Division~~ Authority requires all non-~~payable~~ billing and payable providers to be enrolled consistent with the provider enrollment process described in this rule;

(b) If the ~~rendering~~ provider uses electronic media to conduct transactions with the ~~Division~~ Authority or authorizes a non-~~payable~~ billing provider, e.g. billing service or billing agent, to conduct such electronic transactions, the rendering provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. Enrollment as a payable or non-~~payable~~ billing provider is a necessary requirement for submitting electronic claims, but the provider must also register as an EDI trading partner and identify the EDI submitter in order to submit electronic claims; and~~.~~

(c) The claims and encounters submitted to the Authority must include an NPI for each provider subject to the NPI requirements in 45 CFR Part 162 Subpart D. Rendering and referring providers may not have the same NPI listed on the claim or encounter. Billing and rendering providers may not have the same NPI listed on the claim or encounter.

(~~9~~6) To be enrolled and able to bill and receive payment as a provider, an individual or organization must:

(a) Meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules.~~;~~ The provider's license must be active. Authority may deny enrollment, re-enrollment or revalidation when a provider's licensing body has placed limitations on the provider's license or an action that created a limitation on the provider's license impacts the quality or safety of services provided to OHP members. Authority may request additional documentation from the provider or the licensing body or require additional screening.

(b) Comply with all Oregon statutes and regulations for provision of Medicaid and CHIP services. This includes meeting all applicable national and state licensure and certification requirements for all employees, subcontractors, vendors or other third parties providing services to Medicaid members for which the enrolled provider is receiving reimbursement from Authority;

(c) If providing services within ~~the State of~~ Oregon, have a valid Oregon business license if such a license is a requirement of the state, federal, county, or city government to operate a business or to provide services; and~~.~~

Commented [AT79]: Updated to align with current record retention rules and agency audit practices.

Commented [KN80R79]: Are we removing the word five? I can't read the tracked changes for this section

Commented [TM81R79]: yep. removing 5.

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Commented [TAM82]: Recommend OHA require that all claims include the NPI. May not apply to all provider types enrolled as not all providers receive an NPI. CFR included in this recommendation to limit applicability to those providers who have an NPI.

(dX) Comply with all requests from Oregon dDepartment of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) for records and information when MFCU determines it is necessary to carry out its responsibilities. The records and information must be provided without charge and in the form requested by MFCU. A provider must comply with a request from MFCU for access to any records and information kept by providers to which OHA, ODHS, MCEs and MFCUs are authorized access by 42 CFR s431.107, including, but not limited to, any records necessary to disclose the extent of services provided to beneficiaries and any information regarding payments claimed by the provider for furnishing said services. The records and information must be provided without charge and in the form requested by MFCU. When a MFCU request for access is made in person such access must be granted immediately. A provider must make available to MFCU, copies of all procedural and policy statements, directives, and proposed or adopted regulations concerning the Medicaid program, and any other information relevant to the work of MFCU. Providers may shall disclose protected health care information to the MFCU for oversight activities as authorized by 45 CFR s164.512(d).

Commented [TAM83]: Recommend OHA consider adding language from the MOU between MFCU and OHA/ODHS to ensure that DOJ has the access necessary for successful audit/investigations of suspected fraud.

(107) An Indian Health Service facility meeting enrollment requirements shall be accepted enrolled on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.

(118) A n individual or organizationprovider that is currently subject to sanction by the DivisionAuthority, another state's Medicaid program, or the provider, a person with ownership or control of the provider, or a provider's managing employee is excluded, sanctioned or suspended by the federal government or another state from Medicare or Medicaid participation the provider is not eligible for enrollment, consistent with (see OAR 410-120-1400, 943-120-0360, Provider Sanctions); except when the Agency determines good cause exists, in accordance with 42 CFR 455.23.;

(129) All providers listed in section (5) of this rule must meet provide the following requirements information before the Division Authority may enroll and issue or revalidaterenew an Authority assigned provider number. Information disclosed by the provider is subject to verification by Authority and all providers must provide documentation at any time upon written request by the DivisionAuthority:

(a) The provider must disclose to the Authority the name, federal Tax Identification Number (TIN), date of birth, primary business address, every business location and P.O Box address of the provider and, as applicable, for the followingDivision:

(A) The identity of anyEach person who has a direct or indirect ownership or control interest in the provider, is an agent or is a managing employede by of the provider., regardless of whether that person is an individual or corporate entity;

(B) Each person who has a direct or indirect ownership or control interest in the provider, is an agent or is a managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the CHIP program in the last ten years;

(B) If the provider is an entity other than an individual practitioner or group of practitioners, disclose the following:

(C)~~(i) The name, date of birth, address, and tax identification number of each person with an ownership or controlling interest in the provider or in a~~Any subcontractor in which the provider has a direct or indirect ownership interest of five (5) percent or more.

(D) For the purpose of this rule, a person with direct or indirect ownership or control interest is defined in 42 CFR 455.101 and Authority calculates ownership and control percentage as required by 42 CFR 455.102.

(E) When disclosing tax identification numbers:

(~~I~~i) For corporations, use the federal ~~Tax Identification Number~~TIN;

(ii~~II~~) For individuals ~~in a solo practice or billing as an individual practitioner,~~ use the Social Security Number (SSN);

(iii~~III~~) All other providers use the ~~Employer Identification Number (~~EIN~~)~~;

(iv~~IV~~) The SSN or EIN of the rendering provider may not be the same as the Tax Identification Number of the billing provider;

(v~~V~~) Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041, SSN~~'s~~ and EIN~~'s~~ provided are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.

(F~~ii~~) Whether any of the persons so named with an ownership or control interest in the provider requesting enrollment:

(i~~I~~) Is related to another person with ownership or controlling interest in the provider requesting enrollment as a spouse, parent, child, sibling, or other family members by marriage or otherwise; and

(I~~ii~~) The name of any other current or former Medicaid providers in which an owner of the provider requesting enrollment has an ownership or control interest.~~Has an ownership or controlling interest in any other entity.~~

(G~~C~~) A provider ~~must~~ shall submit, within 35 calendar days of the date of a request by the Authority full and complete information about:

(i) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(ii) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

(H) Failure to disclose or submit required information: Authority will not reimburse a provider for services furnished in the period beginning the day following the date the information was due to the Authority and ending on the day before the date on which the information was supplied. Authority will suspend or terminate the provider's enrollment and Authority assigned provider number, in accordance with 42 CFR 455.104.

(b) The provider must submit ~~the following~~ required information to the ~~Division~~Authority:

(A) ~~For non-payable providers, a complete Non-Paid~~ Provider e~~E~~nrollment ~~Request~~ application based on the type of provider, Provider Enrollment Agreement, Provider Disclosure Statement, and all Attachments. Authority only accepts current versions of enrollment forms. All required forms are available at all times on OHA's Provider Enrollment website;

~~(B) For payable providers, a complete Provider Enrollment Request, Provider Enrollment Attachment, Disclosure Statement, and Provider Enrollment Agreement;~~

(B~~C~~) Application fee if required under 42 CFR 455.460;

(C~~D~~) Consent to criminal background check to complete Authority established screening process and comply with 42 CFR § 455.410 and § 455.450 requirements for provider categories which pose increased financial risk of fraud, waste or abuse to the Medicaid program, 42 CFR § 455.434 when required;

(D~~E~~) ~~To fulfill federal provider screening requirements pursuant to 42 CFR 455.436 and upon request, the name, date of birth, address, Division provider numbers, NPIs, and Social Security Number (SSN) of any provider who is enrolled or seeking enrollment with the Division~~. Authority may use Medicare provider enrollment data to satisfy the requirement of (C), above; and

(E~~e~~) Copy of provider's ~~Loss of the appropriate~~ licens~~eure~~, ~~or~~ certification, or both. ~~shall result in immediate disenrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;~~

(13) Authority will screen providers and validate information disclosed by providers as required under 42 CFR 455.436. Authority reserves the right to conduct and review providers requesting enrollment or revalidation in a more stringent manner than Medicare or other state Medicaid programs, conduct additional screening, or impose additional requirements on providers, or all three, for a provider or a group of providers identified by the Authority as at increased risk for fraud, waste or abuse.

(14) Authority may at its sole discretion require providers to enroll as a Medicare provider prior to enrolling in Oregon's Medicaid program.

(15) Authority may implement 180-day moratoriums on the enrollment of providers in a specific service category, on a statewide basis, or within a specific Oregon geographic area, when the Authority determines the action is necessary to safeguard public funds or to maintain the fiscal integrity of the Oregon Medicaid program.

(16) Provider enrollment and the signed Provider Enrollment Agreement expires five (5) years from the date of enrollment. Authority will revalidate all enrolled providers at least every five (5) years, compliant with 42 CFR §455.414. Authority reserves the right to revalidate more frequently, at its discretion. Failure of a provider to respond to Authority notice or failure to return requested information for revalidation will result in termination of the provider enrollment agreement and Authority assigned provider number.

Commented [TAM84]: Language added to permit OHA the flexibility to impose more stringent standards or screening activities if/as necessary to ensure Medicaid program integrity. OHA may apply more stringent standards than other states and than the Medicare program.

Commented [TAM85]: Not in CFR. Reflects current HSD practice of requiring HH and DME providers to enroll with Medicare. 42 CFR 455.450 permits states to enact additional screening

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Commented [TAM86]: Termination only. HSD provider enrollment unit process does not currently allow for suspension.

(~~d~~17) Enrolled providers ~~must~~ shall notify the ~~Division~~ Authority in writing using Authority forms within 35 calendar days of a material change~~s~~ in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including, but not limited to, those listed in this subsection:

(a~~A~~) Changes in federal TIN, SSN or EIN. Failure to notify the ~~Division~~ Authority of a change of Federal T~~ax Identification N~~umber for entities or a S~~ocial Security N~~umber, or E~~mployer Identification N~~umber for individual ~~rendering~~ providers may result in the imposition of a $50 fine per incident:

~~(i) If the Division notifies a provider about an error in their Federal Tax Identification, including Social Security Numbers or Employer Identification Numbers for individual rendering providers, the provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the Division's notice;~~

~~(ii) Failure to comply with this requirement may result in the Division imposing a fine of $50 for each such notice. Federal Tax Identification requirements described in this rule refer to any such requirements established by the Internal Revenue Service.~~

(b~~B~~) Changes in business service location, affiliation, ownership, NPI ~~and Federal Tax Identification Number~~, ownership and control~~ling~~ information, or criminal convictions. The provider must notify the Authority using Agency provided forms;~~may require the submission of a provider enrollment form, provider enrollment agreement, provider certification, or other related documentation;~~

(c) Providers who have more than one (1) NPI or receive a new NPI after enrolling with the Authority must complete a separate enrollment with the Authority for each NPI prior rendering services or listing the NPI on claims or encounters submitted to Authority.

(d~~C~~) ~~In the event of~~ B~~b~~ankruptcy proceedings, the provider shall immediately notify ~~immediately~~ the ~~Division~~ Authority ~~administrator~~ Provider Enrollment Unit in writing;

(e~~D~~) Claims submitted by or payments made to providers who have not furnished the notification required by this rule or to a provider that fails to submit a new application as required by the Division under this rule may be denied or recovered.

(17) If Authority notifies the provider of an error in the federal TIN, the provider must supply the appropriate valid federal TIN within 35 calendar days of the date of Authority's notice. Failure to comply with this requirement may result in Authority imposing a fine of $50 for each such notice. Federal TIN requirements described in this rule refer to any such requirements established by the Internal Revenue Service.

Commented [MTJ87]: Recommend change to 35 days to be consistent with 35 days above.

(18~~0~~) ~~Rendering P~~providers upon request may be enrolled by Authority ~~retroactive~~ up to 12 months prior to the date application for enrollment is received ~~services are provided to an~~by the Authority ~~Division client~~ only if:

(a) The provider is appropriately licensed, certified, and otherwise meets all federal and Authority ~~Division~~ requirements for providers at the time services are provided;

(b) The MCE submits to the Authority all required documentation to enroll the provider as an encounter only provider and that provider has an executed contract with and has successfully completed a credentialing process with the MCE;

(c) Upon request, the provider or MCE must submit to Authority a clear written statement as to why retro-enrollment is necessary to increase access to care and advance the triple aim.

~~(b) Services are provided fewer than 12 months prior to the date the application for provider status is received by the Division as evidenced by the first date stamped on the paper claim submitted with the application materials for those services, either manually or electronically.~~

~~(11) The Division reserves the right to retroactively enroll the provider prior to the 12-month period based upon extenuating circumstances outside the control of the provider, consistent with federal Medicaid regulations, and with approval of the Division's Provider Enrollment Unit Manager.~~

(12) The Authority requires ~~are~~ two types of provider numbers:

Commented [TAM88]: Recommend revising to align with current OHA practices.

(a) The ~~Division~~ Authority issue~~d~~s Oregon Medicaid provider number~~s~~ which~~to~~ establishes an individual or organization's enrollment as an Oregon Medicaid provider:

(A) The Provider Enrollment Agreement and the provider's enrollment as an Oregon Medicaid provider is specific to the provider type and specialty type listed on the application for enrollment and constitutes a contractual relationship with the Authority. This Authority assigned number designates the specific categories of services covered by the ~~Division~~ Authority Provider Enrollment Agree~~ttach~~ment. For example, a pharmacy provider number applies to pharmacy services ~~but~~ and cannot be used by the provider provide or bill for~~to~~ durable medical equipment.

(B) A provider seeking to render services or bill ~~, which requires~~ as more than one provider type shall complete a separate provider application ~~attachment~~ and establish~~es~~ a separate Oregon Medicaid provider number;

(C~~B~~) For providers not subject to NPI requirements, this Authority issued number is the provider identifier for billing the ~~Division~~Authority.

(b) The ~~Division~~ Authority requires a National Provider Identification (NPI) in compliance with ~~NPI requirements in~~ 45 CFR Part 162 Subpart D, for providers subject to NPI and Taxonomy requirements, as enumerated by the National Plan and Provider Enumeration System (NPPES). A provider must obtain an NPI and Taxonomy code prior to requesting enrollment and include these numbers in the application to request enrollment. The NPPES NPI information and provider applications are available at all times online: https://nppes.cms.hhs.gov/#/. For providers subject to NPI requirements:

(A) The NPI ~~and taxonomy codes~~is ~~are~~ the provider identifier for billing the ~~Division~~Authority. The Provider Enrollment Agreement and the provider's enrollment as an Oregon Medicaid provider is specific to the NPI listed on the application for enrollment and constitutes a contractual relationship with the Authority;

(B) Providers c~~C~~urrently enrolled ~~providers~~ that obtain a new or additional NPI ~~are~~ shall ~~required~~ complete a new application for provider enrollment~~to~~ ~~update their records~~ with the Division's Provider

Enrollment Unit and the application must be approved by the Authority prior to the provider rendering or billing for services associated with that NPI;

~~(C) Provider applicants must obtain an NPI and include it in their provider enrollment request to the Division.~~

(20~~13~~) Enrolled providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A,655 before prescribing a schedule II-controlled substance pursuant to 42 U.S.C 1396w-3a.

(a) The PDMP check does not apply to clients in exempt populations:

(A) Individuals receiving hospice;

(B) Individuals receiving palliative care;

(C) Individuals receiving cancer treatment;

(D) Individuals with sickle cell disease; and

(E) Residents of a long-term care facility, of a facility described in 42 U.S.C. 1396d, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w–3a(h)(2)(B); and

(F) Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.

(b) PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.

~~(14)~~ (2~~0~~1) Providers of services outside ~~the State~~ of Oregon shall be enrolled as a provider if they comply with the requirements in OAR 410-120-1260 and under the following conditions:

(a) The provider is appropriately licensed or certified in the state in which the provider is located and meets standards for participation in the Medicaid program. Disenrollment or sanction from other states' Medicaid programs or exclusion from any other federal or state health care program is a basis for disenrollment, termination, or suspension from participation as a provider in Oregon's medical assistance programs;

~~(b) The Division shall enroll only an out-of-state non-contiguous pharmacy as a provider when enrollment is necessary to meet a need that cannot be met by an in-state pharmacy. The pharmacy is required to be licensed in the state they are doing business where the client filled the prescription and must be enrolled with the Division in order to submit claims. Identified needs include but are not limited to the following:~~

~~(A) Enrollment is necessary to reimburse an out-of-state pharmacy for services rendered to a client that travels out of Oregon and is unable to use a pharmacy licensed in Oregon. The out-of-state pharmacy must be licensed in the state where the services are rendered;~~

Commented [AT89]: Recommend re-structuring section (20) subsection for clarity.

Commented [TM90]: This paragraph 20 was drafted before the Rule sec. 1180 proposed updates (above). May require additional edits/updates in this paragraph 20 depending on what the 1180 final version is.

~~(B) Enrollment is necessary to ensure the Division is the payer of last resort, such as when a client's TPL payer requires use of an out-of-state mail order pharmacy;~~

~~(C) Enrollment is necessary to ensure access to covered pharmacy services that are not otherwise generally available either through the Division's contracted mail order pharmacy or through enrolled in-state pharmacies;~~

~~(D) Enrollment is necessary to ensure access to covered pharmacy services provided to clients residing in a licensed in-state facility, such as a long-term care facility. The out-of-state pharmacy and the enrollment is limited to services provided to residents of the in-state facility.~~

(b~~c~~) The provider bills only for services provided within the provider's scope of licensure or certification;

(~~d~~c) For noncontiguous out-of-state providers, the services provided must be authorized in the manner required under OAR Ch 410 and Ch 309 rules specific to the service, OAR 410-120-1180 and these rule~~s~~ for out-of-state services ~~(OAR 410-120-1180) or other applicable Division rules~~:

(A) The services provided are for a specific Oregon Medicaid ~~client~~ member who is temporarily outside Oregon or the contiguous area of Oregon; ~~or~~

(B) Services provided are for foster care or subsidized adoption children placed out of state; or

(C) The provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) member~~clients~~; or

(D) The services for which the provider bills are covered services under the Oregon Health Plan (OHP) and follow Authority requirements for prior authorization, when applicable.

(~~e~~d) Facilities including but not restricted to hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, psychiatric hospitals, and residential care facilities shall be enrolled as providers only if the facility is enrolled as a Medicaid provider in the state in which the facility is located or is licensed as a facility provider of services by ~~the State of~~ Oregon;

(e~~f~~) Out-of-state providers may provide contracted services per OAR 410-120-1880; and

(f~~g~~) Out-of-state entities seeking to enroll, or enrolled, as a billing provider~~s~~ shall ~~may need to~~ register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to ORS 63.701 and OAR 410-120-1260.

(g) The Authority shall enroll an out-of-state noncontiguous pharmacy as a provider only when enrollment is necessary to meet a need that cannot be met by an in-state pharmacy. The pharmacy is required to be licensed in the state where the member filled the prescription (i.e. state where medication is dispensed) and must be enrolled with the Authority as a Medicaid provider in order to submit claims or encounters to Authority. Identified needs include but are not limited to the following:

(A) Enrollment is necessary to reimburse an out-of-state pharmacy for services rendered to a member that travels out of Oregon and is unable to use a pharmacy licensed in Oregon. The out-of-state pharmacy must be licensed in the state where the services are rendered;

(B) Enrollment is necessary to ensure the Authority is the payer of last resort, OAR 410-120-1280, such as when a member's TPL payer requires use of an out-of-state mail order pharmacy;

Commented [MTJ91]: Recommend review by Policy. We are uncertain if these services are still being provided by OHP.

(C) Enrollment is necessary to ensure access to covered pharmacy services that are not otherwise generally available either through the Authority's contracted mail order pharmacy or through enrolled in-state pharmacies; or

(D) Enrollment is necessary to ensure access to covered pharmacy services provided to members residing in a licensed in-state facility, such as a long-term care facility. The out-of-state pharmacy and the enrollment is limited to services provided to residents of the in-state facility.

~~(15) When a substitute physician is retained to take over another physician's professional practice while he or she is absent or unavailable, the following shall apply:~~

~~(a) The Division recognizes that absentee physicians may retain substitute physicians as a locum tenens or as part of a reciprocal billing arrangement. For purposes of this rule:~~

~~(A) A "locum tenens" means a substitute physician retained to take over another physician's professional practice while he or she is absent (i.e., absentee physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.;~~

~~(B) A locum tenens may not be retained to take over a deceased physician's professional practice without becoming enrolled with the Division;~~

~~(C) A "reciprocal billing arrangement" means a substitute physician retained on an occasional basis.~~

~~(b) Substitute physicians are not required to enroll with the Division; however, the Division may enroll such providers at the discretion of the Division's provider enrollment manager if the provider submits all information required for provider enrollment as described in this rule;~~

~~(c) In no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;~~

~~(d) The absentee physician must be an enrolled Division provider and must bill with their individual Division assigned provider number and receive payment for covered services provided by the substitute physician:~~

~~(A) Services provided by the locum tenens must be billed with a modifier Q6;~~

~~(B) Services provided in a reciprocal billing arrangement by the substitute physician must be billed with a modifier Q5;~~

~~(C) In entering the Q5 or Q6 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection and are services for which the absentee physician is authorized to submit a claim;~~

~~(D) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled provider's right to receive payment or to submit claims may be revoked.~~

~~(e) These requirements do not apply to substitute arrangements among physicians in the same medical practice when claims are submitted in the name of the practice or group name;~~

~~(f) Nothing in this rule prohibits physicians sharing call responsibilities from opting out of the substitute provider arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled rendering providers and as long as duplicate claims for services are not submitted.~~

(22~~16~~) ~~Provider~~ Termination of provider enrollment and the Authority assigned provider number:

(a) The provider may terminate enrollment at any time. The request ~~must~~ shall be in writing and signed by the provider. The notice shall specify the ~~Division~~ Authority assigned provider number to be terminated and the effective date of termination. Termination or deactivation of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;

(b) The ~~Division~~ Authority may deny enrollment, revalidation, or re-enrollment, or sanctio~~termina~~te and~~or~~ suspend or terminate a provider~~s when a~~t ~~provider fails to meet on~~y~~e or more of t~~ime~~he including but not limited to any of the reaso~~quirement~~s ~~governing a provider's participation~~listed in OAR~~regon's~~ 410-120-1400~~medical assistance programs such as, but not limited to~~; and~~:~~

(c) Authority will send written notice to the provider when a provider's application for enrollment, revalidation or re-enrollment is denied, enrollment is terminated or suspended, or a sanction is imposed by Authority under OAR 410-120-1400, regardless of whether the provider is continuously enrolled, or the provider number is active at the time notice is issued. Authority notice will state the effective date of the Action.

~~(A) Breaches of provider agreement;~~

~~(B) Failure to submit timely and accurate information as requested by the Division;~~

~~(C) Failure to submit fingerprints in a form determined by the Division within 30 days of request;~~

~~(D) Failure to permit access to provider locations for site visits;~~

~~(E) Failure to comply with federal or state statutes and regulations or policies of the Division that are applicable to the provider;~~

~~(F) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;~~

~~(G) Any person who has an ownership or controlling interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid CHIP, or the Title XX services program in the last ten years;~~

~~(H) Failure to fully and accurately make any disclosure required under this section (9) of this rule.~~

(23~~17~~) A provider may appeal a termination, suspension or other sanction. If a provider's enrollment, revalidation, or re-enrollment ~~in the OHP program~~ is denied, enrollment is suspended, ~~or~~ terminated or any sanction is imposed by the Authority under this rule, the provider~~s~~ may request a contested case hearing pursuant to OAR 410-120-1400, 410-120-1460, 410-120-1600 and 410-120-1860.

Commented [TAM92]: Language revised or moved to 410-120-1400 to eliminate duplication. See 410-120-1400 for revised language.

Commented [KN93R92]: Jesse, did you see this suggestion by Allison? Should we delete thi section since it's in 1400?

Commented [TM94R92]: Just to clarify - the proposed deletion is to move what are currently the (A) - (H) subparagraphs of (16)(b):

(16)(b)...
(A) Breaches of provider agreement;
(B) Failure to submit timely and accurate information as requested by the Division;
(C) Failure to submit fingerprints in a form determined by the Division within 30 days of request;
(D) Failure to permit access to provider locations for site visits;
(E) Failure to comply with federal or state statutes and regulations or policies of the Division that are applicable to the provider;
(F) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;
(G) Any person who has an ownership or controlling interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid CHIP, or the Title XX services program in the last ten years;
(H) Failure to fully and accurately make any disclosure required under this section (9) of this rule.

(24) If a provider's enrollment is suspended or terminated, the Authority may notify board of registration or licensure, federal or other state Medicaid agencies, MCEs and the National Practitioner Data Base of the finding(s) and the sanction(s) imposed.

(25) If a provider's enrollment has been deactivated, terminated or suspended for any reason the provider must complete a new application for enrollment, including all required documentation, and submit it to the Authority. To re-enroll the provider, Authority review is contingent upon the risk-based screening in section (3) of this rule. A re-enrollment by Authority has the same requirements and process as a new enrollment.

(26) Authority may deny enrollment, revalidation or re-enrollment request (for encounter purposes) to an encounter only provider, or sanction and suspend or terminate an enrolled encounter only provider, for any of the reasons in OAR 410-120-1400:

(a) Authority will notify the encounter only provider and the MCE. Authority notice will state the effective date of the Action;

(b) Authority may recoup any overpayments in accordance with OAR Ch 410, Div. 120, CH 410 Div. 141, and the contract between the MCE and the Authority; and

(c) The MCE must adjust encounter claims in accordance with OAR 410-141-3570 and recoup overpayments from the provider in accordance with OAR 410-141-3510.

(27~~18~~) The provision of health care services or items to ~~Division~~ Authority ~~client~~members is a voluntary action on the part of the provider. Providers are not required to serve all ~~Division~~ Authority ~~client~~members seeking service.

(28) Providers seeking to enroll in the Authority must be a provider type established in the State Plan as approved for Medicaid reimbursement.

Commented [TAM95]: Verify with Jesse to make sure this is consistent with State Plan.

[NOTE: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-120-1280

410-120-1280
Billing

Commented [KN96]: Billing- client right to private pay- Need to include use of the agreement to pay form as the written documentation.
Larger lift is to get new workgroup to review the 3 agreement forms to see if it can be combined into a single forms- OMBUSMAN office request.

Summary: Electronic Signatures and agreement to pay form

(1) A provider enrolled with the Authority or providing services to a client in an 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. 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 shall~~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 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 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, and the provider does not have a completed agreement to pay form (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 ~~may~~must ~~shall~~ 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.

(5) Providers shall~~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 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 has

passed. The provider shall 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;

(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) recipients prior to June 30, 2023, that received services that are not part of the CWM emergency only benefits; see OAR 410-134-0003(3) for coverage and limitations. See OAR 410-134-0004 for coverage and billing guidance.

(i) Members receiving CWM benefit plan before June 30, 2023; before providing the non-covered service, the client must have signed the provider-completed Agreement to Pay OHP 3165, 3166, or 4109.

(ii) CWM clients who are limited English proficient, the provider must have provided translation or interpretation services to ensure the client understood the Agreement to Pay.

(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 shall~~must~~ complete the OHP 3165 pursuant to section (5)(h) of this rule before providing these services;

(f) The client has requested to privately pay for services denied as not meeting the prior authorization, HERC or other criteria. Refer to non-covered services 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 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 (Authority or MCE) may pay for the service, and that the provider may not bill the client for an amount greater than the amount the appropriate payer may pay; and

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

(D) The provider documents in writing, signed by the client or the client's representative, indicating that:

(i) The provider gave the client 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 service by signing an agreement to pay form (3165, 3166, 4109) -and provider assures they have given~~incorporating~~ all of the information described above; and

Commented [SG97]: Will this be a benefit identifier used after HOP coverage is in place?

Commented [KN98R97]: Before the permanent filing for both HOP and these rules, will merge with CWM/HOP changes, IIBHT changes, EPSDT changes, and other programs that are currently amending in Division 120

Commented [SG99R97]: Thank you.

(iv) 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 Authority or to the client's MCE or third-party payer that is subject to the agreement.

(h) Non-covered services 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 the provider-completed Agreement to Pay (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. The completed OHP 3165, 3166, 4109 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. For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy. Providers must make a copy of the completed OHP 3165, 3166 or 4109 form or facsimile available to the Authority or MCE upon request.

(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, 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;

(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;

(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;

Commented [TM100]: I would recommend leaving this language in. I realize its antiquated, but there are so many ways that a claim could be altered (with intent to defraud or not) that could result in a false claim. There is just no way to address in this rule all possible/potential claim issues that would potentially trigger a False Claims Act (FCA) violation.

(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~~must ~~to~~ shall 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~~ Authority 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~~ Authority for up to triple the amount of the ~~Division~~ established overpayment received as a result of the violation.

(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 be the code that most accurately describes the services provided. 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:

Commented [AJ101]: This is standard language under medical billing structure, HIPAA, AMA etc.Biller and medical practitioners know what this means so if you change it to be understandable to others then the practitioners may be confused. But the plain m eaning is if there is a diagnosis that says cut on finger and there is a diagnosis that says 1.2 cu cut on right 3rd digit finger then the provider is required to use that more defined diagonosis per their standard committee rules.

Commented [KN102]: Where is this standard defined?? Highest degree according to who? IS there some sort of guide? Is there a CFR? And why not "accurate degree of specificity" ?? or "required degree" ???

(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.

Commented [KN103]: Do we mean state of Oregon?

(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.

Commented [KN104]: Can this sentence say "When a provider decides to bill the Division, once the Division makes payment, no additional billing to a third party is permitted by the provider, even if a third-party payer may reimburse the service at a higher rate than the Division.

(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;

Commented [KN105]: Is honor the correct term? Should we say "shall comply with that request" instead?

(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

410-120-1320

410-120-1320
Authorization of Payment

Summary: Unknown

(1) Some services or items covered by the Division require authorization before the service can be provided. See the appropriate Division rules for information on services requiring authorization and the process to be followed to obtain authorization.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in the appropriate Division rules.

(3) The Division ~~will~~ shall authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

(4) The Division ~~will~~ may not make payment for authorized services under the following circumstances:

(a) The client was not eligible at the time services were provided. The provider is responsible for checking the client's eligibility each time services are provided;

(b) The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency;

(c) The service has not been adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the provider's files;

(d) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be medically appropriate;

(e) The services billed are not consistent with those provided;

(f) The services were not provided within the timeframe specified on the authorization of payment document;

Commented [KN106]: Conflicts with rule & PA request. Refer to email from med unit "conflicting PA rule"
Not able to find what needed to be revised at this time. Need to reach out to med unit.

Commented [TM107]: this would change the intent of the subparagraph. this does not have the same meaning.

there is a standard being applied in (4)(b) - if the provider cannot 'produce' the record/chart (i.e. give/show OHA a copy) OHA may deem the record not to exist.

Commented [SG108R107]: Comment: The proposed change "(4)(b) - if the provider cannot 'produce' the record/chart (i.e. give/show OHA a copy) OHA may deem the record not to exist. would be very helpful in justifying why documentation is required for prior authorization.

Commented [TM109R107]: @Kumar Nita so it sounds like for OPI audit purposes and for PA purposes - (4)(b) should not be changed. TY

Commented [SG110R107]: A change from "Cannot" to "May not", sounds as though producing the documentation is optional. The intent is that it is not optional. We will not pay if they cannot produce the necessary (required or requested) documentation.

Commented [TM111R107]: agreed.

Commented [KN112R107]: Currently, I'm going to stay in alignment with the DOJ Manual, page B7, but can discuss the word choice in the future.
https://dhsoha.sharepoint.com/teams/OHA-HSD-MedicaidPrograms/Shared%20Documents/Forms/AllItems.aspx?id=%2Fteams%2FOHA%2DHSD%2DMedicaidPrograms%2FShared%20Documents%2FFFS%20Process%20Library%2FFFS%20Operations%20Process%20Documents%20%2D%20Finalized%2FRulemaking%20Resources%2F2019%20Appendix%20B%20%2D%20AG%20Administrative%20Law%20Manual%20%281%29%20%281%29%2Epdf&parent=%2Fteams%2FOHA%2DHSD%2DMedicaidPrograms%2FShared%20Documents%2FFFS%20Process%20Library%2FFFS%20Operations%20Process%20Documents%20%2D%20Finalized%2FRulemaking%20Resources&p=true&ga=1

(g) The services were not authorized or provided in compliance with the rules in these General Rules and in the appropriate provider rules.

(5) Retroactive authorizations:

(a) Authorization for payment may be given for a past date of service if:

(A) The client was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules, and;

(C) The request for authorization is received within 90 days of the date of service;

(b) Any requests for authorization after 90 days from date of service require documentation from the Provider that authorization could not have been obtained within 90 days of the date of service.

(7) Payment authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the cClient's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.

(8) When clients have other health care coverage (third-party resources, or TPR), the Division only requires payment authorization for the services that TPR does not cover. Examples include:÷

(a) When Medicare is the primary payer for a service, no payment authorization from the Division is required, unless specified in the appropriate Division program rules;

(b) When other TPR is primary, such as Blue Cross, CHAMPUS, etc., the Division requires payment authorization when the other insurer or resource does not cover the service or reimburses less than the Division rate.

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

410-120-1360

410-120-1360
Requirements for Financial, Clinical and Other Records

Summary: Routine services for clinical trials – following HSD adding these services in 2022, OPI recommended several updates to Sec. 1360: goal of these updates was to ensure OPI can access to the documents/records needed/necessary for auditing these types of services. Because HSD did not create new rule section in Div. 120 (or any other div. of OAR CH 410) for these types of services the request from OPI was to use Sec. 1360 (general recordkeeping). Even incorporating a minor update into rule would be helpful.

Commented [KN113]: to ensure OPI can access to the documents/records needed/necessary for auditing these types of services. Because HSD did not create new rule section in Div. 120 (or any other div. of OAR CH 410) for these types of services the request from OPI was to use Sec. 1360 (general recordkeeping).

Commented [TM114R113]: propose adding language to records rule specific to record keeping/access to records for routine services for clinical trials.

(1) The Authority shall analyze, monitor, audit, and verify the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, quality of care, and access to care of the Medical Assistance Programs and the Children's Health Insurance Program.

(2) The provider or the provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records shall develop and maintain adequate financial and clinical records and other documentation that supports the specific care, items, or services for which payment has been requested. Payment shall be made only for services that are adequately documented. Documentation shall be completed before the service is billed to the Division and meet the following requirements:

(a) All records shall document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service is provided, and the individual providing the service. Patient account and financial records shall also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the provider shall maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records shall be accurate and in sufficient detail to substantiate the data reported;

(b) Clinical records, including records of all therapeutic services, shall document the client's diagnosis and the medical need for the service. The client's record shall be annotated each time a service is provided and signed or initialed by the individual who provided the service or shall clearly indicate the individual who provided the service. For purposes of medical review, the Authority adopts Medicare's electronic signature policy as outlined in the CMS Medicare Program Integrity Manual. Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider or practitioner and any additional standards for documentation found in this rule, the individual provider rules, and any relevant contracts. When a provider maintains records electronically, within an EHR, EMR or other electronic clinical trial management or billing system, the provider must be able to provide:

(A) hard copy versions, upon request; and

(B) an auditable means of demonstrating the date the record was created, the identity of the creator of a record, the date the record was modified, what was modified in the record, and the identity and credentials of any individual who has modified the record.

(C) If the provider maintains records electronically or permits the use of electronic signatures, the provider must document any aspect of the provision of services. The provider must maintain appropriate safeguards to assure the authenticity of the electronic records and signatures.

(c) Electronic Data Transmissions shall comply with the Uniform Electronic Transactions Act cited in ORS chapter 84 and OAR 943-120-0100;

(d) Policies and procedures shall ensure the maintenance of the confidentiality of medical record information. These procedures ensure the provider may release information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, and 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50.

(e) Retain clinical records for seven years and financial and other records described in paragraphs (a) and (b) of this rule for at least five years from the date(s) of service.

Commented [TM115]: propose adding subparagraphs to (b) to address EHR access/records. However, this proposed update may also fit within proposed new paragraph (e).

sample/example language:
"(b).... and any relevant contracts; When a provider maintains records electronically, within an EHR, EMR or other electronic clinical trial management or billing system, the provider must be able to provide:
(A) hard copy versions, upon request; and
(B) an auditable means of demonstrating the date the record was created, the identity of the creator of a record, the date the record was modified, what was modified in the record, and the identity and credentials of any individual who has modified the record.
(C) If the provider maintains records electronically or permits the use of electronic signatures, the provider must document any aspect of the provision of services. The provider must maintain appropriate safeguards to assure the authenticity of the electronic records and signatures."

(f) Record requirements applicable only to providers who are providing routine services for clinical trials:

(A) Information must be retained and provided if requested for medical review, audit or investigation by ~~OHA~~Authority, DOJ MFCU or other state or federal regulators and shall include:

(i) T~~t~~he trial name, sponsor, and sponsor-assigned protocol number (This is the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov).

(ii) A~~a~~ copy of the member's signed consent form

(B) Record for clinical trials must be maintained and accessible for 10 years

(C) T~~t~~he records be stored and protected compliant with HIPAA and other applicable standards.

(3) Upon written request from the Authority, the Medicaid Fraud Control Unit Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives furnish requested documentation immediately or within the time-frame specified in the request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority, Medicaid Control Unit, or DHHS may review and copy the original documentation in the provider's place of business. Upon the written request of the provider, the program or the unit may, at their sole discretion, modify or extend the time for providing records if, in the opinion of the program or unit good cause for an extension is shown. Factors used in determining whether good cause exists include:

(a) Whether the written request was made in advance of the deadline for production;

(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;

(c) The efforts already made to comply with the request;

(d) The reason(s) for not meeting the deadline~~cannot may not be met~~;

(e) The degree of control that the provider had over its ability to produce the records prior to the deadline;

(f) Other extenuating factors.

(4) Access to records, inclusive of medical charts and financial records does not require authorization or release from the client if the purpose is:

(a) To perform billing review activities;

(b) To perform utilization review activities;

(c) To review quality, quantity, and medical appropriateness of care, items, and services provided;

(d) To facilitate payment authorization and related services;

(e) To investigate a client's contested case hearing request;

(f) To facilitate investigation by the Medicaid Fraud Control Unit or DHHS; or

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Commented [TM116]: @Kumar Nita Hi - Just to confirm - this pared down language is what HSD is willing to implement, at this time? or would HSD consider the full recommendation? I was not sure if you had been able to see the full track-changes recommendations in the draft I sent you. TY

Commented [KN117R116]: Thank you, Allison! This is the version that Jesse Anderson created. I can ask him to review again

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Commented [TM118]: alternative wording proposed to removed 'cannot' from (d).

Commented [KN119R118]: I like this edit!

(g) Where review of records is necessary to the operation of the program.

(5) Failure to comply with requests for documents within the specified time-frames means that the records subject to the request may be deemed by the Authority not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination may subject the provider to possible denial or recovery of payments made by the Division or to sanctions.

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135 & 414.145

410-120-1385

410-120-1385
Compliance with Public Meetings Law

Summary: No more communications unit

(1) Advisory committees with the authority to make decisions for, conduct policy research for, or make recommendations on administration or policy related to the medical assistance programs operated by the Authority pursuant to ORS Chapter 414 must comply with provisions of ORS 192.610 to 192.690 — Public Meetings Law.

(2) This rule applies to those advisory committees of the medical assistance programs operated under ORS Chapter 414 that are both:

(a) Created by state constitution, statutes, administrative rule, order, intergovernmental agreement, or other official act, including direct or delegated authority from the Director of the Authority; and

(b) Comprised of at least two committee members who are not employed by a public body.

(3) Advisory committees subject to this rule must comply with the following provisions:

(a) Meetings ~~must~~ shall be open to public attendance unless an executive session is authorized. Committees ~~must~~ shall meet in a place accessible to persons with disabilities and, upon request, shall make a good faith effort to provide a sign language interpreter for persons with hearing impairment;

(b) Groups ~~must~~shall provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the Authority or Health System Division (Division) shall be sufficient compliance of the advanced notice requirement.

~~(b) Groups must provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the Authority Division of Medical Assistance Programs (Division) will be sufficient compliance of the advanced notice requirement. Interested persons, including news media, may request hard copy notices by contacting the Division's communications unit;~~

(c) Groups ~~must~~ shall take minutes at meetings and make them available to the public upon request to the contact person identified on the public notice;

(d) Any meeting that is held through the use of telephone or other electronic communication must be conducted in accordance with the Public Meetings Law.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065 & 414.227

410-120-1396

410-120-1396
Provider and Contractor Audits

Summary: 1396 addresses claims and electronic signature but in the pandemic there were questions about using electronic signatures for the agreement to pay form. Program integrity brought up some concerns so thought the GR should address these specific to the agreement form used in rule. Refer to Allison Tonge--- Allison said the question came from the pharmacy program

(1) Individual providers or business entities (providers) ~~Providers (individuals or business entities)~~ enrolled with or under contract with the Oregon Department of Human Services (ODHS) or the Oregon Health Authority (Authority) (hereafter referred to as "provider") receiving payments from the ODHS or Authority are subject to audit or other post payment review procedures (hereafter referred to as "audit") for all payments applicable to items or services furnished or supplied by the provider to or on behalf of ODHS or Authority Medicaid members.

(a) Audit rules and procedures ensure proper payments were made based on requirements applicable to covered services, ensure program integrity of the Authority or ODHS programs and services as outlined in Oregon Administrative Rules (OARs) 407-120-0310, 943-120-1505, 410-120-1160, OAR Ch 410 sections applicable to specific services, and establish authority for the Authority Office of Program Integrity (OPI) to recover overpayments and discover possible instances of fraud, waste, and abuse in the Medicaid member program.

(b) Audits are conducted of providers paid under Oregon's Medicaid program who direct, furnish or supply items or services as fee-for-service providers, as defined in OAR 410-120-0000, or as participating providers, non-participating providers or subcontractors of a Managed Care Entity (MCE), as defined in OAR 410-141-3500. This includes all provider types enrolled by the Authority or ODHS under OAR 410-120-1260 or by agreement or contract with the Authority or ODHS.

(c) The Authority and ODHS share duties and functions related to audits and have the authority to determine which of the two agencies is authorized to fulfill a particular function.

(2) The Authority may employ internal staff, consultants, or contractors, or cooperate with federal or state oversight authorities or other designees to conduct an audit or perform other audit procedures.

Commented [SG120]: Recommend changing "must" to "shall" for rule continuity.

Commented [KN121]: Is this redundant? If it's an entity, a provider is an entity? Is there a better word that can use?

Commented [SG122R121]: Recommend: Individual providers or business entities (providers) enrolled with Oregon department of Human Services (ODHS) and/or the Oregon Health Authority (OHA), are subject to audit or other post payment review (Audit), for all payments applicable to items or services provided by the provider to or on behalf of ODHS &/or OHA Medicaid members.

Commented [KN123R121]: Thank you Gloria

Commented [TM124R121]: That works. TY gloria.

Commented [KN125]: Plain language suggestion: "Audits or other post payment review procedures are referred to as "audits" in this rule. Entities that are enrolled with or under contract with the Department of Human Services (DHS) or the Oregon Health Authority (Authority), and receiving payments from DHS or the Authority are referred to as "provider" in this rule. Providers can be audited for all payments applicable to items or services furnished or supplied by the provider to or on behalf of DHS or Authority Medicaid members.

Commented [TM126R125]: Recommend not revising this opening paragraph. OPI intended the language in this paragraph to address any and all types of payments that ODHS and OHA make to providers - and all types of contracts/relationships that OHA and ODHS have with providers - individuals or entities.

Audits are not limited to post payment reviews. A financial audit - for example - would consider current payment processes within the business not only past behavior.

If you believe edits are necessary for clarity, OPI would recommend retaining maximum flexibility in (1) to allow for any type of review or audit that may be necessary for OPI in carrying out its work of fraud/abuse investigations or identifying or preventing overpayments across any program or type of provider that receives payment/funds.

Commented [AJ127]: I think this gives a bit more detail so I don't think it is redundant but just gives more than given in (1).

Commented [KN128]: Didn't we already define in section (1) who is subject to an audit? All providers or entities contracted or enrolled with …. And receiving payments? Is this section saying something different?

The Authority will assign a contractor or one or more individuals to conduct the audit (hereafter referred to as "auditor").

(a) The Authority ~~will~~ shall ensure auditors have appropriate training and subject matter expertise to conduct the audit and perform other audit procedures.

(b) OPI may, at its sole discretion, modify or extend the timeframes noted in this rule when the provisions of OAR 410-120-0011 are in effect or in response to local emergencies that are outside the control of Authority or providers.

(3) The auditor and OPI management will determine the scope, time period, objective, and subject matter covered by the audit.

(4) The authority for access to records is found in OARs 407-120-0370 and 410-120-1360, as well as other terms of agreements or contracts authorizing access to records for audit purposes.

(5) The auditor may conduct an on-site audit, examine and copy records using provider's on-site resources or at the provider's expense, interview employees, and conduct such work as the auditor determines is necessary to provide sufficient and competent evidential basis for drawing conclusions about the audit subject matter.

(6) The auditor may conduct a desk audit of records requested by the auditor and supplied by the provider, at the provider's expense, or other source as necessary for the auditor to determine sufficient and competent evidential basis for drawing conclusions about the audit subject matter.

(7) The auditor may consider other audits of the provider including, but not limited to, reviews conducted by a federal or state authority, which may include those performed by internal auditors, audit organizations, or contractors established by the federal or state government for the auditing of the Authority or DHS programs, an MCE, and the provider's independent audit of the provider's claims and financial statements.

(a) The auditor may consider other indicators or issues related to program integrity activities. The auditor may also consider past or present Authority program integrity activities conducted under OAR 410-120-1395 and OAR 407-120-0310 that have identified same or similar instances of non-compliance.

(b) The auditor ~~will~~ shall determine the scope of other audit work and evaluate the reliability of its relationship to the scope and objective of the audit being conducted in determining the weight to be given to the other audit work.

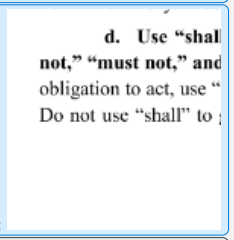
(c) (c) The auditor may, in addition to the record request sent to the provider, request documentation from an MCE when the items or services within the audit scope were furnished or supplied to or on behalf of a Medicaid member enrolled in that MCE.

(A) The auditor ~~will~~ shall provide copies of the preliminary and final audit report to the MCE;

(B) The MCE must hold the audit, the preliminary report and its preliminary findings in confidence and must not act directly or indirectly to discourage a provider's participation in the audit;

Commented [TM129]: it was my understanding that in the OARs whenever the agency or agency staff take an action the rules use 'will' not 'shall.' The 'auditor' referred to here in the rule is exclusively an OHA employee or a contractor of OHA employed to perform an audit.

Commented [KN130R129]: Appendix B of the DOJ Manual, on page 7 recommends shall, and says to avoid "will"


d. Use "shal
not," "must not," and
obligation to act, use "
Do not use "shall" to

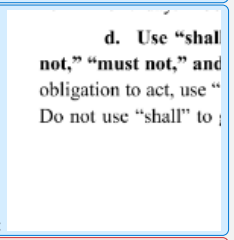
Commented [KN131R129]:

Commented [TAM132R129]: Thank you for your feedback.
OPI would like to continue to use 'will' throughout this rule and not make the change to 'shall'. I am aware of the DOJ's recommendation and OPI has chosen to use this language.

Commented [KN133R129]: Will continue working on this after the notice. Need to check in with Hearings Unit and Shared Services about the wording

Commented [TM134]: it was my understanding that in the OARs whenever the agency or agency staff take an action the rules use 'will' not 'shall.' The 'auditor' referred to here in the rule is exclusively an OHA employee or a contractor of OHA employed to perform an audit.

Commented [KN135R134]: Appendix B of the DOJ Manual, on page 7 recommends shall, and says to avoid "will"


d. Use "shal
not," "must not," and
obligation to act, use "
Do not use "shall" to

Commented [KN136R134]:

Commented [AJ137]: the MCE is not a provider and this is giving our audit unit the ability to get records from the performing provider and the CCO's records they have that the provider does not.

Commented [KN138]: In section (1) we said we would use the term "provider" "hereafter" for entities that receive payment from OHA or DHS. Is there are reason we switch to saying MCE here?

(C) The auditor may consider the MCE documentation requested by the auditor as necessary for the auditor to determine sufficient and competent evidential basis for drawing conclusions about the audit subject matter; and

(D) The auditor ~~will~~ shall evaluate the relevance and reliability of the MCE's documents in relationship to the scope and objective of the audit being conducted in determining the weight to be given to any MCE documents.

(8) The Authority's OPI may use a ~~random~~ statistical sampling methodology in audits. The OPI may use, but is not limited to, the statistical and sampling methods ~~such as that detailed~~ in the ~~paper~~ book entitled "~~Development of a~~ Sample~~ing~~ Techniques, 3rd Edition~~Design for the Post-Payment Review of Medical Assistance Payments~~," written by William G. Cochran~~Lyle Calvin, Ph.D.~~, (C~~alvin Paper~~ochran)~~. The OPI adopts by reference but is not limited to fo~~For ~~llowing the method of random~~ sampling and calculation of overpayments~~. described in the Calvin Paper:~~

(a) In determining whether to use an overpayment calculation method ~~set forth~~ in section (8) of this rule, the auditor and OPI management may consider:

(A) The provider's overall error rate identified in the audit;

(B) If past audits have identified the same or similar instances of non-compliance;

(C) The severity of the errors established in the audit; or

(D) Any adverse impact on the health of members and their access to services in the provider's service area.

(b) If OPI determines an overpayment amount by a random sampling and overpayment calculation method ~~set forth~~ in section (8) of this rule, the provider may request, for the services within the scope of the audit, a 100 percent audit of all billings from the same time period of the audit submitted to the DHS or Authority for items or services furnished or supplied to or on behalf of members. If a 100 percent audit is requested by the provider:

(A) Payment and arrangement for a 100 percent audit must be paid by the provider requesting the audit;

(B) The audit must be conducted by an independent auditor or other individual whose qualifications the Authority has determined, in writing, to be acceptable; who is knowledgeable with OAR and the billing and coding standards covering the payments in question; and who must waive any privilege to OPI in relation to the work papers and work product of the independent auditor;

(C) The 100 percent audit must be completed within 90 calendar days of the provider's request to use such audit in lieu of the Authority's ~~random~~ sample, or within a timeframe approved by OPI;

(D) The provider must waive all rights to appeal the findings of the independent auditor; and

(E) The independent auditor must produce a final audit report or similar document, detailing the findings of the 100 percent audit, including the overpayment assessment and recommendations to the provider and OPI. The independent auditor's work papers must be made available, at the providers' expense, to OPI upon request.

Formatted: Superscript

Commented [AJ139]: I assume it is but the audit unit wouod be the one that could answer that.

Commented [TM140R139]: that is correct. depending on the size of the audit the workpapers generated in the audit could be extensive. there is a cost for copies - either for making a paper copy or for time of employees to make electronic version copies. OHA has historically declined to pay providers for this.

Commented [KN141]: There is a cost for this?

(c) For providers furnishing or supplying items or services to or on behalf of Medicaid members enrolled in an MCE, the overpayment amount will be determined by OPI:

(A) Using the Authority fee-for-service fee schedule in effect on the date of service; or

(B) If requested by the MCE, OPI may use the MCE's rate per claim or encounter when that rate increases the accuracy of the calculated overpayment. OPI reserves the right to review the MCE rate for reasonability.

(9) The auditor ~~will~~ shall prepare a records request letter and deliver the records request to the provider in person, or by secure encrypted email, or registered or certified mail.

(a) A provider's refusal to accept the secure encrypted email, registered or certified mail or in-person delivery will ~~may~~ not stop the audit from proceeding.

(b) The provider ~~will~~ shall have 30 calendar days from the postmark date or email sent date of the records request letter to respond with the requested records. The provider must provide immediate access to the requested records when the request is made in person.

(c) The provider may request, in writing to the auditor, up to a 15 calendar-day extension to the records request due date for preparing documentation. The request must be received by OPI before the timeframe in subsection 9(b) ~~above~~ of this rule expires and the extension must be authorized in writing by the auditor or OPI management. An additional 15 calendar-day extension, requested in writing, may be granted at the discretion of OPI management.

(10) The auditor will prepare a preliminary audit report or similar document. The preliminary audit report informs the provider of the opportunity to provide additional documentation to the auditor about the services within the scope of the preliminary audit report;~~.~~

(a) Auditor will deliver the preliminary audit report to the provider in person, by secure encrypted email, or by registered or certified mail;~~.~~

(b) Refusing to accept the secure encrypted email, registered or certified mail or in-person delivery will not stop the audit process from proceeding;~~.~~

(c) The provider and MCE have 30 calendar days from the in-person delivery date, postmark date, or email sent date of the preliminary audit report to respond to the audit. The MCE must hold the preliminary report and its preliminary findings in confidence and must not act directly or indirectly to discourage a provider's participation in the audit;~~.~~

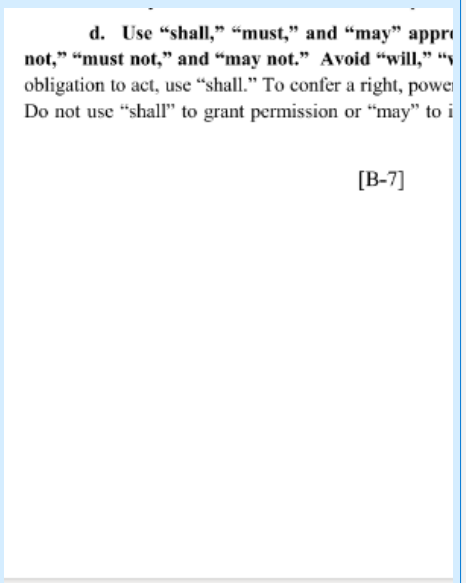
(d) The provider may request, in writing to the auditor, up to a 15 calendar-day extension to the preliminary audit report response due date for submitting additional documentation. The request must be received before the 30 calendar-day timeframe in subsection 10(c) ~~above~~ of this rule expires and the extension must be authorized in writing by the auditor or OPI management. An additional 15 calendar-day extension, requested in writing, may be granted at the discretion of OPI management.

(11) The auditor will prepare a final audit report or similar document which is also the Authority's final order. The final audit report includes an overpayment amount, findings, recommendations, and appeal rights. Auditor will deliver the final audit report to the provider in person, by secure encrypted email or by registered or certified mail. When the audit is of an MCE provider, the auditor will also deliver a copy

Commented [TM142]: this should be a definite statement. Using 'may' makes this sound conditional.

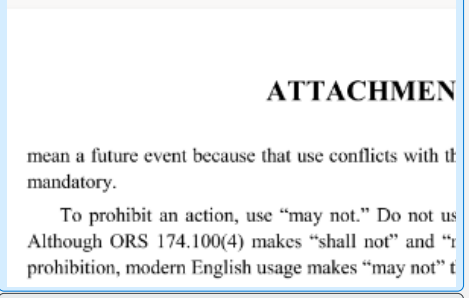
alternative language could be: "does not" or "shall not."

Commented [KN143R142]: The DOJ Manual asks us to use may not, and avoid shall not.



d. Use "shall," "must," and "may" appr
not," "must not," and "may not." Avoid "will," "
obligation to act, use "shall." To confer a right, powe
Do not use "shall" to grant permission or "may" to i

[B-7]



ATTACHMEN

mean a future event because that use conflicts with th
mandatory.

To prohibit an action, use "may not." Do not us
Although ORS 174.100(4) makes "shall not" and "r
prohibition, modern English usage makes "may not" t

Commented [TAM144R142]: Thank you for your feedback.
OPI would like to continue to use 'will' throughout this rule and not make the change to 'shall' or 'may' in subparagraph (9)(a). I am aware of the DOJ's recommendation and OPI has chosen to use this language.

of the final audit report to the MCE in person, by secure encrypted email or by registered or certified mail;

(a) The overpayment amount stated in the final audit report includes but is not limited to the amount of overpayment OPI is authorized to recover and:

(A) Is not limited to amounts determined by criminal or civil proceedings;

(B) May include interest to be charged at allowable state rates; and

(C) May include triple damages as described in section (20) of this rule.

(b) Refusing to accept the secure encrypted email, registered or certified mail or in-person delivery will not stop the audit process from proceeding;

(c) If the provider or MCE disagrees with the final audit report or the overpayment amount, the provider or MCE may appeal the decision. The provider or MCE must appeal the decision within 30 calendar days from the in-person delivery date, postmark date, or email sent date of the final audit report by submitting a written request for either an administrative review or a contested case hearing to OPI. The written request for appeal must outline in detail the areas of disagreement;

(A) The OPI Administrator or designee ~~(hereafter~~ is referred to as "Administrator" in this rule.~~)~~ The Administrator will determine which appeals may be suitable for review as administrative review or a contested case hearing, taking into consideration the issues presented in the request for appeal and the purposes served by administrative review in section (13) or contested case hearing in section (14) of this rule;

(B) If the Administrator decides the determinations of the final audit report or the content of appeal is appropriate for a contested case hearing or denies a request for an administrative review on the basis the appeal should be heard as a contested case hearing, the Administrator notifies the provider and refers the appeal directly to the Office of Administrative Hearings (OAH) for a contested case hearing pursuant to these rules;

(C) The MCE is a party in an appeal only where a provider furnished or supplied items or services to the MCE member. An MCE appeal of the final audit report or the overpayment amount will proceed as outlined in sections (11) through (21) of this rule;

(D) The MCE must comply with provisions for handling of overpayments made to providers as required by any contracts or agreements between the MCE and the Authority.

(12) If a provider or MCE fails to request an appeal within 30 calendar days from the date of the final audit report, the overpayment amount, findings, and all recommendations shall become final. Provider or MCE appeal requests submitted to OPI must:

(a) Be in writing to the Administrator;

(A) The appeal request is not required to follow a specific format as long as it provides clear written expression from the provider or MCE expressing disagreement with the final audit report findings;

(B) The request must specify issues or decisions being appealed and the specific reason for the appeal on each finding or decision. The request must provide specifics for each claim such as procedure code,

Commented [AJ145]: I think it is fine either way you choose to do it.

Commented [KN146]: Should this be explained in section (1) with the other definitions?

diagnosis code, reason for denial, administrative rules, or other authority applicable to the issue, and why the provider or MCE disagrees with the decision. If this information is not included in the appeal request in a manner that reasonably permits the Administrator to understand the decision being appealed or the basis for the appeal, the request will be returned to the provider or MCE and the provider or MCE must resubmit the appeal within 10 calendar days from the date on OPI's notice returning the appeal.

(b) Be received by OPI within 30 calendar days from the in-person delivery date, postmark date, or email sent date of the final audit report;~~.~~

(A) Late appeal requests require written supporting documentation clearly explaining the reason for a provider's or MCE's late request. The Administrator will determine whether failure to file a timely request was caused by circumstances beyond the provider's or MCE's control and enter an order accordingly. The Administrator may conduct further inquiry as deemed appropriate. In determining timelines of filing a request for review, the amount of time the Administrator determines accounts for circumstances beyond the control of the provider is not counted.

(B) The untimely request may be referred to the OAH for a hearing on the question of timeliness.

(13) Administrative review allows an opportunity for the Administrator to review a decision affecting the provider or MCE. Administrative review is limited to legal or policy issues where there is a stipulation of factual matters to be heard. The administrative review may be conducted as a desk review of available documentation or as a meeting, in-person or through the use of telephonic or electronic communication, between OPI and the provider or MCE, at the sole discretion of Administrator;~~.~~

(a) Administrative review meetings will be:

(A) Scheduled within 90 calendar days from receipt of the written request by the Administrator;~~.~~

(i) The Administrator will send written notice to the provider or MCE of the date, time, and place of the meeting;~~.~~

(ii) If the Administrator decides a preliminary meeting, in-person or through the use of telephonic or electronic communication, between the provider or MCE and OPI may assist the administrative review, the Administrator ~~will~~ shall provide written notice to the provider or MCE of the date, time, and place the preliminary meeting is scheduled.

(B) Held in Salem, unless otherwise stipulated to by OPI;

(C) Conducted by the OPI Administrator;

(D) Authority or ODHS staff will not be available for cross-examination;

(E) Authority or ODHS staff may attend and participate in the meeting; and

(F) The provider or MCE is not required to be represented by legal counsel and will be given ample opportunity to present relevant information from the existing case record.

(b) If a provider, MCE, or legal representative fails to appear at the administrative review meeting, the final audit report, all findings including the overpayment, and recommendations and sanctions as specified in the report will become final. In addition, the provider or MCE may not further appeal the

final audit report. The Administrator may cancel the final order upon request of the provider, MCE, or legal representative. The provider or MCE must be able to show evidence that the provider, MCE, or legal representative was unable to attend the Administrative Review and unable to request a postponement for reasons beyond the provider's or MCE's control;

(c) The results of the meeting will shall be sent to the provider or MCE, in writing, by secure encrypted email, registered or certified mail within 30 calendar days of the conclusion of the administrative review proceedings. The result of the administrative review is final;

(d) All administrative review decisions are subject to procedures established in OARs 137-004-0080 to 137-004-0092 and judicial review under ORS 183.484 in the Circuit Court.

(14) The contested case hearing process is conducted in accordance with ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings (OAH), OAR 137-003-0501 to 137-003-0700;

(a) If the Administrator decides an informal pre-hearing conference, in-person or through the use of telephonic or electronic communication, between the provider or MCE and OPI will shallassist the contested case hearing, the Administrator will notify the provider or MCE of the time and place of the informal pre-hearing conference without the presence of an Administrative Law Judge (ALJ). The purpose of the informal pre-hearing conference is to:

(A) Provide an opportunity to settle the matter or discuss Model Rules of Procedure for contested case hearings listed in OAR 137-003-0575. Any agreement reached in a pre-hearing conference will be submitted to the ALJ in writing or presented orally on the record at the contested case hearing;

(B) Provide an opportunity for the provider or MCE and OPI to review the information, correct any misunderstanding of facts, and understand the reason for the action that is the subject of the contested case hearing; or

(C) Determine if the parties wish to have witness subpoenas issued when the contested case hearing is conducted.

(b) Prior to the date of the contested case hearing, the provider may request additional informal conferences with OPI representatives. The request must be made in writing to the Administrator. A second informal conference may be granted at the sole discretion of the Administrator if the second informal conference is determined to facilitate the contested case hearing process or resolution of disputed issues;

(c) The contested case hearing will shall be held in Salem, unless otherwise stipulated to by OPI;

(d) The OAH will shall serve a proposed order on behalf of OPI unless the Administrator notifies the parties that OPI will issue the final order. The proposed order will shall become the final order if no exceptions are filed within the time specified in this rule;

(e) The provider or MCE may file exceptions or written argument to the proposed order to be considered by OPI. The exceptions must be in writing and received by OPI within 10 calendar days after the date the proposed order is issued. No additional evidence may be submitted. After receiving the

exceptions or argument, OPI may adopt the proposed order as the final order, amend the order, or prepare a new order;

(f) A provider or MCE may withdraw a contested case hearing request at any time. The OAH will send a final order confirming the withdrawal to the provider pursuant to OARs 137-003-0670 to 137-003-0672.

(15) If the provider, MCE, or legal representative fail to appear at the contested case hearing, OPI may elect one of the following options at its sole discretion:

(a) The contested case hearing request may be dismissed by order. The Administrator may cancel the dismissal order upon request of the provider, MCE, or legal representative. The provider or MCE must be able to show evidence that the provider, MCE, or legal representative was unable to attend the hearing and unable to request a postponement for reasons beyond the provider's or MCE's control;

(b) OPI may enter a final order by default when the Administrator determines that the issuance of a final order with findings is appropriate as a basis of sanction authority or to establish a basis for future sanction authority or other reason consistent with the administration of the Authority or DHS programs. The designated record, for purposes of a default order, will be the record as designated in the notice issued to the provider or MCE. If not so designated, the designated record will consist of the files and records held by OPI in the contested case hearing packet prepared by OPI.

(16) Final orders are effective immediately upon being signed or as otherwise specified in the order.

(a) Final orders resulting from a provider's or MCE's withdrawal of a contested case hearing request is effective the date the provider's or MCE's request is received by OPI or the OAH, whichever is sooner.

(b) When the provider, MCE, or legal representative fails to appear for the contested case hearing, the effective date of the dismissal order or the final order by default is the date of the scheduled contested case hearing.

(17) The burden of presenting evidence to support a fact or position in an administrative review or a contested case hearing rests on the provider and MCE. All copies of documentation and records submitted by a provider or MCE for an appeal are provided at the provider's or MCE's expense.

(18) The Administrator, in consultation with the Authority or DHS Director, may grant the provider or MCE the relief sought at any time.

(19) For providers furnishing or supplying items or services to or on behalf of Medicaid members enrolled in an MCE, overpayments ~~must~~ shall be paid by the MCE within 30 calendar days from the postmark date or email sent date of the final audit report;

(a) The MCE may submit a request to OPI for a modified payment plan as provided in section (20) of this rule to satisfy this requirement;

(b) The Authority ~~will~~ shall recoup from future MCE payments up to the amount of the overpayment and any applicable interest. The auditor and OPI management may not waive this overpayment requirement;

(c) MCE recovery of overpayments made by the MCE to the applicable provider must comply with any MCE contractual requirements. MCEs' internal overpayment recovery practices are not covered by this rule.

(20) Overpayments ~~must~~ shall be paid within 30 calendar days from the postmark date or email sent date of the final audit report. The provider or MCE may submit a request to OPI for a payment plan to satisfy this requirement. The auditor and OPI management may not waive this overpayment requirement:~~.~~

(a) A request for an administrative review or contested case hearing will not change the date the overpayment is due, or a payment plan is to commence, unless otherwise stipulated in writing by the Administrator. OPI will make any change in the reimbursement period or terms in writing:~~.~~

(A) The request for a payment plan or to modify an existing payment plan must be made in writing to OPI. The auditor or OPI management will notify the provider or MCE, in writing, of the decision regarding acceptance or denial of the request;~~.~~

(B) If the payment plan is agreeable, the auditor will ensure the payment plan is in writing and signed by all parties. A payment plan may include charging interest at the allowable state rate pursuant to ORS 82.010.

(b) If the provider or MCE refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, OPI may take one or more of the following actions:

(A) Recoup future payments up to the amount of the overpayment and any applicable interest;

(B) Pursue civil action to recover the overpayment and any applicable interest;

(C) Refer to Department of Revenue for collection;

(D) Recoup the overpayment through other methods pursuant to the provider's or MCE's contract or agreement with the Authority or DHS; or

(E) Recommend suspension or termination of the provider's enrollment in Authority or DHS medical programs and the Authority assigned provider number in the Oregon Medicaid Program. This action may be reported by the Authority to CMS, or other federal or state entities as appropriate.

(c) As a result of a contested case hearing or an administrative review, the amount of the overpayment may be reduced in part or in full;~~.~~

(d) OPI may at any time decrease the amount of the overpayment in accordance with this rule. The provider or MCE will be notified of any changes in writing by secure encrypted email, certified or registered mail. OPI will refund the provider or MCE any monies paid to OPI in excess of the overpayment;~~.~~

(e) If a provider is terminated from participation in Authority or DHS programs or sanctioned for any reason, OPI may pursue civil action to recover any amounts due and payable, to include any applicable interest;~~.~~

(f) The provider or MCE may be liable for up to triple the total overpayment amount of the current final audit report when:

(A) The auditor, in the course of an audit, discovers the provider employs the same or similar improper billing practices as previously identified in a preceding final audit report published by the OPI;

(B) The provider has previously been warned in writing by the Authority, DHS, Centers for Medicare and Medicaid (CMS) or their designee, or the Department of Justice (DOJ) of the same or similar improper billing practices.

(21) Providers and MCEs who conduct electronic data transactions with the Authority or DHS must adhere to requirements of OARs 943-120-0100 to 943-120-0200 and OARs 407-120-0100 to 407-120-0200. If the provider maintains financial or clinical records electronically, the provider must ensure the use of electronic record keeping systems does not alter the requirements of OARs 410-120-1360 and OAR 407-120-0370:

(a) When the provider maintains financial or clinical records electronically, the provider must be able to provide OPI with hard copy versions, upon request. The provider must also be able to provide an auditable means of demonstrating the date the record was created, the identity of the creator of a record, the date the record was modified, what was modified in the record, and the identity and credentials of any individual who has modified the record. The provider must supply the information to individuals authorized to review the provider's records pursuant to OAR 410-120-1360 and OAR 407-120-0370.

(b) If the provider maintains records electronically or permits the use of electronic signatures, the provider must document any aspect of the provision of services. The provider must maintain appropriate safeguards to assure the authenticity of the electronic records and signatures.

(A) The provider is not allowed to challenge the authenticity or admissibility of the electronic signature in any audit, review, hearing, or other legal proceeding.

(B) The provider is not allowed to challenge the authenticity or admissibility of the electronic documents and records due to internal transaction or operation failures of a provider's or its billing entity's electronic record system in any audit, review, hearing or other legal proceeding.

(c) Providers must comply with the documentation review requirements in OAR 410-120-1360 and OAR 407-120-0370 by providing the electronic record in a secure Health Insurance Portability and Accountability Act (HIPAA) compliant electronic format acceptable to an authorized reviewer. Provider's electronic records must be made available within the audit timeframes in this rule and at the providers' expense. The authorized reviewer must agree to receive the documentation electronically.

Statutory/Other Authority: ORS 413.032
Statutes/Other Implemented: ORS 414.025 & 414.065

410-120-1400

410-120-1400
Provider Sanctions

Commented [KN147]: IS this clear enough for OPI? The provider needs to have sageguards. We probably don't need to make an amendment here and I can remove this ?

Commented [AJ148R147]: I think this should be since most of the reg's use this type of terminology but if audist has requested a revision we would look to them as the SME and revise accordingly.

Commented [KN149]: 1396 addresses claims and electronic signature but in the pandemic there were questions about using electronic signatures for the agreement to pay form. Program integrity brought up some concerns so thought the GR should address these specific to the agreement form used in rule.

Commented [AJ150R149]: I think for the 3165 we cn include this in the instructions and leave this as is in rule since it is dealing with more data requirements and the agreement form is less legalize and more of what we can accept on that specific form. Let me know if you disagree.

Commented [KN151]: 1396 has language specific to the providers and contractors OPI audits who use electronic signatures in clinical records, but does not speak to whether members may use an electronic signature or whether a provider (such as a pharmacy) may accept an electronic signature from a member.

Commented [KN152R151]: In section (21)(b) it clearly states that the provider can permit the use of electronic signatures. Does that not clearly mean that providers can allow their members to submit an electronic signature? How does pharmacy not fall under the definition of "provider" that was in section (1) that was defined as ...

Commented [AJ153R151]: I addressed the 3165 signature above. 21(b) from a medical providers perspective is not speaking about electronic signatures of a patient but it relates to the electronic signatures used in ...

Commented [TM154R151]: This is accurate - when OPI added this section to the 1396 it was only intended to address the provider/staff signatures in the medical chart/record. there was concern and several issues that ...

Commented [KN155]: See email from Allison 03/09/23

was to integrate HSD process changes due to changes to ...

Commented [TM156R155]: proposed updates to address:
1. clarify sanction of providers not continuously enrolled; providers with lapsed enrollment or in revalidation; ...

Commented [TM157R155]: updates can be limited, or address all proposed areas, depending on HSD preference/time.

Summary: HSD process changes due to changes to unit work and evolving CMS requirements for provider enrollment.

1) The Authority recognizes two classes of Medicaid provider sanctions, mandatory and discretionary, outlined in sections (43) and (54) of this rule.

(2) ~~Except as otherwise noted, T~~the Authority shall impose ~~provider~~ sanctions on Medicaid providers at the discretion of the Authority Director or delegate ~~the Administrator of the Division whose budget includes payment for the services involved~~. Nothing in this rule limits the ability of Authority or the Oregon Department of Human Services (ODHS) to also seek monetary recovery, or pursue remedies specific to a contract with Authority or ODHS, or as otherwise permitted by state or federal law. Authority sanctions of its contracted managed care entities are governed by OAR 410-141-3530.

(3) Authority may sanction and suspend or terminate a provider who:

(a) is applying for enrollment, re-enrollment or revalidation as an Oregon Medicaid provider;

(b) is enrolled as an Oregon Medicaid provider; regardless of whether enrollment is continuous or active; or

(c) was an enrolled Oregon Medicaid provider at the time the sanctionable conduct, action, conditions or activity occurred.

Commented [TAM158]: Language added to address the question/issue of providers not 'active' at time issue is identified but is sanctionable.

(34) The Authority~~'s Health Systems Division (Division)~~ shall impose mandatory sanctions and deny enrollment, suspend or terminate the enrollment of the provider from participation in Oregon's medical assistance programs, regardless of whether the provider was directly enrolled or contracted by Authority or was enrolled or contracted by an Authority designee including but not limited to ODHS:

(a) When a provider, or any person with five (5) percent or more direct or indirect ownership interest in the provider, or any agent, affiliate or managing employee of the provider ~~of medical services~~ is, or was in the preceding then (10) years, ~~-~~convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act, any other federal program, or related state laws; regardless of whether an appeal from that judgment is pending;

(b) When a provider, or any person with five (5) percent or more direct or indirect ownership interest in the provider, or any agent, affiliate or managing employee of the provider, is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG) or from ~~the~~ Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services; regardless of whether an appeal from that judgment is pending. The provider shall also be ~~excluded~~ terminated or~~and~~ suspended from participation with the ~~Division~~ Authority for the duration of exclusion or suspension from the Medicare program or by the OIG~~ffice of the Inspector General~~;

(c) When~~If~~ ~~the~~ a provider fails to disclose ownership or controlling information required under 42 CFR 455.104 that is required to be reported at the time the provider submits a provider enrollment application, or when there is a material change in the information that must be reported or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(d) When a provider, or any person with a five (5) percent or greater direct or indirect ownership or controlling interest in the provider, fails to submit sets of fingerprints in a form and manner determined by the Authority within 30 days of CMS or an Authority request;

(e) When a provider, or any person with a five (5) percent or greater direct or indirect ownership or control interest, an agent, affiliate or managing employee of the provider, fails to submit timely and accurate information, comply with Authority screening methods, or both as required under 42 CFR 455 Subpart E;

(f) When a provider fails to permit access to a provider location for any site visit under 42 CFR § 455.432; unless the Authority determines the termination is not in the best interest of the Medicaid program. 42 CFR 455.416(f);

(g) When a provider is suspended or excluded from participation in a state Medicaid or CHIP program for reasons related to professional competence, professional performance, debarment or other reason;

(h) If the Authority:

(A) Determines that the provider has falsified any information provided on the application for enrollment; or

(B) Cannot verify the identity of the provider.

(i) When a provider is convicted of fraud related to any federal, state, or locally financed health care program or commits fraud, receives kickbacks, or commits other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;

(j) When a provider is convicted of interfering with the investigation of health care fraud;

(k) When a provider is convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(l) When a provider, or any person with five (5) percent or more direct or indirect ownership interest in the provider, or any agent, affiliate or managing employee of the provider, is subject to an adverse Legal Action including conviction of a felony crime against persons, financial crime(s) or misdemeanor conviction of patient abuse or neglect, theft, embezzlement or fraud;

(l) When there is a credible allegation of fraud as defined in 42 CFR 455.2 for which an investigation is pending under the Medicaid program, unless good cause not to suspend payments exists, in accordance with 42 CFR § 455.23;

(m) When Authority receives a referral from a Medicaid Fraud Control Unit (MFCU), Authority will initiate any available administrative or judicial action to recover improper payments to a provider and suspend the provider to prevent future payments, unless good cause not to suspend payments exists, in accordance with 42 CFR § 455.23;

(n) When the provider's enrollment has been terminated or revoked for cause by Medicare or another state's Medicaid program and such termination has been published in the Data Exchange System (DEX), the Authority will terminate the provider's enrollment in its program pursuant to 42 CFR 455.416(c) and455.101.

Commented [TAM159]: Restructure and several additions to ensure rule clearly captures federal provisions in 455.416 where OHA is **required** to disenroll the provider.

Commented [TAM160]: Required at enrollment, revalidation and within 30 days of the action.
Applies to individual providers, organizations, owners, managing employees, AO/DO.
Failure of provider to report will result in denial of application or revocation of billing privileges – possibly back to date of the action.

(~~4~~5) The ~~Division~~ Authority may impose discretionary sanctions and deny enrollment, suspend or terminate a provider when the ~~Division~~ Authority determines that the provider fails to meet one or more of the ~~Division's~~ Authority's requirements in ~~OAR~~ all applicable administrative rules or the contract between Authority and the provider governing participation in its medical assistance programs. Conditions that may result in a discretionary sanction include but are not limited to ~~when a provider is~~:

(a) breech of the provider agreement;~~Convicted of fraud related to any federal, state, or locally financed health care program or commits fraud, receives kickbacks, or commits other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;~~

~~(b) Convicted of interfering with the investigation of health care fraud;~~

~~(c) Convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;~~

(b~~d~~) ~~By findings or~~ actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, quality of care, or financial integrity including but not limited to:

(A) Having the health care license suspended or revoked, or otherwise loses their license; or

(B) Surrendering their license while a formal disciplinary proceeding is pending before the licensing authority.

(c~~e~~) Suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(~~f~~d) Billings excessive charges (i.e., charges more than the usual charge). Furnishes items or services substantially more than the ~~Division~~ Authority client's needs or more than those services ordered by a medical provider or more than generally accepted standards or of a quality that fails to meet professionally recognized standards;

(e~~g~~) Fails to furnish medically necessary services as required by law or contract with the ~~Division~~ Authority if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the ~~Division~~ Authority client;

(~~f~~h) Fails to disclose required ownership information;

(g~~i~~) Fails to supply requested records and information on subcontractors, providers, and suppliers of goods or services;

(h~~j~~) Fails to supply requested payment information;

(i) Fails to provide or disclose requested information or documentation to Authority, within the timeframe listed on the Authority's written request;

(j~~k~~) Fails to grant access or to furnish as requested, records, or grant access to facilities upon request of the ~~Division~~ Authority or designee, ODHS, the Authority's Office of Program Integrity (OPI), OIG, or the

Commented [TAM161]: Revised to use 'Authority' throughout rule per recommendation from Fritz.

Commented [TAM162]: Could specify which OAR CH, or just use 'all applicable'

Commented [KN163R162]: I agree

State of Oregon's Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) conducting their regulatory or statutory functions;

(~~l~~k) In the case of a hospital, fails to take corrective action as required by the ~~Division~~Authority, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by the ~~Division~~Authority;

(L~~m~~) Defaults on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The ~~Division~~Authority:

(A) ~~Must~~ shall make a reasonable effort to secure payment;

(B) ~~Must~~ shall take into account access of beneficiaries to services; and

(C) May not exclude a community's sole physician or source of essential specialized services.

(m~~n~~) ~~Repeatedly~~ Ssubmits one or more~~a~~ claims with required data missing or incorrect;~~:~~

~~(A) When the missing or incorrect data allows the provider to:~~

~~(i) Obtain greater payment than is appropriate;~~

~~(ii) Circumvent prior authorization requirements;~~

~~(iii) Charge more than the provider's usual charge to the general public;~~

~~(iv) Receive payments for services provided to persons who are not eligible;~~

~~(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount, or type of health care provided.~~

(n~~B~~) Fails to comply with the requirements of OAR 410-120-1280, Ch 410, Ch 943, Ch 309 or any other OAR CH applicable to the service or good when billing or submitting claims or encounters to Authority ~~(Billing)~~.

(o) Fails to develop, maintain, and retain in accordance with OAR 410-120-1360 and relevant rules Ch 410, Ch 943, Ch 309 or any other OAR CH applicable to the service or good and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;

(p) Fails to develop, maintain, and retain in accordance with OAR 410-120-1360 and relevant rules in Ch 410, Ch 943, Ch 309 or any other OAR CH applicable to the provider and ~~standards~~ adequate financial records as defined in OAR 410-120-0000 that document charges incurred by a client and payments received from any source;

(q) Fails to develop, maintain, and retain adequate financial or other records of all assets, liabilities, income, and expenses that support information submitted on a cost report;

(r) Fails to follow generally accepted accounting principles or accounting standards or cost principles sanctioned by recognized authoritative bodies such as the Governmental Accounting Standard Board and the Financial Accounting Standards Board and required by federal or state laws, rules, or regulations applicable to Medicaid;

Commented [TAM164]: Does this term need to be updated?

Commented [KN165R164]: I agree, Just don't know what to update it to.

(s) Submits claims or written orders contrary to generally accepted standards of medical practice of the provider receiving or requesting payment;

(t) Submits claims or encounters for services that exceed that requested or agreed to by the ~~client~~ member or the responsible relative or guardian or requested by another medical provider;

(u) Breaches the terms of the provider contract or the provider enrollment agreement with the Authority or Oregon Department of Human Services (ODHS). This includes failure to comply with the terms of the provider certifications on the medical claim form;

(v) Rebates or accepts a fee or portion of a fee or charge for an ~~Division~~ Authority client referral, or collects a portion of a service fee from the client and bills the ~~Division~~ Authority for the same service;

(w) ~~Submits false or fraudulent information when applying for the Division assigned provider number, or F~~fails to disclose information requested on the provider enrollment application or as otherwise requested by Authority;

(x) Fails to correct deficiencies in operations after receiving written notice of the deficiencies from the ~~Division~~Authority; including deficiencies in licensing or certification procedures;

(y) Submits any claim or encounter for payment for which payment has already been made by the ~~Division~~ Authority or any other source unless the amount of the payment from the other source is clearly identified;

(z) Threatens, intimidates, or harasses ~~clients~~ members or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the ~~Division~~Authority;

(aa) Fails to properly account for an ~~Division~~ Authority ~~client's~~ member's Personal Incidental Funds, including but not limited to using a client's Personal Incidental Funds for payment of services that are included in a medical facility's all-inclusive rates;

(bb) Provides or bills for services provided by ineligible or unsupervised or unqualified ~~staff~~employees, providers, or interns;

(cc) Participates in collusion that results in an inappropriate money flow between the parties involved, for example, referring clients unnecessarily to another provider;

(dd) Refuses or fails to repay in accordance with an accepted schedule an overpayment established by the Authority, Authority's OPI, MFCU or as ordered by a court~~Division~~;

(ee) Refuses or fails to repay in accordance with an accepted schedule repayment of identified overpayment or settlement agreements established by Authority, Authority OPI, MFCU or as ordered by a court;

(ff~~ee~~) Fails to report to Authority or ODHS~~Division~~ payments received from any other source after the ~~Division~~ Authority made payment for the service;

~~(ff) Failure to comply with the requirements listed in OAR 410-120-1280 (Billing).~~

(gg) Fails to comply with federal or state statutes and regulations or policies of the Authority or ODHS that are applicable to the provider;

(hh) Fails to obtain or maintain required provider credentials or has credentials suspended or otherwise revoked by the credentialing entity, for any reason;

(ii) Fails to correct subcontractor deficiencies in operations or non-compliance with Medicaid program requirements after receiving written notice of the deficiencies from the Authority;

(jj) Acts to discriminate among members on the basis of their health status or need for health care services, or on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability; violates member civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A;

(kk) When a person with five (5) percent or more direct or indirect ownership interest in the provider, or an agent, affiliate, supplier or managing employee of the provider is found to be in violation, independently or in tandem with the provider, of one or more of the provision of section (4) or (5) of this rule;

(LL) When a MCE participating provider or subcontractor enrolled or seeking enrollment as an encounter only provider is found to be in violation of one or more of the provision of section (4) or (5) of this rule;

(mm) Submits a bill or invoice or otherwise seeks payment from a member for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by OAR 410-120-1280. If the member was eligible for medical assistance on the date of service, and the provider does not have a completed signed agreement to pay form (3165, 3166), the provider is not allowed to bill the member, collect payment from the member, or assign an unpaid claim to a collection agency or similar entity pursuant to ORS 414.066, except as authorized by section (5) of OAR 410-120-1280. The Authority sanction of the provider may include but is not limited to any amount necessary to fully repay the member for the billed services, fines, fees or other financial penalties imposed on the member by the provider or any third party collections agency, and any accrued interest.

(nn) Failure to comply with Authority or its designee's notice that the provider is in violation of ORS 414.066 within 30 days or within the time required in the Authority's written notice;

(oo) Failure to comply with federal or state statutes and regulations or policies of the Authority that are applicable to the provider;

(pp) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;

(6~~5~~) A provider excluded, suspended, or terminated from participation in a federal or state medical program, such as Medicare or Medicaid or CHIP, or whose license or certification to practice is suspended or revoked by a state licensing board or Authority may not submit encounters or claims to the Authority for payment, either personally or through claims submitted by any billing agent/service, billing provider, or other provider for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension, or termination; unless good cause not to suspend payments exists, in accordance with 42 CFR § 455.23.

(~~6~~7) A Provider~~s~~ may not submit encounters or claims for payment to the ~~Division~~ Authority for payment for any services or supplies provided by an individual provider or provider entity that is excluded, suspended, or terminated from participation in a federal or state medical program or whose license to practice is suspended or revoked by a state licensing board, except for those services or supplies

provided prior to the date of exclusion, suspension, or termination; unless good cause not to suspend payments exists, in accordance with 42 CFR § 455.23.

(~~8~~7) When any one of the provisions of sections (~~4~~5) or (~~6~~5) of this rule are violated, the ~~Division~~ Authority may suspend or terminate the billing provider's enrollment agreement or the enrollment agreement of any individual ~~performing~~ provider ~~within said organization~~ who is ~~responsible for the~~in violation. When a provider is sanctioned, all other enrolled providers in which the sanctioned provider has ownership or controlling interest of five (5) percent or greater, may also be sanctioned and suspended or terminated.

(9) When any of the provisions of section (4) are violated, Authority shall withhold and recover all payments made to the provider for services furnished after the effective date of the sanction; unless good cause not to recover payments exists, in accordance with 42 CFR § 455.23. When provisions of section (5) are violated, Authority may withhold and recover all payments made to the provider for services furnished after the effective date of the sanction.

(10) When a provider sanctioned as a result of exclusion from participation in federal or another state's health care programs the scope of the provider appeal of the Authority's Action is limited to a review of whether the provider was, in fact, terminated by the initiating program. The appeal will not review the underlying reasons for the initiating termination. The provider must contact the federal or state agency which issued the initial decision.

(11) Authority will, for any provider or any person with a relationship with the provider who meets the circumstances for exclusion listed in 42 CFR 1001.1001, promptly notify the OIG of any action(s) Authority takes on the provider's application for enrollment in the program and any action(s) taken to limit the ability of a provider, whether an individual or entity, to participate in Oregon's Medicaid program, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where the provider voluntarily withdraws from the program to avoid formal sanction(s).

(12) Authority will, for any provider sanctioned by the Authority under this rule 410-120-1400 list the name(s) of the provider, NPI, duration and the effective date of the sanction on the Authority's website.

410-120-1460

410-120-1460
Type and Conditions of Sanction

Summary: allow emails to be used for sanctions

(1) The Health Systems Division~~Division of Medical Assistance Programs~~ (Division) may impose mandatory Sanctions on a Provider pursuant to OAR 410-120-1400(~~4~~3), in which case:

(a) The Provider ~~will~~ shall be either Terminated or Suspended from participation in Oregon's medical assistance programs;

Commented [AT166]: Recommend additional language to clearly identify that Authority may recoup any identified overpayments.

Commented [AT167]: Recommend additional language to clarify limitations of Authority appeal process when provider has been excluded from participation by fed or other states.

Commented [AT168]: Recommend additional language to comply with 42 CFR 1002.4 and 1001.1001

Commented [TAM169]: Recommend adding section for HSD posting of sanctioned providers.

Commented [TM170]: recommend updating to use 'Authority' rather than 'Division.'

Commented [KN171]: OAR 410-120-1400(3), says "Shall"

Commented [KN172]: If the sanction is mandatory, why do we use the word may? instead of shall?

Commented [AJ173]: I think it is may because depending upon the ofense the agency may sanction a provider and those types of sanctions are listed in rule.

Commented [KN174]: This is either a shall or a must

(b) If Suspended, the minimum duration of ~~s~~Suspension ~~will~~ shall be determined by the Secretary of the Department of Health and Human Services (DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The ~~State~~ Authority may ~~S~~suspend a Provider from participation in Oregon's medical assistance programs longer than the minimum ~~S~~suspension determined by the DHHS Secretary.

(2) The Division may impose the following discretionary Sanctions on a Provider pursuant to OAR 410-120-1400(~~5~~4):

(a) The ~~p~~Provider may be Terminated from participation in Oregon's medical assistance programs;

(b) The ~~p~~Provider may be ~~S~~suspended from participation in Oregon's medical assistance programs for a specified length of time, or until specified conditions for reinstatement are met and approved by Division;

(c) The Division may withhold payments to a ~~p~~Provider;

(d) The Provider may be required to attend ~~p~~Provider education sessions at the expense of the Sanctioned Provider;

(e) The Division may require that payment for certain services are made only after the Division has reviewed documentation supporting the services;

(f) The Division may recover investigative and legal costs;

(g) The Division may provide for reduction of any amount otherwise due the Provider~~.; and T~~the reduction may be up to three times the amount a Provider sought to collect from a client in violation of OAR 410-120-1280; or

(h) Any other Sanctions reasonably designed to remedy or compel future compliance~~s~~ with federal, state, or Division regulations.

(3) The Division ~~will~~ shall consider the following factors in determining the Sanction(s) to be imposed: ~~(this list includes but is not limited to these factors):~~

(a) Seriousness of the offense(s);

(b) Extent of violations by the Provider;

(c) History of prior violations by the Provider;

(d) Prior imposition of Sanctions;

(e) Prior Provider education;

(f) Provider willingness to comply with program rules;

(g) Actions taken or recommended by licensing boards or a Quality Improvement Organization (QIO); ~~and~~

(h) Adverse impact on the health of Division clients living in the Provider's service area; and

(i)~~.~~ Any other relevant factors.

Commented [KN175]: is it the State or the Division?

Commented [AJ176]: I think this would be the broader OHA and not just HSD because audits is part of OHA but not HSD.

Commented [KN177R176]: I will change this to say "The Authority"

Commented [KN178]: Does this mean the same thing as "reduce?" instead of "provide for the reduction of?"

Commented [KN179]: "wanted?" "tried to collect" ???

Commented [AJ180]: not sure require is the same thing here. I'd leave it as is unless the units that sanctions feels it need to be changed.

Commented [KN181R180]: Thank you!

Commented [KN182]: can we change this to "require"?

Commented [AJ183]: Yes that would work the same intent.

Commented [KN184]: Can we remove this and instead create a (3)(i) that says "any other relevant factors."

(4) Immediate Suspension. When a Provider fails to meet one or more of the requirements identified in this rule the Division, at its sole discretion, may immediately Ssuspend the ~~provider's~~ Povider's ~~Division~~ Authority assigned billing number to prevent public harm or inappropriate expenditure of public funds:

(a) The ~~provider~~ Provider subject to immediate ~~s~~Suspension is entitled to a contested case hearing as outlined in OAR 410-120-1600 through 410-120-1700 to determine whether the Pprovider's ~~Division~~ authority assigned number ~~will~~ shall be revoked;

(b) The notice requirements described in section (5) of this rule do not ~~preclude~~ stop the Division's decision of immediate Ssuspension ~~at the Division's sole discretion~~ to prevent public harm or inappropriate expenditure of public funds. Suspension ~~may~~ shall ~~be invoked~~start immediately while the notice and contested case hearing rights are exercised.

(5) If the ~~Division~~ Authority decides to Sanction a Provider, the Division ~~will~~ shall notify the Provider of the intent to Sanction by certified mail, personal delivery service or other traceable services such as email with delivery and read receipt. Notices sent certified mail ~~will~~shall be sent to the "mail-to" address on file for the Provider at the time of Sanction. Notices sent via secure email ~~will~~shall be sent to the Providers email if on file or the most current contact on file for the Provider a time of Sanction. The notice of immediate or proposed Sanction ~~will~~shall identify: ~~the provider by certified mail or personal delivery service of the intent to sanction. The notice of immediate or proposed sanction will identify:~~

(a) The factual basis used to determine the alleged deficiencies;

(b) Explanation of actions expected of the Provider;

(c) Explanation of subsequent actions the Division intends to take;

(d) The Provider's right to dispute the Division's allegations, and submit evidence to support the Pprovider's position; and

(e) The Provider's right to appeal Division's proposed actions pursuant to OARs 410-120-1560 through 410-120-1700.

(6) If the Division makes a final decision to Sanction a Pprovider, the Division ~~will~~ shall notify the Provider in writing at least 15 days before the effective date of action, except in the case of immediate Ssuspension to avoid public harm or inappropriate expenditure of funds.

(7) The Pprovider may appeal the Division's immediate or proposed Sanction(s) or other action(s) the Authority intends to take, including but not limited to the following list. The Pprovider must appeal these actions separately from any appeal of audit findings and overpayments:

(a) Termination or Ssuspension from participation in the Medicaid-funded medical assistance programs;

(b) Termination or Ssuspension from participation in the Division's state-funded programs;

(c) Revocation of the Pprovider's ~~the~~ Division assigned Pprovider number.

(8) Other provisions:

(a) When a Provider has been Sanctioned, all other Provider entities in which the Provider has ownership (five percent or greater) or control of, may also be Sanctioned;

Commented [KN185]: we capitalized the word Provider in other sections of the rule

Commented [KN186]: Capitalize?

Commented [TM187]: the rule appears to assume that immediate suspension is delivered in person - this is not necessarily the case when site visits and other Authority compliance work is carried out via a telecommunication platform (e.g. TEAMS or WebEX etc.).

What would be considered legally sufficient in a case where a virtual inspection identified an health/safety violation that required immediate suspension? could this be a verbal notification, would the state employee add a notice to the chat? or would the employee use one of the methods outlined in (5)?

Commented [KN188]: "intent" doesn't make sense here because (5) includes notices for when immediate suspension has already occurred.

Commented [TM189R188]: (5) is applicable to all times the provider is sanctioned - not only where the provider has been immediately suspended under paragraph (4). The paragraphs are not dependent.

Commented [KN190]: does this need to be spelled out as electronic mail?

Commented [KN191]: is "read receipt" the accepted term, or is it slang?

Commented [KN192]: should this be "Notices sent by certified mail" or "Notices sent through certified mail"

Commented [KN193]: The word Sanction needs to be capitalized throughout this paragraph.

Commented [KN194]: inserted tiffany's language

Commented [KN195]: If there's an immediate suspension that is not an "intent" to sanctin. the sanction has already occurred.

Commented [KN196]: Should this say "when" since the following list only applies when the division makes a final decision.

Commented [TAM197]: Would OHA be able to send this notice by email? similar to the mail options provided in paragraph (4) above.

(b) When a Pprovider has been Sanctioned, the Division may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon ~~Health Plan Prepaid Health Plans~~managed care entities, and the National Practitioner Data Base of the findings and the Sanctions imposed;

(c) At the discretion of the Division, Pproviders who have previously been Terminated or Suspended may or may not be re-enrolled as Division Pproviders;

(d) Nothing in this rule prevents the Authority from simultaneously seeking monetary recovery and imposing Sanctions against the Pprovider;

(e) If the Division discovers continued improper billing practices from a Pprovider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices and has had an opportunity for a contested case hearing, that Pprovider will be liable to the Division for up to triple the amount of the Division's established overpayment received as a result of such violation.

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

410-120-1860

410-120-1860
Contested Case Hearing Procedures

Summary: Clarify which part applies to Coordinated Care Organizations

(1) These rules apply to all contested case hearings provided by the Authority involving a client's health care benefits, except as otherwise provided in OAR 410-141-3890. The hearings are conducted in accordance with ORS 183.411 through 183.497 and the Attorney General's model rules, OAR 137-003-0501 through 137-003-0700. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Authority for purposes of this rule except for OAR 137-003-0528(1)(a). The method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of client requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Authority contested cases.

(2) Medical provider appeals and administrative reviews involving the Division are governed by OAR 410-120-1560 through 410-120-1600.

(3) Grievances, complaints, and appeals for clients requesting or receiving medical assistance from an MCE shall be governed exclusively by the procedures in OARs 410-141-3875 through 410-141-3915. This rule describes the procedures applicable when MCE clients request and are eligible for an Authority contested case hearing.

Commented [TM198]: updated to MCE for consistency with other OARs.

Commented [KN199]: we are inconsistent on whether we capitalize or don't capitalize suspend / suspended / suspension

Commented [KN200]: (5)(f)(A) and (B) amend to clarify (A) refers to CCOs and (B) refers to FFS

(4) Contested Case Hearing Requests:

(a) A client has the right to a contested case hearing in the following situations upon the timely completion of a request for a hearing:

(A) The Authority makes an adverse determination or action or, as it relates to an MCE, an adverse benefit determination such as denial of client services, payment of a claim, or to terminate, discontinue, or reduce a course of treatment, or issues related to disenrollment in an MCE; or

(B) The right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-3885 when a client of an MCE may request a state hearing.

(b) To be timely, a request for a hearing is complete when the following requirements are met:

(A) The Authority receives the Authority approved appeal and hearing forms not later than the 60th day following the date of the decision notice;

(B) When enrolled in an MCE, the member files the request for contested case hearing within the time frames specified in OAR 410-141-3900.

(c) In the event a request for hearing is not timely, the Authority shall determine whether the client showed there was good cause, as defined in OAR 137-003-0501(7), for their failure to timely file the hearing request. In determining whether to accept a late hearing request, the Authority requires the request to be supported by a written statement that explains why the request for hearing is late. The Authority may conduct such further inquiry as the Authority deems appropriate. If the Authority finds that the client has good cause for late filing, the Authority shall refer the case to the Office of Administrative Hearings (OAH) for a contested case hearing. The following factual disputes shall be referred to the OAH for a hearing:

(A) Whether the hearing request was received timely;

(B) Whether the client received the notice of adverse benefit determination or action;

(C) The information included in the client’s statement of good cause.

(d) In the event the claimant is not entitled to a contested case hearing on an issue, the Authority may enter an order accordingly. The Authority may refer a hearing request to the OAH for a hearing on the question of whether the claimant has a right to a contested case hearing;

(e) A client who requests a hearing shall be referred to as a claimant. The parties to a contested case hearing are the claimant and, if the claimant has requested a hearing about a decision of an MCE, the claimant's MCE;

(f) A client may be represented by any of the individuals identified in ORS 183.458. An MCE that is a corporation may be represented by any of the individuals identified in ORS 410.190.

(g) For clients enrolled in an MCE, the following applies:

(A) May request a contested case hearing with the state after receiving notice that the adverse benefit determination or MCE action is upheld or, in the case of an MCE that fails to adhere to the notice and

timing requirements, the state may deem that the member has exhausted the MCE's appeals process and may initiate a state contested case hearing pursuant to OAR 410-141-3900;

(B) A request for an Authority administrative hearing made prior to an MCE appeal by the member or member's representative or provider shall be forwarded by the Authority to the MCE for review, except in the case where the Authority determines the MCE failed to act within required timelines.

(5) Expedited hearings:

(a) A claimant who feels their health care problem ~~cannot~~ may not wait for the normal review process may be entitled to an expedited hearing;

(b) A request for an expedited hearing for a service that has already been provided (post-service) to the claimant ~~will~~ may not be granted;

(c) Expedited hearings are requested using Authority Form 443 or other Division approved appeal and/or hearing request forms;

(d) Authority staff shall request all relevant health care documentation and present the documentation obtained in response to that request to the Authority medical director or the medical director's designee for review. The Authority medical director or designee shall decide if the claimant is entitled to an expedited hearing within, as nearly as possible, two working days from the date of receiving the documentation applicable to the request;

(e) An expedited hearing shall be allowed if the Authority medical director or the designee determines that the claimant has a health care condition that could jeopardize the claimant's life, health, or ability to maintain or regain maximum function and claimant has been denied a health care service;

(f) Expedited hearing requests shall be completed as expeditiously as the claimant's health condition requires with the following timelines:

(A)For members enrolled in an MCE's the ~~F~~for expedited hearing requests responding to any claim requiring review of an MCE written notice of expedited appeal resolution, hearing requests shall be no later than three working days after the agency receives from the MCE the case file and information for any appeal of a denial of a service as indicated by the MCE;

(B) For recipients of Fee For Service the~~F~~for expedited state contested hearing requests, no later than seven working days after the agency receives a request for expedited fair hearing responding to any request for the following reasons:

Commented [KN201]: (A) is about CCO (or MCE. I'm still teaching myself how to tell the difference between the two); and
(B) is about Fee for Service?
Email from Melissa Mumey on

(i) Claim for services is denied or is not acted upon with reasonable promptness;

(ii) Requests because the claimant believes the agency has taken an action erroneously;

(iii) Requests because the claimant believes a skilled nursing facility or nursing facility has erroneously determined that they must be transferred or discharged;

(iv) Requests because the claimant believes the state has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act; or

(v) For expedited state administrative hearing for claims related to prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under CFR §435.912, based on the date the application is submitted to any insurance affordability program.

(g) The Authority shall take final administrative action on a contested hearing request within the time limits set forth in 42 CFR Part 431 and Part 435 except in unusual circumstances when:

(A) The Authority ~~cannot~~ may not reach a decision because the appellant requests a delay or fails to take a required action; or

(B) There is an administrative or other emergency beyond the Authority's control.

(6) Informal conference:

(a) The Authority hearing representative and the claimant, and their legal representative if any, may have an informal conference without the presence of the Administrative law Judge (ALJ) to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Authority and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is the subject of the hearing request;

(C) Give the claimant and the Authority an opportunity to review the information that is the basis for that action;

(D) Inform the claimant of the rules that serve as the basis for the contested action;

(E) Give the claimant and the Authority the chance to correct any misunderstanding of the facts;

(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and

(G) Give the Authority an opportunity to review its action.

(b) The claimant may at any time prior to the hearing date request an additional informal conference with the Authority representative, which may be granted if the Authority representative finds in their sole discretion that the additional informal discussion ~~will~~ shall facilitate the hearing process or resolution of disputed issues;

(c) The Authority may provide to the claimant the relief sought at any time before the Final Order is served;

(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Authority or the ALJ, whichever is first. The ALJ shall send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth day following the date such an order is effective.

(8) Contested case hearings are closed to non-participants in the hearing; however, a client may choose to have another individual present.

(9) Proposed and Final Orders:

(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings shall serve a proposed order on all parties and the Authority, unless prior to the hearing the Authority notifies the ALJ that a final order may be served. The proposed order issued by the ALJ shall become a final order if no exceptions are filed within the time specified in subsection (b)(A) below, unless the Authority notifies the parties and the ALJ that the Authority shall issue the final order;

(b) If the ALJ issues a proposed order, a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for the Authority's consideration:

(A) The exceptions must be in writing and reach the Authority not later than ten working days after date the proposed order is issued by the ALJ;

(B) After receiving the exceptions, if any, the Authority may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority shall issue an amended proposed order.

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Authority shall cancel the dismissal order on request of the party upon the party being able to show good cause, as defined in OAR 137-003-0501(7), as to why they were unable to attend the hearing and unable to request a postponement.

(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the claimant's withdrawal of the hearing request is effective the date the claimant withdraws. When the claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.

(12) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

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

Statutory/Other Authority: ORS 183.341 & 413.042
Statutes/Other Implemented: ORS 183.411 - 183.471, 411.408, 414.025 & 414.065

410-120-1865

410-120-1865
Denial, Reduction, or Termination of Services

(1) The purpose of this rule is to describe the requirements governing the denial, reduction, or termination of medical assistance and access to the Authority administrative hearings process for clients requesting or receiving medical assistance services paid for by the Authority on a fee-for-service basis.

Grievance, complaint, and appeal procedures for clients receiving services from an MCE shall be governed exclusively by the procedures in OAR 410-0141-3260 and where applicable OAR 410-141-3475.

(2) When the Authority authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend, or reduce the course of treatment or a covered service, the Authority or its designee shall mail a written notice to the client at least ten days before the date of the termination or reduction of the covered service unless there is documentation that the client had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.

(3) The written client notice must inform the client of the action the Authority has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the client's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Authority for additional information. The Authority is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

(4) The Authority shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the client requests an administrative hearing ~~before~~ by the ~~effective date~~tenth day following the date of the client notice, or before the effective date of the action proposed in the notice, if applicable, and requests that the services be continued, the Authority shall continue the services. The service shall be continued until whichever of the following occurs first, but may not exceed ninety days from the date of the client's request for an administrative hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the case that is the subject of the administrative hearing; or

(C) The client is no longer eligible for medical assistance benefits or the health service, supply, or item that is the subject of the administrative hearing is no longer a covered benefit in the client's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy, and the Authority promptly informs the client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the client in writing that it is continuing the service. The notice shall inform the client that if the hearing is resolved against the client, the cost of any services continued after the effective date of the client notice may be recovered from the client pursuant to 42 CFR 431.230(b);

(c) The Authority shall reinstate services if:

(A) The Authority takes an action without providing the required notice and the client requests a hearing;

(B) The Authority does not provide the notice in the time required under section (2) of this rule and the client requests a hearing within 10 days of the mailing of the notice of action; or

Commented [KN202]: Mumey This rule seems to distinguish a separation between continuation of benefit and reinstatement of benefit. As you are aware, the term *Continuation of benefit* is clearly explained in rule; however, the term Reinstatement of benefit is not explained or defined.

(4)(d) In addition, the word *promptly* is very subjective.

Commented [BRM203]: I believe this word should be "by" rather than "before" to stay consistent with the language in 410-141-3910.

Commented [MM204R203]: Agree

Commented [KN205]: Suggested edit per Rosey Ball Email

(C) The post office returns mail directed to the client, but the client's whereabouts become known during the time the client is still eligible for services;

(D) The reinstated services must be continued until a hearing decision, unless at the hearing it is determined that the sole issue is one of federal or state law or policy.

(d) The Authority shall promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the client, or the Authority decides in the client's favor before the hearing.

Statutory/Other Authority: 413.042
Statutes/Other Implemented: 411.408, 414.025 & 414.065