-Secretary of State Website Division 120 MEDICAL ASSISTANCE PROGRAMS

Instructions: Please turn on tracked changes before making edits. Do not manually change the font color to red. Do not manually add underline or strikeout. Enable editing on the word document, and at the top of the word document, click on the tab that says “Review” Then click on “Track Changes” so that it is turned on / selected. Then select “All markup” from the drop down menu.

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."

Commented [KN3]: David Knight – did research for definitions, NCART has a definition – differentiate equipment

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~~is~~ and Treatment (EPSDT). ~~as specified in the Oregon Health Plan 1115 Demonstration Project (waiver).~~

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 and Treatment (EPSDT).

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.

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

(B~~b~~) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and

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

(D~~d~~) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement.~~;~~

(b~~e~~) 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.

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Commented [KN4]: Comment from Beth – Remove – needs to be clear that not everything is related to "above the line of funding" – just delete the line for above the line
Will have continued discussion on how to edit
Comment from Ann Ford about breaking up the line without removing Prioritized list
Comment from Holly Jo on how we define the benefits package and may not be able to remove the line.
Will check with DOJ on what options we have

Commented [KN5]: Will continue conversation. Could drop the as determined by the legislature?

Commented [L(6]: @Kumar Nita with Track Changes on this doesn't show the changes we are making for EPSDT (the entire definition shows as new because of Track Changes). Please see the document I sent on 7/21 - somehow some of those changes did not make it into this document. Our changes are only to (d) on this definition.

Commented [KN7]: Do we add more exceptions to this rule? Will continue discussion

Commented [TAM8]: 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.

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Commented [KN9]: Lets look at a way to have less offensive wording, agreement from ann and max as well

Commented [KN10]: Comment from Beth to remove the "not solely for the convenience or preference"

Commented [KN11R10]: Ann ford, CMS Guidance phrasing, can double check with Waiver team on how to reword and legal sufficiency.

Dietitian

An individual licensed by the Board of Licensed Dietitians to provide nutrition services as outlined in the Standards of Practice in the OR Administrative Rules, Chapter 834, Division 60 (OAR 834-060-0000).

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.~~

Early and Periodic Screening, Diagnostic and Treatment

(85) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means the program defined in chapter 410 Division 151.

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.

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;

Commented [KN12]: Added per email 08/18/23 Ansley Hill

Commented [KN13]: State Plan Amendment (SPA) Response "We did include Dieticians into the state plan as an independent provider type so that makes sense to include the definition. The only difference for the SPA is Dietitian, (RDN) and (RD) licensed by the Oregon board of Licensed Dietitians. I'm not sure your rules definition need both designation of Rd and the RDN but the Oregon board

Commented [KN14R13]: Response from Janet to include Janet

Commented [GRVA15]: Should this DME ?

Commented [KN16]: Suggestion from Kelly Jamison 07/21/23 DME Meeting

Commented [KN17]: Comment from Tamara Bakewell "I think the DMEPOS acronym needs to be removed as well,

Commented [KN18R17]: This makes sense to me! Will check with the DME Meeting

Commented [KN19]: Comment from Catherine Sweeney "Can we change to "can serve a medical and/or functiona

Commented [KN20]: Comment from Tina Treasure "This reads as a double negative."

Commented [KN21R20]: Comment from Kelly that we are using the direct definition from Medicaid/Federal

Commented [KN22]: Suggestion from Gloria Stubbs

Commented [JK23]: In the DME rules 410-122-0010 we have broken these out into two different definitions to

Commented [BRM24]: This definition does not appear to align with the definition that is in the DME rules.

Commented [KN25]: David explains problems with how old this definition is and how technology has changed.

Commented [KN26]: Max comment about being inclusive about things that support members and still havi

Commented [KN27]: Douglas comment on how OARs are silent, and have had to go to CMS to find information.

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Commented [L(28]: @Kumar Nita This one also did not make it in from the document I sent on 7/21 so I've added

Commented [TAM29]: Recommend including CFR language for managing employee. Providers enrolling with

Commented [TAM30]: OHA OPI supports keeping the term 'medically appropriate'. But would not recommend

Commented [KN31]: Comment from David, end up applying CMS guidance. Also brings up the conversation

(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, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.

Additional Edits to Medically Appropriate from Ellen Taussig Conaty

(14~~9~~7) "Medically Appropriate"

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

(A)~~a)~~ Rrecommended 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, Diagnosti~~cis~~ and Treatment (EPSDT), see chapter 410 Division 151.

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~~

Commented [KN32]: Suggestion from OLC to remove: "Eliminate all language in the rules that references 'not solely for the convenience or preference of an OHP client, member or a provider of the service item or medical supply'"

Commented [LS(33R32]: As we discussed with Jesse, removing this language contradicts federal requirements. In the draft EPSDT definitions, we changed the order of wording a bit so it reads:

Commented [DK34R32]: The word "convenience" is not clearly defined as it relates to Medical Equipment. Is

Commented [LS(35]: In the draft EPSDT definition, we are using this language, which is (we think) more

Commented [KN36]: Comment to try to find a better word than "deference"

Commented [LS(37R36]: As we discussed with Jesse, deference to the physician contradicts federal requiremer

Commented [JK38R36]: I agree with Liz. Had similar discussion with Jesse about this.

Commented [DK39R36]: If deference is not given to the treating medical professional then we are saying that the

Commented [KN40]: The tracked changes reflect suggested text from the OLC

Commented [KN41]: Comment from JSA: "check with Jessica- However response could be- changes to medica

Commented [LS(42R41]: Our proposed edits are included here. Adding (f) is the most important as it direct

Commented [KN43]: Suggestion to remove this entire subsection

Commented [DK44R43]: Agreed this is extremely redundant and confusing.

Commented [KN45R43]: Melissa Mumey: 07/27/23 I would support this. We struggle with notices ONLY citing

Commented [LJ46]: If we can legally delete the "Medically Appropriate" section from existence, I'd

Commented [DK47R46]: I agree. This definition is not widely used by other states and It causes a lot of problem

Commented [LS(48]: @Nita when we met with you and Jesse, this is the wording we agreed on. This directs folks t

Commented [KN49]: DOJ Advice "CMS does not use medically appropriate, the CMS

Commented [MM50]: the only issue I see with this format could be that the reviewer does not select (a) and

Commented [LS(51]: EPSDT changes remove this definition entirely. This language hasn't been used since li

~~of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.~~

Medical Nutrition Therapy (MNT)

An evidence-based application of the Nutrition Care Process provided by licensed dietitians; focused on prevention, delay or management of diseases and conditions; and involving an in-depth assessment, periodic reassessment and intervention(s). (OAR 834-020-0000)

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, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.

Additional Edits to Medically Necessary from Ellen Taussig Conaty

(1~~50~~48) "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 [KN52]: Added per email 08/18/23 Ansley Hill

Commented [KN53]: Comment from David, Section E, medcially necessary, problem for someone who is challenging a denial

Commented [KN54]: 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 [LJ55R54]: 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 [KN56]: 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 [MM57R56]: 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 [KN58]: Suggestion to remove this entire subsection

Commented [LJ59R58]: Agreed on removal. Causes too much confusion & wrongful denial opportunities

Commented [LS(60]: See comment above.

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

Commented [KN61]: Sub section added per E

Commented [TAM62]: 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.

(c~~f~~) For Early and Periodic Screening, Diagnostic~~is~~ 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 [TAM63]: 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 [TAM64]: 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 [TAM65]: 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 [KN66]: Ask Jesse or Allison about this

Commented [KN67R66]: 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 [KN68]: Added per Jesse Anderson (Email from Thu 6/22/2023 7:57 AM)

Commented [TAM69R68]: 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 [KN70]: 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 [MTJ71]: 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.~~

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.

Asynchronous

(X) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages.

Audio Only

(X) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

Meaningful Access

(X) "Meaningful access" means client or member-centered access reflecting the following statute and standards:

(a) Pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the corresponding Federal Regulation at 45 CFR Part 92 and The Americans with Disabilities Act (ADA), providers' telemedicine or telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have Limited English Proficiency (LEP) including providing access to auxiliary aids and services as described in 45 CFR Part 92;

(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards; and

(c) As applicable to the client or member, Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx;

Commented [KN72]: Jesse, please review this text suggestion

Commented [KN73]: I like the clarification! Considering how to define "suspension" without using the word Suspension. It's a temporary shut off, not a permanent deactivation.

Commented [TAM74]: Is this CFR still active/correct?

Commented [KN75R74]: I think this needs to be updated

Commented [DQ76]: @Kumar Nita - I've inserted starting here, all the "definitions / terms" that currently sit in OAR 410-120-1990 and I'd like to move these into the 120-0000 rule. Obviously, these will need to move / be inserted into the existing list arranged alphabetically where appropriate.

(d) “Synchronous” means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring.

Telecommunication Technologies

(x) “Telecommunication technologies” means the use of devices and services for telemedicine or telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.

Telehealth

(x) “Telehealth” includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration.

Telemedicine

(x) “Telemedicine” means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member’s healthcare.

Trauma Informed Approach

(x) “Trauma informed approach” means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.

Trauma Informed Services

(x) “Trauma Informed Services” means those services provided using a trauma informed approach.

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;

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

Commented [SG77]: Recommend using full description in (a) for reference to MCE throughout the remainder of the rule.

Commented [TM78]: 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 [TM79]: 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 [KN80]: Language added by brandon per question raised in email from Dee on 01/27/23

(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.

Commented [KN81]: 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 [KN82]: 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)."

(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.

(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, Diagnostics 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

(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

Commented [KN83]: 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 [KN84]: Added per EPSDT group

Commented [LJ85]: 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 [LJ86]: Would this be another "aid or assist" spot?

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;

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

Commented [LJ87]: Who & how is this determined? Things that could appear as "intentional" could very easily be circumstance or accidental.

Commented [LJ88]: 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 [LJ89]: Who & how is this determined? Things that could appear as "convenient" could very easily be a medical necessity.

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

(st) Post-mortem exams or burial costs;

(tu) Radial keratotomies;

(uv) Recreational therapy;

(vw) 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.

(wx) 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;

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

~~(yz) Immunizations prescribed for foreign travel;~~

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

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

(bbcc) Transportation to meet a client's personal choice of a provider;

(ccdd) Alcoholics Anonymous (AA) and other self-help programs;

(ddee) 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;

(eeff) 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

410-120-1260

410-120-1260
Provider Enrollment

Commented [LJ90]: 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 [KN91]: 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;"

Commented [KN92]: Travel Immunizations

Commented [KN93]: 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 [TM94R93]: 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.

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

(1) This rule applies to providers requesting enrollmentd, 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.

(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:

Commented [TAM95]: Language added to comply with 42 CFR 455.450 and update rule to reflect HSD provider enrollment current processes/procedures.

Commented [TAM96]: 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 [TAM97]: Recommend this be updated to align with HSD's current processes for screening and enrollment of high risk providers.

Commented [TAM98]: Language added to address Agency process for conducting pre and post provider enrollment site visits.

(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~~.~~

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

Commented [TAM99]: 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 [TAM100]: Term 'CCO' updated to align with OAR 410-141. All MCE providers must enroll, not just CCO providers.

(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~~.~~

(d~~X~~) Comply with all requests from Oregon ~~d~~Department of J~~j~~ustice (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

Commented [AT101]: Updated to align with current record retention rules and agency audit practices.

Commented [KN102R101]: Are we removing the word five? I can't read the tracked changes for this section

Commented [TM103R101]: yep. removing 5.

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Commented [TAM104]: 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.

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 [TAM105]: 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.

(10~~7~~) 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.

(11~~8~~) A ~~n individual or organization~~provider that is currently subject to sanction by the ~~Division~~Authority~~, 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~~.~~;

(12~~9~~) 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 revalidate~~renew~~ 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 ~~Division~~Authority:

(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 following~~Division~~:

(A) ~~The identity of any~~Each person who has a direct or indirect ownership or control interest in the provider, is an agent or is a managing employe~~de 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~~I~~) For individuals ~~in a solo practice or billing as an individual practitioner,~~ use the Social Security Number (SSN);

(iii~~II~~) 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~~ure~~, ~~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.

(~~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:

Commented [TAM106]: 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 [TAM107]: 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 [TAM108]: Termination only. HSD provider enrollment unit process does not currently allow for suspension.

(aA) Changes in federal TIN, SSN or EIN. Failure to notify the ~~Division~~ Authority of a change of Federal T~~ax Identification~~ Number for entities or a S~~ocial Security~~ Number, or E~~mployer Identification~~ Number 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.~~

(bB) 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.

(dC) ~~In the event of~~ Bbankruptcy proceedings, the provider shall immediately notify ~~immediately~~ the ~~Division~~ Authority ~~administrator~~ Provider Enrollment Unit in writing;

(eD) 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 [MTJ109]: Recommend change to 35 days to be consistent with 35 days above.

(180) ~~Rendering~~ Pproviders 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 [TAM110]: 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.~~

(2013) 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) (201) 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;~~

~~(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;~~

Commented [AT111]: Recommend re-structuring section (20) subsection for clarity.

Commented [TM112]: 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.

~~(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~~client~~s; 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;

(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

Commented [MTJ113]: Recommend review by Policy. We are uncertain if these services are still being provided by OHP.

(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.~~

(2216) ~~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~~termin~~ate and~~or~~ suspend or terminate a provider~~s when~~ at ~~provider fa~~ils to meet on~~ye or more of t~~ime~~he~~ including but not limited to any of the reaso~~quirements 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.~~

(2317) 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.

(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

Commented [TAM114]: Language revised or moved to 410-120-1400 to eliminate duplication. See 410-120-1400 for revised language.

Commented [KN115R114]: Jesse, did you see this suggestion by Allison? Should we delete thi section since it's in 1400?

Commented [TM116R114]: 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.

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.

(2718) 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 [TAM117]: 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

410-120-1340

410-120-1340
Payment

Summary: Include process for 340B

(1) The Division shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division sets fee-for-service (FFS) payment rates for the billed services or items. The FFS payment rates are the Division's maximum allowable rates for billed services or items.

(4) The Division reimburses providers for billed services or items at the lesser of:

(a) The amount billed;

(b) The Division's FFS payment rate in effect on the date of service; or

(c) The rate specified in the individual program provider rules.

(5) The amount billed may not exceed the provider's "usual charge" (see definitions 410-120-0000).

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates. The Division updates all CPT/HCPCS codes assigned an RVU weight effective January 1 of each year, based on the annual RVU updates published in the Federal Register:

(A) The Division applies RVU weights as follows:

(i) The Non-Facility Total RVU weight, to professional services not typically performed in a facility;

(ii) The Facility Total RVU weight, to professional services typically performed in a facility.

(B) The Division applies the following conversion factors:

(i) $40.79 for labor and delivery codes (59400-59622);

(ii) $38.76 for neonatal intensive care and pediatric intensive care professional service codes (99468-99480);

(iii) $27.82 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider types and specialties ("Oregon Primary Care Providers and Procedure Codes") is available at http://www.oregon.gov/OHA/HSD/OHP/Pages/Providers.aspx;

(iv) $25.48 for all remaining RVU weight-based CPT/HCPCS codes.

(C) The Division calculates rates using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) (Work RVU) X (Work GPCI) + (Practice Expense RVU) X (Practice GPCI) + (Malpractice RVU) X (Malpractice GPCI). The formula used to create the statewide GPCI is (3*(Portland GPCI) + 33* (Rest of State GPCI))/36 = GPCI.

(ii) The sum in paragraph (C)(i) is multiplied by the applicable conversion factor in section (B) to calculate the rate;

(b) Non-RVU-weight-based rates:

(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

(B) Clinical lab codes are 70 percent of the Medicare clinical lab fee schedule effective on the date of service;

(C) All approved Ambulatory Surgical Center procedures are 80 percent of the Medicare fee schedule effective on the date of service;

Commented [KN118]: (256) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.

(D) Physician-administered drugs billed under a HCPCS code are 100 percent of the Medicare rate. The Medicare rate is equal to Average Sales Price (ASP) plus six percent;

(c) When no ASP rate is available, the rate is based upon the Wholesale Acquisition Cost (WAC) provided by First Data Bank;

(d) If no WAC is available, then the rate is the Acquisition Cost. These rates may change periodically based on drug costs;

(e) All procedures used for vision materials and supplies are contracted rates that include acquisition cost plus shipping and handling;

(f) Individual provider rules may specify rates for particular services or items.

(7) The Division reimburses inpatient hospital services under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.

(8) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services program rules (chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(9) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.

(10) For services provided by out-of-state institutions and facilities such as skilled nursing care facilities, psychiatric facilities and rehabilitative care facilities, the Division sets rates that are:

(a) Consistent with the rate for similar services provided in Oregon; and

(b) The lesser of the rate paid to the most similar licensed Oregon facility or the rate paid by the other state's Medicaid program; or

(c) Consistent with the rate established by APD for out-of-state nursing facilities.

(11) The Division may not make payment on the following claims:

(a) Assigned, sold or otherwise transferred claims; or

(b) Claims where the billing provider, billing agent, or billing service receives a percentage of the amount billed, amount collected or payment authorized. This includes, but is not limited to, claims transferred to a collection agency or individual who advances money to a provider for accounts receivable.

(12) Nursing facility payments:

(a) The Division may not make a separate payment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate (OAR 411-070-0085).

(b) The following services are not in the all-inclusive rate and may be reimbursed separately:

(A) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services program administrative rules (chapter 410, division 148);

(B) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);

(C) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);

(D) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);

(E) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);

(F) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);

(G) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).

(13) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.

(14) For payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;

(b) The Division pays the allowable rate for covered services that are not covered by Medicare.

(15) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.

(16) The Division payments including contracted Managed Care Entity (MCE) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down. For the Division, payment in full includes:

(a) Zero payments for claims when a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(17) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742 & 414.743

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 [KN119]: 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 [TM120R119]: 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.

(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:

Commented [TM121]: 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."

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Commented [TM122]: @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 [KN123R122]: Thank you, Allison! This is the version that Jesse Anderson created. I can ask him to review again

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(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

(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

410-120-1400

410-120-1400
Provider Sanctions

Commented [TM124]: alternative wording proposed to removed 'cannot' from (d).

Commented [KN125R124]: I like this edit!

Commented [KN126]: See email from Allison 03/09/23

was to integrate HSD process changes due to changes to unit work and evolving CMS requirements for provider enrollment.

Commented [TM127R126]: proposed updates to address:
1. clarify sanction of providers not continuously enrolled; providers with lapsed enrollment or in revalidation;
2. incorporate CFR re: providers with direct/indirect ownership interest;
3. incorporate CFR re: agent, affiliate and managing employees;
3. process for if provider declines FPBC or site visit or when identity cannot be verified;
4. updates to conviction and credible allegation of fraud language;
5. process for breech of provider agreement or failure to disclose;
6. add/clarify sanctionable offenses;

Commented [TM128R126]: 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 [TAM129]: 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 [TAM130]: Restructure and several additions to ensure rule clearly captures federal provisions in 455.416 where OHA is **required** to disenroll the provider.

Commented [TAM131]: 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~~s~~ 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 [TAM132]: Revised to use 'Authority' throughout rule per recommendation from Fritz.

Commented [TAM133]: Could specify which OAR CH, or just use 'all applicable'

Commented [KN134R133]: 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 [TAM135]: Does this term need to be updated?

Commented [KN136R135]: 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~~f~~ails 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.

Commented [AT137]: Recommend additional language to clearly identify that Authority may recoup any identified overpayments.

Commented [AT138]: Recommend additional language to clarify limitations of Authority appeal process when provider has been excluded from participation by fed or other states.

Commented [AT139]: Recommend additional language to comply with 42 CFR 1002.4 and 1001.1001

Commented [TAM140]: Recommend adding section for HSD posting of sanctioned providers.