OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 10

HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

ScreenWise Breast and Cervical Cancer Program

333-010-0100
Description of the ScreenWise Breast and Cervical Cancer Program

The mission of the Oregon ScreenWise Program is to reduce breast cancer, cervical cancer, cardiovascular disease and other diseases by promoting early detection through screening, risk reduction counseling, behavior modification support, and referral to medical treatment. ScreenWise includes the Breast and Cervical Cancer Program (ScreenWise BCC), a federal screening and early detection program administered by the Oregon Health Authority to provide screening and diagnostic services to eligible Oregonians statewide. ScreenWise BCC provides coverage for screening and diagnostic services to Oregonians with family incomes up to 250 percent of the Federal Poverty Level through a contract network of qualified providers. OAR 333-010-0100 through 333-010-0197 apply only to providers who have an approved medical services agreement to provide screening and diagnostic services through this program. The program is limited to a finite source of funds which may restrict availability of services on an annual basis.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0105
Definitions

(1) "Agency number" means the administrative number assigned to the service provider by the Center for Prevention and Health Promotion (Center) for identification as a ScreenWise Breast and Cervical Cancer services (ScreenWise BCC) provider.
(2) "Ancillary provider" means a provider that performs services beyond the scope of an enrolling provider. Ancillary providers may include but is not limited to laboratories, imaging centers, surgeons and surgical facilities, and hospitals.
(3) "Approved medical services agreement" means the completed ScreenWise BCC agreement, submitted to and approved by the Center for Prevention and Health Promotion.
(4) "Authority" means the Oregon Health Authority.
(5) "BCCTP" means the Breast and Cervical Cancer Treatment Program. ORS 414.534, 414.536.
(6) "Care coordination or case management" means that a client is provided with services, results, follow-up recommendations, and active tracking of progress towards follow-up recommendations.
(7) "Center" means the Center for Prevention and Health Promotion, the office within the Oregon Health Authority that administers the ScreenWise BCC.
(8) "CLIA" means the federal Clinical Laboratory Improvement Amendments of 1988, establishes quality standards for all laboratory testing to ensure the accuracy, reliability and

timeliness of patient test results, and allows for certification of clinical laboratories operating in accordance with these federal amendments.
(9) "Client" means a person of any age or gender who is enrolled in and receives screening or diagnostic services from the ScreenWise BCC.
(10) "Enrolling provider" means a provider that enrolls a client into the ScreenWise BCC, provides care coordination for the client and timely data submission to ScreenWise BCC.
(11) "FPL" means the federal poverty level guidelines established each year by the Department of Health and Human Services, used to determine eligibility for ScreenWise BCC and other federally funded programs.
(12) "HIPAA" means the Health Insurance Portability and Accountability Act.
(13) "ScreenWise BCC" means the ScreenWise program component that provides statewide breast and cervical cancer screening and diagnostic services to eligible clients, that is administered by the Center for Prevention and Health Promotion within the Oregon Health Authority.
(14) "ScreenWise BCC Provider Network" means the combination of all contracted ScreenWise providers, including enrolling and ancillary providers.
(15) "Service provider" or "provider" means a licensed health care provider operating within a scope of practice, who is authorized by the Center to bill for breast and cervical cancer screening and diagnostic services for eligible clients.
(16) "Site number" means the administrative number assigned to the provider by the Center for identification of the geographic location of each ScreenWise BCC provider.
(17) "Underinsured" means that health insurance does not fully cover breast and cervical cancer screening services or that out-of-pocket cost sharing for diagnostic services would pose a financial hardship.
Stat. Auth.: ORS 413.042
Stats. Implemented: 413.042

333-010-0110
Client Eligibility
In order to be eligible for the ScreenWise BCC a client must meet the following eligibility criteria:
(1) Have an income based on family size that is at or below 250 percent of the Federal Poverty Level at the time of enrollment; and
(2) Reside or declare an intent to reside in Oregon; and
(3) Have no health insurance or be underinsured; and
(4) Meet one of the following criteria:
(a) Be a woman age 21 or over for clinically recommended breast and cervical cancer screening and diagnostic services; or
(b) Be a man of any age who is displaying signs or symptoms that may indicate breast cancer.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0115
Client Enrollment
(1)(a) Clients are determined eligible on a self-declared basis, when they submit a completed and signed ScreenWise BCC enrollment form at the clinic site at the time of service.

(b) Prior to enrolling a client in ScreenWise BCC, providers with access to the Medicaid Management Information System (MMIS) shall check MMIS to verify that applicant is not currently receiving Medicaid. Clients enrolled in Medicaid are ineligible for ScreenWise BCC.
(2) Eligibility is effective for one year unless a client justifiably needs to begin a second breast or cervical cycle, as defined in the program manual, before the end of one year. Justifications include:
(a) The presence of new signs or symptoms; or
(b) The necessity of short-term follow-up, as defined in the program manual.
(3) If breast or cervical services are justifiably initiated again before the end of one year, then eligibility will automatically extend through the end of that cycle, even if the cycle lasts into a new year.
(4) ScreenWise BCC providers must keep a signed enrollment form on file at the clinic for a minimum of four years. Clients enrolled into the program who are found ineligible will be disenrolled.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0120
Covered Services
(1) ScreenWise BCC covers screening and diagnostic services specific to breast and cervical cancer. Contracted providers will only be reimbursed for services related to breast and cervical cancer screening and diagnosis.
(2) Screening and diagnostic services include, but are not limited to:
(a) For breast cancer, both a clinical breast examination and a mammogram;
(b) For cervical cancer, both a pelvic examination and a Pap smear; and
(c) Laboratory tests and medical procedures necessary for detection and diagnosis of breast and cervical cancer.
(3) Information regarding covered services and CPT code lists, including required notice to providers regarding revisions, may be found in the provider's Medical Services Agreement.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0125
Excluded Services
(1) Services and laboratory tests not directly related to breast and cervical cancer screening and diagnosis are not covered by ScreenWise BCC for any eligible client. If the client accepts financial responsibility for a non-covered service that is received during a visit, payment arrangements are between the provider and the client, per OAR 333-010-0140(5)(a).
(2) No payment will be made for any expense incurred for any of the following services or items:
(a) Treatment for cancer or pre-cancerous conditions; or
(b) Any medical service or laboratory tests whose primary purpose is for a reason other than breast or cervical cancer screening or diagnostic testing.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0130

Standards of Care for Breast and Cervical Cancer Screening and Diagnostic Services

Participating ScreenWise BCC providers must agree to provide screening and diagnostic services according to the following standards:

(1) Informed Consent. The client's decision to participate in and consent to receive breast and cervical cancer screening and diagnostic services must be voluntary and without bias or coercion.

(a) The informed consent process, provided verbally and supplemented with written materials, must be presented in a language the client understands.

(b) Consent must be obtained from the individual client receiving screening and diagnostic services.

(2) Confidentiality. Services must be provided in a manner that respects the privacy and dignity of the individual.

(a) Providers must inform clients that services and medical records will be kept confidential.

(b) Records cannot be released without written client consent, except as required by law, or otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

(3) Linguistic and Cultural Competence. All services, support and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of the individuals who are receiving services, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program.

(a) All persons providing interpretation services must adhere to confidentiality guidelines.

(b) The provider must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The provider must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964.

(c) The provider must assure the competency of language assistance provided to limited English proficiency clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services, unless requested by the client.

(d) Provider shall make available easily understood client related materials and post signage in the languages of groups commonly encountered in the service area.

(e) All print, electronic, and audiovisual materials must be appropriate according to the client's language and literacy. Providers must accommodate a client's request for alternate formats.

(4) Access to Care. Services covered by ScreenWise BCC must be provided without cost to eligible clients. Providers must inform clients of the scope of services available through the program.

(a) Although not covered by ScreenWise BCC, treatment and supplies for pre-cancerous, cancerous conditions, and sexually transmitted infections must be available at the site, or by referral.

(b) Clients in need of additional medical services beyond the scope of the ScreenWise BCC provider network must be provided with information about available local resources.

(c) Clients with a qualifying breast or cervical cancer diagnosis, including specific pre-cancerous conditions, shall be screened to determine presumptive eligibility for the BCCTP and enrolling providers shall facilitate the application process.

(d) All services must be offered to eligible clients without regard to marital status, race, parity, disability, or sexual orientation.

(5) Clinical and Preventive Services. The scope of breast and cervical cancer screening and diagnostic services offered to clients must include:

(a) A health history, including health risk facts and personal and family medical history as it pertains to breast and cervical cancer screening.

(b) An initial physical examination that includes a breast and pelvic exam with a Pap smear.
(c) Follow-up recommendations.
(d) Care coordination to ensure that appropriate follow-up screening, diagnostic testing and care is provided, including:
(A) An explanation of the results of the physical examination and the laboratory tests; and
(B) The opportunity for questions concerning procedures, methods and results.
Stat. Auth.: ORS 413.042, 414.540
Stats. Implemented: ORS 413.042, 414.534, 414.536

333-010-0135
Provider Enrollment
(1) This rule applies only to providers participating in ScreenWise BCC through an approved provider agreement with the Center.
(2) An individual or organization must meet applicable licensing or regulatory requirements set forth by federal and state statutes, regulations, and rules to be enrolled and to bill as a provider. In addition, all providers of services within the State of Oregon must 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.
(3) An individual or organization that is currently subject to sanctions by the Authority or the federal government is not eligible for enrollment.
(4) A ScreenWise BCC agency number will be issued to an individual or clinic upon:
(a) Completion of the application and submission of the required documents;
(b) The signing of the provider agreement by the provider or person authorized by the provider to bind the organization or individual to comply with these rules;
(c) Verification of licensing or certification; and
(d) Approval of the application by the Center.
(5) Issuance of an agency number establishes enrollment of an individual or organization as a provider for ScreenWise BCC services.
(6) If a provider changes address, business affiliation, licensure, ownership, certification, billing agents, registered name, or Federal Tax Identification Number (TIN), the Center must be notified in writing within 30 days of the change. Failure to notify the Center of a change of TIN may result in the imposing of a fine. Changes in business affiliation, ownership, registered name, and TIN may require the submission of a new application. Payments made to providers who have not furnished such notification may be recovered.
(7) Providers of services outside the state of Oregon will be enrolled under the following conditions:
(a) The provider is appropriately licensed or certified by the provider's state;
(b) The provider lives in a state contiguous to Oregon, and is within seventy-five miles of the Oregon border.
(8) Provider termination:
(a) The provider may terminate enrollment at any time. The request must be sent to the Center in writing, via certified mail, return receipt requested. The notice shall specify the agency number to be terminated and the effective date of termination. Termination of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect.

(b) ScreenWise BCC provider terminations or suspensions and subsequent recovery of any payments made by the Center may be for, but are not limited to, the following reasons:
(A) Breaches of the medical services agreement;
(B) Failure to comply with the statutes, regulations and policies of the Authority, and federal or state regulations that are applicable to the provider;
(C) Loss of the appropriate licensure or certification.
(9) The provider is entitled to a contested case hearing to determine whether the provider's agency number will be revoked.
(10) In the event of bankruptcy proceedings, the provider must notify the Center in writing within 15 days.
(11) Providers must receive information about administering the ScreenWise BCC from a ScreenWise BCC representative before services are initiated.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0140
Billing
(1) Only clinics providing breast and cervical cancer screening and diagnostic services pursuant to an approved medical services agreement, and who have been assigned an agency number may submit claims for ScreenWise BCC services.
(2) All services must be billed by submitting claim information in the method specified by the ScreenWise BCC.
(3) A primary diagnosis code is required on all claims. All billings must be coded with the most current and appropriate International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), incorporated by reference and the most appropriate Current Procedural Terminology (CPT) codes. Information regarding CPT code lists, including required notice to providers regarding CPT code list revisions, may be found in the provider's Medical Services Agreement. Claims including primary diagnosis codes that are not listed on the approved CPT code list will not be paid without program approval.
(4) The provider must use CLIA certified laboratories for all tests whether done at the clinic site or by an outside clinic.
(5) Enrolled providers with ScreenWise BCC must not seek payment from an eligible client, or from a financially responsible relative or representative of that individual, for any services covered by ScreenWise BCC.
(a) A client may be billed for services that are not covered by ScreenWise BCC. However, the provider must inform the client in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the client or client's representative is financially responsible for payment for the specific service. Providers must document in writing that the client was provided this information and the client knowingly and voluntarily agreed to be responsible for payment. The client or client's representative must sign the documentation.
(b) Services not covered by ScreenWise BCC are those outside of the scope of standard breast and cervical cancer screening and diagnosis, or those not included in the ICD-10 list, incorporated by reference and approved CPT code lists.
(6) Prior to submission of a claim to the Center for payment, an approved provider agreement must be in place.
(7) All claims must be submitted with data, as described in the claims section of the rules.

(a) Except for services performed by a CLIA certified laboratory outside of the clinic, all billings must be for services provided within the provider's licensure or certification.
(b) Providers must submit true and accurate information when billing the Center.
(c) A claim may not be submitted prior to providing services.
(8) Diagnosis Code Requirement:
(a) A primary diagnosis code is required on all claims.
(b) Use the highest degree of specificity within the diagnosis codes listed in the ICD-10-CM codes, incorporated by reference, for breast and cervical screening or diagnostic testing.
(9) No provider shall submit to the Center:
(a) Any false claim for payment;
(b) Any claim altered in such a way as to result in a payment for a service that has already been paid;
(c) Any claim upon which payment has been made by another source unless the amount paid is clearly entered on the claim form;
(10) The provider must submit a billing error edit correction, or refund the amount of the overpayment, on any claim where the provider identifies an overpayment made by the Center.
(11) A provider who, after having been previously warned in writing by the Authority or the Department of Justice about improper billing practices, is found to have continued such improper billing practices and has had an opportunity for a contested case hearing, shall be liable to the Center for up to triple the amount of the established overpayment received as a result of such violation.
(12) Third Party Resources:
(a) Providers must make all reasonable efforts to ensure that ScreenWise BCC will be the payor of last resort with the exception of clinic or offices operated by the Indian Health Service (IHS) or individual American Indian tribes;
(b) Providers must make all reasonable efforts to obtain payment first from other resources. For the purposes of this rule reasonable efforts include:
(A) Determining the existence of insurance coverage or other resource by asking the client;
(B) Except in the case of the underinsured, when third party coverage is known to the provider, by any other means available:
(i) The provider must bill the third party resource;
(ii) Comply with the insurer's billing and authorization requirements.
(C) Providers are required to submit a billing error edit correction showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit a billing error edit correction within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery or sanction.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0145
Claims and Data Submission
(1) In addition to submitting standard claims information, enrolling providers are required to submit client data in order to receive payment for the claim. The data is used to collect information pertaining to breast and cervical cancer prevention, diagnosis, and treatment and is

used by the National Breast and Cervical Cancer Early Detection Program and the ScreenWise BCC primarily to monitor the delivery of services and clinical outcomes of the program.
(2) Although data requirements may require more information than necessary for payment of a specific claim, all related fields must be completed and submitted.
(3) Data requirements for enrolling providers and ancillary providers are as follows:
(a) Enrolling providers must provide required information on client data forms, as defined by the program and posted on the Program website: www.healthoregon.org/screenwise.
(b) Ancillary providers must provide results of services to enrolling providers. Ancillary providers are not required to provide data to the ScreenWise BCC directly.
(4) If a provider terminates the medical services agreement all data must be submitted through the completion of each client's cycle.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0150
Timely Submission of Claims and Data
(1) All claims for services must be submitted within 120 days of the date of service. Claims older than 120 days from the date of service will not be paid, except as provided for in section (2) and (3) of this rule.
(2) If a claim is denied, the claim must be resolved within 120 days of the date of the denial. Claims older than 120 days from the date of denial will not be paid, except as provided for in section (3) of this rule.
(3) When the Center has made an error that caused the provider not to be able to bill within 120 days of the date of service, then the claim may be submitted to the Center. The error must be confirmed by the Center.
(4) Client data not related to payment of the claim may be updated or corrected at any time after the date of service.
(5) Ancillary providers must provide results of services to enrolling providers within 14 calendar days from the date of service.
(6) Enrolling providers must provide the ScreenWise BCC with enrollment and eligibility information immediately or within five calendar days from the date of enrollment. All other data must be submitted within 90 days from the date of enrollment. In the event that a case requires additional diagnostic procedures that exceed 90 days from the date of enrollment, the data must be submitted immediately upon receipt.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0155
Payment
(1) The Center will make payment only to providers that have a medical services agreement with the ScreenWise BCC and are billing for an eligible client.
(2) The ScreenWise BCC reimbursement amount will be up to the Medicare reimbursement rate for the Portland metropolitan area for ScreenWise BCC approved CPT codes, on a fee-for-service basis.

(3) Federally qualified health centers or rural health centers are not paid at their Prospective Payment System (PPS) rate; they will receive up to the Medicare reimbursement rate for ScreenWise BCC approved CPT codes, on a fee-for-service basis.
(4) Center payments for ScreenWise BCC provider services, unless in error, constitute payment in full.
(5) The Center will not make payment on claims that have been assigned, sold, or otherwise transferred, or on which a provider of billing services receives a percentage of the amount billed or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0160
Requirements for Financial, Clinical and Other Records
(1) The Center is responsible for analyzing and monitoring the operation of ScreenWise BCC and for auditing and verifying the accuracy and appropriateness of payment, utilization of services, the quality of care, and access to care. The provider shall:
(a) Develop and maintain adequate financial and clinical records and other documentation which supports the services for which payment has been requested. Payment will be made only for services that are adequately documented.
(b) All medical records must document the service provided, primary diagnosis code for the services, the date on which the service was provided, and the individual who provided the services. Patient account and financial records must 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. The records must be accurate and in sufficient detail to substantiate the data reported.
(2) Clinical records must sufficiently document that the client's services were primarily for breast or cervical cancer screening or diagnosis of breast or cervical cancer. The client's record must be annotated each time a service is provided and signed or initialed by the individual who provided the service or must clearly indicate the individual who provided the service. Information contained in the record must meet the standards of care for breast and cervical cancer screening and diagnosis, and must be appropriate in quality and quantity to meet the professional standards applicable to the provider or practitioner and any additional standards for documentation set forth in this rule.
(3) The provider must have policies and procedures to ensure the maintenance of the confidentiality of medical record information. These procedures ensure that the provider may release such information in accordance with federal and state statutes, ORS 179.505, 411.320, 45 CFR 205.50.
(4) The provider must retain clinical, financial and other records described in this rule for at least four years from the date of last activity.
(5) Upon written request from the Center, the Authority, the Oregon Department of Justice Medicaid Fraud Unit, the Oregon Secretary of State, or their authorized representatives (Requestor), the provider must furnish requested documentation, without charge, immediately or within the time-frame specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, representatives of the Requestor may review and copy the original documentation in the provider's place of business. Upon the written

request of the provider, the Requestor may, at their sole discretion, modify or extend the time for provision of such records if, in the opinion of the Center, good cause for such extension is shown. Factors used in determining whether good cause exists include:
(a) Whether the written request was made in advance of the deadline for production;
(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;
(c) The efforts already made to comply with the request;
(d) The reasons the deadline cannot be met;
(e) The degree of control that the provider had over its ability to produce the records prior to the deadline; and
(f) Other extenuating factors.
(6) Access to records, inclusive of medical charts and financial records, does not require authorization or release from the client if the purpose of such access is to:
(a) Perform billing review activities;
(b) Perform utilization review activities;
(c) Review quality, quantity and services provided;
(d) Facilitate payment authorization and related services;
(e) Investigate a client's fair hearing request;
(f) Facilitate investigation by the Authority;
(g) Where review of records is necessary to the operation of the program.
(7) Failure to comply with requests for documents and 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, and accordingly subjects the provider to possible denial or recovery of payments made by the Authority, or to sanctions.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0165
Compliance with Federal and State Statutes
(1) Submission of a claim for medical services or supplies provided to a ScreenWise BCC client shall be deemed a representation by the medical provider to the Center of the medical provider's compliance with the applicable sections of the federal and state statutes referenced in this rule:
(a) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973;
(b) Title II and Title III of the Americans with Disabilities Act of 1991;
(c) Title VI of the Civil Rights Act of 1964;
(d) 42 CFR Part 493 Laboratory Requirements and ORS chapter 438 (Clinical Laboratories).
(2) Providers are required to comply with HIPAA regarding the confidentiality of client records.
(3) CLIA requires all entities that perform even one laboratory test, including waived tests on, "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0170

Denial or Recovery of Reimbursement Resulting from Review or Audit

(1) The Center's staff, contractor or auditor may review a claim for assurance that the specific medical service was provided in accordance with the program's policies and rules and the generally accepted standards of a provider's scope of practice or specialty.

(2) Payment may be denied or subject to recovery if review or audit determines the service does not meet the program's policies, rules or the Standards of Care for Breast and Cervical Cancer Screening and Diagnostic Services set forth in OAR 333-010-0130.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: PH 9-2008, f. & cert. ef. 6-16-08

333-010-0175
Recovery of Overpayments to Providers Resulting from Review or Audit
(1) When the Center determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery:
(a) To determine the overpayment amount, the Center may use a statistically valid random sampling, with sufficient sample size allowing a confidence interval of 95 percent.
(b) After the Center determines an overpayment amount by the random sampling method set forth in section (1) of this rule, the provider may request a 100 percent audit of all billings submitted to the Center for breast and cervical cancer screening and diagnostic services provided during the period in question. If a 100 percent audit is requested:
(A) Payment and arrangement for a 100 percent audit is the responsibility of the provider requesting the audit; and
(B) The audit must be conducted by a certified public accountant that is knowledgeable about the Oregon Administrative Rules covering the payments in question, and must be conducted within 120 calendar days of the request to use such audit in lieu of the Center's random sample.
(2) The amount of the review or audit overpayment to be recovered:
(a) Will be the entire amount determined or agreed to by the Center;
(b) Is not limited to amounts determined by criminal or civil proceedings; and
(c) Will include interest to be charged at allowable state rates.
(3) The Center will deliver to the provider by registered or certified mail or in person a request for repayment of the overpayment and the documentation to support the alleged amount.
(4) If the provider disagrees with the Center's determination or the amount of overpayment the provider may appeal the decision by requesting a contested case hearing:
(a) A written request for hearing must be submitted to the Center by the provider within 30 calendar days of the date of the decision affecting the provider. The request must specify the areas of disagreement.
(b) Failure to request a hearing or administrative review in a timely manner constitutes acceptance by the provider of the amount of the overpayment.

(5) The overpayment is due and payable 30 calendar days from the date of the decision by the Center:
(a) An additional 30 day grace period may be granted the provider upon request to the Center;
(b) A request for a hearing does not change the date the repayment of the overpayment is due.
(6) The Center may extend the reimbursement period or accept an offer of repayment terms. Any change in reimbursement period or terms must be made in writing by the Center.
(7) If the provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Center may:
(a) Recoup future provider payments up to the amount of the overpayment; or
(b) Pursue civil action to recover the overpayment.
(8) As the result of a hearing the amount of the overpayment may be reduced in part or in full.
(9) The Center may, at any time, change the amount of the overpayment upon receipt of additional information. Any changes will be verified in writing by the Center. Any monies paid to the Center that exceed an overpayment will be refunded to the provider.
(10) If a provider is terminated or sanctioned for any reason, the Center may pursue civil action to recover any amounts due and payable to ScreenWise BCC.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0180
Provider Sanctions
The following are conditions that may result in the imposition of a sanction on a provider.
(1) Basis for Sanction:
(a) Conviction of a provider of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws (or entered a plea of nolo contendere);
(b) Conviction of fraud related to any federal, state, or locally financed health care program;
(c) Conviction of interference with the investigation of health care fraud;
(d) Conviction of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;
(e) Failure to comply with the state and federal statutory requirements set forth in OAR 333-010-0165;
(f) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity, the provider either:
(A) Had a health care license suspended or revoked, or has otherwise lost such license; or
(B) Surrendered the license while a formal disciplinary proceeding was pending before a licensing authority.
(g) Suspension or exclusion from participation in a federal or state health care program for reasons related to professional competence, professional performance, or other reason;
(h) Improper billing practices, including billing for excessive charges or visits;
(i) Failure to furnish services as required by law or contract with the Center, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the client;
(j) Failure to supply requested information on subcontractors and suppliers of goods or services;
(k) Failure to supply requested payment information;
(l) Failure to grant access to facilities or provide records upon request of the Center or a designated Requestor;

(m) Receiving payments for services provided to persons who were not eligible;
(n) Establishing multiple claims using procedure codes that overstate or misrepresent the level, amount or type of health care provided;
(o) Failure to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;
(p) Failure to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a client and payments received from any source;
(q) Failure to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rule, or regulation;
(r) Submission of claims or written orders contrary to generally accepted standards of medical practice;
(s) Submission of claims for services that exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical practitioner;
(t) Breach of the terms of the medical services agreement;
(u) Failure to correct deficiencies in operations after receiving written notice of the deficiencies from the Center;
(v) Submission of any claim for payment for which payment has already been made by the Center; or
(w) Provision of or billing for services provided by ineligible or unsupervised staff.
(2) A provider who has been suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any billing provider or other provider, for any services or supplies provided under ScreenWise BCC, except those services provided prior to the date of suspension or termination.
(3) When the provisions of section (2) of this section are violated, the Center may suspend or terminate the provider who is responsible for the violation.
(4) Provider sanctions will be imposed at the discretion of the Authority or the administrator of the office whose budget includes payment for the services involved.
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042

333-010-0185

Provider Appeals

A provider may appeal certain decisions affecting the provider made by the Center. There are two levels of appeal. Level 1 is a reconsideration on a claim. Level 2 is a contested case hearing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: PH 9-2008, f. & cert. ef. 6-16-08

333-010-0190

Provider Appeals (Level 1) — Claims Reconsideration

A provider disputing the Center's claim decision may request reconsideration. The provider must submit the request in writing to the Center. The request must include the reason for the dispute, and any information pertinent to the outcome of the dispute. The Center will complete an additional review and respond back to the provider in writing. If the provider is not satisfied with the review, the provider may request a contested case hearing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: PH 9-2008, f. & cert. ef. 6-16-08

333-010-0195

Provider Appeals (Level 2) — Contested Case Hearing

Contested case hearings will be held in accordance with ORS 183.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: PH 9-2008, f. & cert. ef. 6-16-08

333-010-0197
Presumptive Eligibility for BCCTP
(1) Any licensed health care provider who can diagnose breast or cervical cancer may presumptively enroll a client into BCCTP and refer the client to the Oregon Health Plan if she meets the presumptive eligibility criteria as described in section (2) of this rule.
(2) In order to be presumptively enrolled into BCCTP a client must meet the eligibility criteria in OAR 333-010-0110 and OAR 410-200-0400.
Stat. Auth.: ORS 413.042, 414.540
Stats. Implemented: ORS 414.534, 414.536