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

DIVISION 10
HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

WISEWOMAN Program

333-010-0200

Description of the WISEWOMAN Program

The WISEWOMAN (WW) Program is a federal program, administered by the Oregon Health Authority, that provides heart disease, stroke and diabetes screening support to develop and maintain healthy behaviors, and referral services in an effort to prevent cardiovascular disease to eligible women statewide. The WW Program provides these services through a contract network of qualified providers. These rules (OAR 333-010-0200 through 333-010-0290) apply only to providers who have an approved medical services agreement to provide screening and 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, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0205

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 BCCP/WW provider.

(2) "Ancillary provider" means an individual or entity that has met the eligibility requirements for enrollment in the WW Program, has executed a medical services agreement with the Center, has been assigned a BCCP/WW Program agency number, and performs services beyond the scope of an enrolling provider, such as laboratory, imaging, or surgical services.

(3) "Approved medical services agreement" means the completed WW Program agreement, submitted to and approved by the Center for Prevention and Health Promotion.

(4) "Authority" means the Oregon Health Authority.

(5) "BCCP" means the Oregon Breast and Cervical Cancer Program.

(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, within the Oregon Health Authority, Public Health Division.

(8) "CLIA" means the federal Clinical Laboratory Improvement Amendments of 1988 (P.L. 100-578, 42 U.S.C. 201 and 263a)

(9) "Client" means a woman 40 to 64 years of age who is enrolled in and receives screening or services from the WW Program.

(10) "Enrolling provider" means an individual or entity that has met the eligibility requirements for enrollment in the WW Program, has executed a medical services agreement with the Center, has been assigned a BCCP/WW Program agency number, and provides screening, services, or care coordination for WW Program clients.

(11) "FPL" means the federal poverty level guidelines established each year by the United States Department of Health and Human Services, used to determine eligibility for the WW Program and other federally funded programs.

(12) "HIPAA" means the Health Insurance Portability and Accountability Act.

(13) "Site number" means the administrative number assigned to the family planning service provider by the Center for identification of the geographic location of each WW provider.

(14) "WISEWOMAN Program" or "WW Program" means the program that provides statewide heart disease, stroke and diabetes screening and services to eligible clients, that is administered by the Center.

(15) "WW Program provider network" means the combination of all contracted WW Program providers, including enrolling and ancillary providers.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 5-2011(Temp), f. & cert. ef. 7-1-11 thru 12-27-11; PH 11-2011, f. & cert. ef. 10-27-11; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0210

Client Eligibility

A person must meet the following WW Program eligibility criteria in order to be enrolled in the WW Program:

(1) Be a woman 40 to 64 years of age; and

(2) Be enrolled in the BCCP program.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0215

Client Enrollment

(1) A person is determined eligible for the WW Program after submitting a completed and signed BCCP/WW Program enrollment form.

(2) Eligibility is effective for one year.

(3) A person who enrolled in the WW Program but who is later found to be ineligible shall be notified by the Center or her enrolling provider in writing of such disenrollment and may be responsible for the payment of services received from her provider.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0220

Provider Enrollment

(1) An individual or organization that wishes to be an enrolling provider or an ancillary provider with the WW Program shall apply to the Center on a form prescribed by the Center.

(2) In order to be eligible for enrollment, an individual or organization shall:

(a) 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

(b) Meet applicable licensing or regulatory requirements set forth by federal and state statutes, regulations, and rules to be enrolled and to bill as a health care provider.

(3) A laboratory or any other entity that does laboratory tests must provide evidence that it is CLIA certified in order to be a provider or an ancillary provider.

(4) An individual or organization that is currently subject to sanctions by the Authority or the federal government is not eligible for enrollment.

(5) Upon receipt of an application the Center shall verify the information and determine if the individual or organization is eligible to be an enrolling or ancillary provider.

(6) If the Center approves an application, an individual or organization shall:

(a) Sign a medical services agreement that requires the provider to comply with these rules; and

(b) Be issued a BCCP/WW Program agency number.

(7) An enrolling or ancillary provider may not offer services to a client prior to receiving information from a Center WW Program representative about administering the WW Program.

(8) An enrolling provider or ancillary provider shall notify the Center in writing within 30 days of the change if it changes its address, business affiliation, licensure, ownership, certification, billing agents, registered name, or Federal Tax Identification Number (TIN). Changes in business affiliation, ownership, registered name, and TIN may require the submission of a new application. Payments made to an

enrolling provider or an ancillary provider who has not furnished such notification may be recovered by the Center.

(9) An enrolling provider or an ancillary provider shall notify the Center in writing of a bankruptcy proceedings within 15 days.

(10) An individual or organization outside the state of Oregon may be eligible for enrollment if the individual or organization:

(a) Is appropriately licensed or certified in its state; and

(b) Is located in a state contiguous to Oregon, and is within 75 miles of the Oregon border.

(11) An enrolling provider or an ancillary provider may terminate enrollment at any time by sending a written termination notice to the Center, via certified mail, return receipt requested. The notice shall specify the agency number to be terminated and the effective date of termination. Termination of a provider enrollment does not terminate any obligations of the provider for services provided to a client prior to the effective date of the termination.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0225

Standards of Care for WISEWOMAN Program Screening and Services

An enrolling provider shall:

(1) Inform each client, verbally and with supplementary written materials in a language the client understands, without bias or coercion, that the client's decision to participate in the WW Program screening and services is voluntary;

(2) Inform clients of the scope of services available through the program;

(3) Obtain informed consent from each client receiving WW screening and services;

(4) Provide services within the scope by the WW Program without cost to eligible clients;

(5) Offer clients with abnormal or ALERT values additional medical support even though treatment is not covered by the WW Program. The WW Program Manual, October 2014, incorporated by reference, includes a complete list of abnormal and ALERT values and medical support services approved for reimbursement.

(6) Provide information to clients in need of additional medical services beyond the scope of the WW Program provider network with information about available local resources;

(7) Provide all services to eligible clients without regard to marital status, race, parity, disability, or sexual orientation;

(8) Take a health history for all clients, including health risk facts and personal and family medical history as it pertains to heart disease, stroke and diabetes screening;

(9) Provide follow-up recommendations for each client;

(10) Provide care coordination to ensure that appropriate follow-up screening, diagnostic testing and care is provided, including:

(a) An explanation of the results of the screening and laboratory tests; and

(b) The opportunity for questions concerning procedures, methods and results.

(11) Submit enrollment and eligibility information immediately or within five calendar days from the date of enrollment to the Center;

(12) Submit all client data to the WW Program, including required information about client history and screening results;

(13) Provide services to each client in a manner that respects the privacy and dignity of the individual;

(14) Inform clients that services and medical records will be kept confidential and that records cannot be released without written client consent, except as required by law, or otherwise permitted by HIPAA;

(15) Provide all services, support and other assistance in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of the clients receiving services, and in a manner that has the greatest likelihood of ensuring a client's maximum participation in the program;

(16) Notify clients of the availability of interpretation services in accordance with the Civil Rights Act of 1964, and make interpretation services available to all clients needing or requesting such assistance at no cost to the client;

(a) A provider shall ensure that all persons providing interpretation services adhere to confidentiality guidelines;

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

(17) Make available easily understood client related materials and post signage in the languages of groups commonly encountered in the service area;

(18) Ensure that all print, electronic, and audiovisual materials are appropriate according to the client's language and literacy level, including accommodating a client's request for alternate formats; and

(19) Use only CLIA certified laboratories for all tests, whether done at the clinic site or by an outside clinic.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0230

Submission of Information by Ancillary Providers

Ancillary providers shall provide results of services to enrolled providers within 14 calendar days from the date of service.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.150
Hist.: PH 1-2009, f. & cert. ef. 2-13-09

333-010-0235

Covered Services

The WW Program Manual, October 2014, incorporated by reference, includes a complete list of covered services.

[Publications: Publications referenced are available from the Oregon WW Program].

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0240

Excluded Services

(1) Services and laboratory tests not directly related to heart disease, stroke and diabetes, or not included in the ICD-10 and CPT code lists provided in the WW Program Manual are not covered by the WW Program.

(2) No payment will be made for any expense incurred for any other medical service or laboratory tests whose primary purpose is for a reason other than heart disease, stroke, or diabetes screening and prevention.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09

333-010-0245

Claims and Billing

(1) Only an enrolling or ancillary provider providing WW Program covered services pursuant to a fully executed medical services agreement, and who has been assigned an agency number may submit claims for payment to the Center for providing WW Program covered services.

(2) An enrolling or ancillary provider shall, as applicable:

(a) Submit claim information in the manner specified by the WW Program;

(b) Include a primary diagnosis code on all claims;

(c) Code all claims with the most current and appropriate International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes and the most appropriate Current Procedural Terminology (CPT) codes as noted in the WW Program Manual;

(d) Submit to the Center all claims for services 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 (4) of this rule;

(e) Submit a billing error edit correction, or refund the amount of the overpayment, on any claim where a provider identifies an overpayment made by the Center;

(f) Make all reasonable efforts to ensure that the WW Program is the payor of last resort with the exception of clinics or offices operated by the Indian Health Service (IHS) or individual American Indian tribes. For the purposes of this rule "reasonable efforts" include:

(A) Determining the existence of insurance coverage or other resource by asking the client; and

(B) Except in the case of the underinsured, billing any known insurer in compliance with that insurer's billing and authorization requirements.

(g) Submit to the Center a billing error edit correction if it receives a third party payment and refund to the Center the amount received from the other source within 30 days of the date the payment is received.

(3) The Center may not pay a claim older than 120 days, except as provided for in section (4) of this rule. An enrolling or ancillary provider that has a claim rejected because of an error shall resolve the error within 120 days of the date of denial.

(4) If the Center makes an error that makes it impossible for an enrolling or ancillary provider to bill within 120 days of the date of service, the enrolling or ancillary provider shall notify the Center of the alleged error and submit the claim to the Center. The Center shall confirm that it made an error prior to payment being made.

(5) The Center may not pay a claim that includes a primary diagnosis code that is not in the WW Program Manual.

(6) An enrolling or ancillary provider with the WW Program may not seek payment from a client, or from a financially responsible relative or representative of that client for any services covered by the WW Program.

(7) An enrolling or ancillary provider may bill a client for services that are not covered by the WW Program. 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.

(8) Except for services performed by a CLIA certified laboratory outside of the clinic, all billings by an enrolling provider must be for services provided within the provider's licensure or certification.

(9) 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, may 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 the WW Program, except those services provided prior to the date of suspension or termination.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0250

Payment

(1) The Center shall only pay claims submitted by an enrolling or ancillary provider for a client.

(2) The Center shall reimburse an enrolling or ancillary provider an amount up to the Medicare reimbursement rate for the Portland metropolitan area for WW Program approved CPT codes, on a fee-for-service basis.

(3) A federally qualified health center or rural health center shall not be paid at their Prospective Payment System (PPS) rate, but will be paid at the reimbursement rate described in section (2) of this rule.

(4) The Center payments for WW Program provider services, unless in error, constitute payment in full.

(5) The Center may 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, including claims that have been transferred 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, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0255

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 WW Program’s rules or the generally accepted standards of a provider’s scope of practice or specialty.

(2) Payment may be denied or subject to recovery if a review or audit determines the service was not provided in accordance with the WW Program’s rules or the generally accepted standards of a provider’s scope of practice or specialty.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09

333-010-0260

Recovery of Overpayments to Providers Resulting from Review or Audit

(1) If the Center determines that an overpayment has been made to an enrolling or ancillary provider, the Center shall seek to recover the amount of overpayment. The Center may use a statistically valid random sampling, with sufficient sample size allowing a confidence interval of 95 percent to determine if an overpayment has been made.

(2) The amount of the review or audit overpayment to be recovered:

(a) Will be the entire amount determined 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 shall provide an enrolling provider in writing, by registered or certified mail or in person, notice of an overpayment and a request for repayment of the overpayment, along with documentation to support the amount owed.

(4) An enrolling or ancillary provider shall pay the overpayment amount within 30 calendar days from the date the Center mails the notice of overpayment. A request for a hearing does not change the date the repayment of the overpayment is due.

(5) The Center may extend the 30-day repayment period or accept an offer of repayment terms. Any change in reimbursement period or terms must be documented in writing by the Center.

(6) If the provider disagrees with the Center's determination or the amount of overpayment the provider may:

(a) Appeal the decision by requesting a contested case hearing; or

(b) Request a 100 percent audit of all billings submitted to the Center for heart disease, stroke, and diabetes screenings and services provided during the period in question.

(7) 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. Failure to request a hearing or administrative review in a timely manner constitutes acceptance by the provider of the amount of the overpayment.

(8) If a 100 percent audit is requested:

(a) An enrolling or ancillary provider is responsible for arranging and paying for 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 an audit in lieu of the Center's random sample.

(9) 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.

(10) The Center may, at any time, change the amount of the overpayment upon receipt of additional information from an enrolling provider. If the Center changes an overpayment amount it will provide written notice to the enrolling provider. Any monies paid to the Center that exceed an overpayment will be refunded to the provider.

(11) The Center may pursue civil action to recover any amounts due and payable to the WW Program.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0265

Client Data Submission

(1) In addition to submitting the claim information required in OAR 333-010-0225, in order to receive payment an enrolling provider shall submit client data to the Center. The data shall be used by the WW Program to monitor the delivery of services and clinical outcomes of the program.

(2) An enrolling provider shall submit client data to the Center, in a manner specified by the Center, on the Enrollment Form, Assessment Form and the Screening Form, included in the WW Program Manual within 90 days from the date of enrollment. In the event that a client requires additional diagnostic procedures and the information is not available within 90 days from the date of enrollment, the data shall be submitted to the Center immediately once it is received by the provider.

(3) An ancillary provider shall report data to an enrolling provider and is not required to provide data to the Center directly.

(4) An enrolling provider may update or correct client data not related to payment of the claim at any time after the date of service.

(5) If an enrolling provider or the Center terminates the medical services agreement, data are still required to be submitted for each client that was provided services while the agreement was in effect.

[Publications: Publications referenced are available from the agency]

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0270

Requirements for Financial, Clinical and Other Records

(1) An enrolling provider shall:

(a) Develop and maintain adequate financial and clinical records and other documentation that supports the services for which payment has been requested;

(b) Ensure that all medical records 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;

(c) Ensure that patient account and financial records 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 in accurate and sufficient detail to substantiate the data reported;

(d) Ensure that clinical records sufficiently document that the client's services were primarily for heart disease, stroke and diabetes;

(e) Ensure that each time a service is provided to a client, the client's record is signed or initialed by the individual who provided the service or otherwise clearly indicates who provided the service;

(f) Ensure that the information contained in the record reflects that the standard of care for heart disease, stroke and diabetes screening and services were met;

(g) Have policies and procedures to ensure the confidentiality of medical records and that address the circumstances under which information may be released in accordance with federal and state law; and

(h) Retain client enrollment forms, clinical, financial and other records described in this rule for at least four years from the date of last activity.

(2) The Center, the Authority, the Oregon Department of Justice Medicaid Fraud Unit, the Oregon Secretary of State, or their authorized representatives (requestor) may request, in writing, any records related to an enrolling or ancillary provider's participation in the WW Program, including client medical records. An enrolling or ancillary provider shall furnish requested records, 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 the requestor's 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 its sole discretion, modify or extend the time for provision of such records for good cause shown.

(3) 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, 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, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0275

Compliance with Federal and State Statutes

(1) Submission of a claim for medical services or supplies provided to a client shall be deemed a representation by the enrolling or ancillary provider to the Center of the provider's compliance with the applicable sections of the following federal and state statutes:

(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; and

(d) 42 CFR Part 493 Laboratory Requirements and ORS chapter 438 (Clinical Laboratories).

(2) Enrolling and ancillary providers are required to comply with HIPAA regarding the confidentiality of client records.

(3) A provider that performs 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" is considered a laboratory under CLIA and therefore CLIA certification may be required.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0280

Provider Sanctions

(1) The Center may sanction an enrolling provider if the provider:

(a) Is convicted 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) Is convicted of fraud related to any federal, state, or locally financed health care program;

(c) Is convicted of interference with the investigation of health care fraud;

(d) Is convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(e) Fails to comply with the state and federal statutory requirements set forth in OAR 333-010-0275;

(f) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity:

(A) Has a health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrenders a health care license during a pending formal disciplinary proceeding;

(g) Is suspended or excluded from participation in a federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(h) Engages in improper billing practices, including:

(A) Billing for excessive charges or visits;

(B) Submitting a false claim for payment;

(C) Altering a claim in such a way as to result in a payment for a service that has already been paid; or

(D) Making a claim upon which payment has been made by another source unless the amount paid is clearly entered on the claim form;

(i) Fails 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) Fails to supply requested information on subcontractors and suppliers of goods or services;

(k) Fails to supply requested payment information;

(l) Fails to grant access to facilities or provide records upon request of the Center or a designated requestor;

(m) Receives payments for services provided to persons who were not eligible;

(n) Establishes multiple claims using procedure codes that overstate or misrepresent the level, amount or type of health care provided;

(o) Fails 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) Fails 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) Fails to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulation;

(r) Submits claims for services provided that were contrary to generally accepted standards of medical practice;

(s) Submits 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) Breaches the terms of the medical services agreement;

(u) Fails to correct deficiencies in operations after receiving written notice of the deficiencies from the Center;

(v) Fails 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;

(w) Provides or bills for services provided by ineligible or unsupervised staff;

(x) Submits claims for payment, either personally or through claims submitted by any billing provider or other provider, for any services or supplies provided under the WW Program for services provided after being suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or after his or her license to practice has been suspended or revoked by a state licensing board;

(y) Fails to notify the Center of a change of TIN within 30 days; or

(z) Fails to respond to a request for records under OAR 333-010-0270.

(2) Sanctions may include:

(a) Termination from participation in the WW Program;

(b) Suspension from participation in the WW Program for a specified length of time, or until specified conditions for reinstatement are met and approved by the Center;

(c) Withholding payments to an enrolling or ancillary provider;

(d) A requirement to attend provider education sessions at the expense of the sanctioned enrolling or ancillary provider;

(e) A requirement that payment for certain services are made only after the Center has reviewed documentation supporting the services;

(f) The recovery of investigative and legal costs;

(g) Reduction of any amount otherwise due the enrolling or ancillary provider; and the reduction may be up to three times the amount a provider sought to collect from a client;

(h) Any other sanction reasonably designed to remedy or compel future compliances with federal, state or Center regulations.

(3) An enrolling or ancillary provider who has been the subject of repeat sanctions regarding improper billing practices may be liable to the Center for up to triple the amount of the established overpayment received as a result of such violation.

(4) When an enrolling or ancillary provider fails to meet one or more of the requirements identified in this rule the Center, at its sole discretion, may immediately suspend the provider's BCCP/WW Program assigned billing number to prevent public harm or inappropriate expenditure of public funds.

(a) An enrolling or ancillary provider subject to immediate suspension is entitled to a contested case hearing as outlined in OAR 333-010-0290 to determine whether the provider's BCCP/WW Program assigned number will be revoked.

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

(5) If the Center decides to sanction an enrolling or ancillary provider, the Center shall notify the provider by certified mail or personal delivery service of the intent to sanction. The notice of immediate or proposed sanction will identify:

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

(b) Explanation of actions expected of the provider;

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

(d) The provider's right to dispute the Center's allegations, and submit evidence to support the provider's position; and

(e) The provider's right to appeal the Center's proposed actions pursuant to OAR 333-010-0285 through 333-010-0290.

(6) If the Center makes a final decision to sanction an enrolling or ancillary provider, the Center shall notify the provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(7) An enrolling or ancillary provider must appeal an immediate or proposed sanction separately from any appeal of audit findings and overpayments.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0285

Provider Appeals (Level 1) — Claims Reconsideration

An enrolling or ancillary provider disputing a claim or sanction decision by the Center may request reconsideration. The provider must submit the request for reconsideration 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 & 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14

333-010-0290

Provider Appeals (Level 2) — Contested Case Hearing

An enrolling or ancillary provider may request a contested case hearing within 30 calendar days of the date of a decision affecting the provider. Contested case hearings will be held in accordance with ORS chapter 183 and the Attorney General's model rules, OAR 137-003-0501 through 137-003-0700.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042 & 431.250
Hist.: PH 1-2009, f. & cert. ef. 2-13-09; PH 12-2014(Temp), f. & cert. ef. 4-18-14 thru 10-15-14; PH 27-2014, f. & cert. ef. 10-10-14