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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Health Systems Division: Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
Sandy Cafourek	dmap.rules@state.or.us
Rules Coordinator	Email Address
500 Summer St. NE, Salem, OR 97301	503-945-6430
Address	Telephone
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RULE CAPTION

Managed Care Entity (MCE) Billing and Payment
Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-3420

REPEAL: 410-141-0420

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651

Other Auth.:

Stats. Implemented: ORS 414.065 & 414.610 - 414.685

RULE SUMMARY

The Division's rule requires Managed Care Entities (MCEs) to demonstrate that they are able to provide coordinated care services efficiently, effectively, and economically. This is the first OHP managed care rule to consolidate the MCE requirements for billing and payment into one administrative rule. This is also

410-141-3420

Managed Care Entity (MCE) Billing and Payment

- (1) Providers shall submit all billings for MCE members in the following timeframes:
 - (a) Submit bills within no greater than four months of the date of service for all cases, except as provided for in (1) (b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;
 - (b) Submit billings within 12 months of the date of service in the following cases:
 - (A) Pregnancy;
 - (B) Eligibility issues such as retroactive deletions or retroactive enrollments;
 - (C) Medicare is the primary payer, except where the MCE is responsible for the Medicare reimbursement;
 - (D) Other cases that could have delayed the initial billing to the MCE not including failure of the provider to verify the member's eligibility; or
 - (E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered an alternative liability or TPL.
- (2) Providers shall be enrolled with the Division to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Division before enrollment with the Authority or to be eligible for MCE payment for services. FFS providers may be retroactively enrolled in accordance with OAR 410-120-1260 Provider Enrollment.
- (3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.
- (4) Providers shall verify before providing services that the client is:
 - (a) Eligible for Division programs and;
 - (b) Whether the client is assigned to an MCE on the date of service.
- (5) Providers shall use the Authority's tools and the MCE's tools, as applicable, to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek prior authorizations

from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an OHP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(6) MCEs shall pay for all covered capitated and coordinated care services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise. MCEs may require providers to obtain prior authorization to deliver certain capitated or coordinated care services.

(7) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider except as follows:

(a) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider and written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify time frames for:

(A) Date stamping prior authorization requests and claims when received;

(B) Determining within a specific number of days from receipt whether a prior authorization request or a claim is valid or non-valid;

(C) The specific number of days allowed for follow-up on pended prior authorization requests or pended claims to obtain additional information;

(D) The specific number of days following receipt of the additional information that an approval or denial shall be issued;

(E) Providing services after office hours and on weekends that require prior authorization;

(F) Sending written notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.

(b) MCEs shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to urgent services, alcohol and drug services, or care required while in a skilled nursing facility;

(c) Prior authorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent prior authorization for a prescription drug cannot be completed within 24 hours, the MCE shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All pharmacy requests, including those not marked urgent, shall be reviewed and a decision rendered within 72 hours of original receipt of the prior authorization request;

(d) For expedited prior authorization requests in which the provider indicates or the MCE determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(A) The MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;

(B) The MCE may extend the three working day time period no more than 14 calendar days if the member requests an extension or if the MCE justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(e) For all other prior authorization requests, MCEs shall notify providers of an approval, a denial, or the need for further information within 14 calendar days of receipt of the request as outlined in OAR 410-141-3263. MCEs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the MCE may use an additional 14 days to obtain follow-up information if the MCE justifies to the Authority, upon request, the need for additional information and how the delay is in the member's best interest. If the MCE extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in 410-141-3263. The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension;

(f) MCEs shall pay or deny at least 90 percent of valid claims within 30 calendar days of receipt and at least 99 percent of valid claims within 90 calendar days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

(g) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3263;

(h) MCEs may not require providers to delay billing to the MCE;

(i) MCEs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare or require non-Medicare approved providers to bill Medicare;

(j) MCEs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(k) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(L) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis.

(8) MCEs shall pay for Medicare coinsurances and deductibles up to the Medicare or MCE's allowable for covered services the member receives within the MCE participating provider network for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. MCEs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(10) MCEs shall pay for ancillary, as defined in 410-120-0000, covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

(a) It can be verified that a participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(b) The ancillary covered service was delivered in good faith without the prior authorization; and

(c) It was an ancillary covered service that would have been prior authorized with a participating provider if the MCE's referral procedures had been followed;

(d) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727;

(e) Except as specified in OAR 410-141-3140 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(f) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(g) MCEs shall reimburse hospitals for services provided on or after January 1, 2012, using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies including, but not limited to, pay-for-performance, bundled payments, and capitation. An alternative payment methodology does

not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements.

(11) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (11)–(13) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require MCEs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;

(c) For those Type A or Type B hospitals that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3268 and 410-141-3269, as applicable;

(d) For monitoring purposes, MCEs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.

(12) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:

(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;

(b) After determination for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1 of the following (even numbered) year;

(c) Type A and Type B hospitals located in a county that is designated as "Frontier" will not be subject to determination via the algorithm and shall remain on CBR.

(13) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:

(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;

(b) Reimbursement rates effective for the initial calendar year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table section at the following: <http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx>.

(14) Members may receive certain services on a Fee-for-Service (FFS) basis:

(a) Certain services shall be authorized by the MCE or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers shall verify a member's eligibility and MCE assignment as provided for in this rule;

(b) Services authorized by the MCE or CMHP are subject to the Authority's administrative rules and supplemental information including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the Authority's administrative rules, contracts, and billing instructions;

(e) The Authority may not pay a provider for providing services for which an MCE has received an MCE payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility, or foster home, provision of that item or service is not the responsibility of the Authority or an MCE except as provided in Authority administrative rules and supplemental information (e.g., coordinated care and capitated services that are not included in the nursing facility all-inclusive rate);

(g) CCOs and MHOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the CCO and MHOs would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(15) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 Excluded Services and Limitations for OHP Clients.

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