Health Systems Division
Integrated Health Programs

American Indian/Alaska Native Services Administrative Rulebook

Chapter 410, Division 146

Effective October 1, 2015

Table of Contents

410-146-0000 Foreword 1
410-146-0020 Memorandum of Agreement Reimbursement Methodology 2
410-146-0021 American Indian/Alaska Native Provider Enrollment 4
410-146-0040 – ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes 6
410-146-0060 Prior Authorization 8
410-146-0075 Client Copayments 10
410-146-0080 Professional Ambulatory Services 11
410-146-0085 – Encounter and Recognized Practitioners 12
410-146-0086 Multiple Encounters 17
410-146-0100 Vaccines for Children 19
410-146-0120 Maternity Case Management Services 20
410-146-0130 Modifiers 22
410-146-0160 Administrative Medical Examinations and Reports 23
410-146-0200 Pharmacy 24
410-146-0220 Death With Dignity 25
410-146-0240 Transportation 26
410-146-0440 Prepaid Health Plan Supplemental Payments 30
410-146-0460 Compensation for Outstationed Outreach Workers 35

410-146-0000 Foreword

(1) The Division of Medical Assistance Programs (Division) American Indian/Alaska Native (AI/AN) Oregon Administrative Rules are designed to assist the following providers to prepare claims for services provided to clients with Medical Assistance Program coverage:

(a) Indian Health Service (IHS) facilities; and

(b) Tribal 638 facilities, defined as Tribally-operated health care clinics owned or operated by a Tribe or Tribal organization with funding authorized by Title I or Title V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), and recognized by the Centers for Medicare and Medicaid Services (CMS) under the 1996 Memorandum of Agreement (MOA);

(2) Health care facilities not designated an IHS or Tribal 638 facility should refer to Oregon Health Plan (OHP) General Rules (OAR chapter 410, division 120) and other applicable program-specific rules to enroll and operate as any other provider type recognized under the state plan.

(3) CMS does not recognize Urban Indian Health Program (UIHP) clinics as eligible for reimbursement of services under the MOA. UIHP Clinics should refer to:

(a) Federally Qualified Health Centers (FQHC) and Rural Health Clinics administrative Rules (OAR chapter 410, division 147) to enroll as a FQHC if the clinic is an urban Indian organization under the Indian Health Care Improvement Act, Public Law 94-437; or

(b) OHP General Rules (OAR chapter 410, division 120) and other applicable program-specific rules to enroll and operate as any other provider type recognized under the state plan.

(4) The AI/AN administrative rules include important information about general program policy, provider enrollment, maintenance of financial records, special programs, and billing. Unless specifically directed by the AI/AN rules, do not use other Division administrative rules to determine appropriate action.

(5) AI/AN Division-enrolled providers must use the OHP General Rules (OAR chapter 410, division 120) and the OHP Administrative Rules (OAR chapter 410, division 141) as directed in the AI/AN rules and in conjunction with applicable program-specific rules including the AI/AN administrative rules.

(6) The Health Services Commission's Prioritized List of Health Services defines Medicaid-covered services under Division. For more information, refer to the OHP Administrative Rules (OAR 410-141-0520).

410-146-0020 Memorandum of Agreement Reimbursement Methodology

(1) In 1996, a Memorandum of Agreement (MOA) between the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS) established the roles and responsibilities of CMS and IHS regarding the Division of Medical Assistance Programs' (Division) American Indian/Alaska Native (AI/AN) Program individuals. The MOA addresses payment for Medicaid services provided to AI/AN individuals on and after July 11, 1996, through health care facilities owned and operated by AI/AN tribes and tribal organizations, which are funded through Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

(2) The IHS and CMS, pursuant to an agreement with the Office of Management and Budget (OMB), developed an all-inclusive rate to be used for billing directly to and reimbursement by Medicaid. This rate is sometimes referred to as the "OMB," "IHS," "All-Inclusive" (AIR), "encounter," or "MOA" rate and is referenced throughout these rules as the "IHS rate." The IHS rate is updated and published in the Federal Register each fall:

(a) The rate is retroactive to the first of the year;

(b) The Division automatically processes a retroactive billing adjustment each year to ensure payment of the updated rate.

(3) IHS direct health care service facilities, established, operated, and funded by IHS; enroll as an AI/AN provider and receive the IHS rate.

(4) Under the MOA, tribal 638 health care facilities can choose to be designated a certain type of provider or facility for enrollment with Division. The designation determines how the Division pays for the Medicaid services provided by that provider or facility. Under the MOA, a tribal 638 health care facility may do one of the following:

(a) Operate as a Tribal 638 health care facility. The health center would enroll as AI/AN provider and choose reimbursement for services at either:

(A) The IHS rate; or

(B) A cost-based rate according to the Prospective Payment System (PPS). Refer to OARs 410-147-0360, Encounter Rate Determinations, 410-147-0440, Medicare Economic Index (MEI), 410-147-0480, Cost Statement (DMAP 3027) Instructions, and 410-147-0500, Total Encounters for Cost Reports; or

(b) If it so qualifies, operate as any other provider type recognized under the State Plan, and receive that respective reimbursement methodology.

(5) AI/AN and the Division's Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC) Program providers may be eligible to receive the

supplemental/wraparound payment for services furnished to clients enrolled with a Prepaid Health Plan (PHP). Refer to AI/AN OAR 410-146-0420 and FQHC/ RHC administrative rules OAR chapter 410, division 147.

(6) AI/AN providers may be eligible for an administrative match contract with the Division. AI/AN providers are not eligible to participate in the Medicaid Administrative Claiming (MAC) Program if they:

(a) Receive reimbursement for services according to the cost-based PPS rate methodology; or

(b) Receive financial compensation for out-stationed outreach worker activities.

(7) An AIAN clinic that chooses to participate in the Patient Centered Primary Care Home Program (PCPCH) must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through 409-055-0080 Office for Oregon Health Policy and Research and OAR 410-141-0860 Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment.

(a)The PCPCH program is outside the Prospective Payment system and the IHS/MOA rate. Providers who choose to participate and meet all PCPCH related requirements shall receive a separate reimbursement per the per member per month (PMPM) payment established by OAR 410-141-0860;

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0021 American Indian/Alaska Native Provider Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (Division) requirements for Indian Health Service (IHS) and Tribal 638 clinics to enroll as American Indian/Alaska Native (AI/AN) providers (refer to OAR 410-120-1260, Provider Enrollment).

(2) An IHS or Tribal 638 clinic that operates a retail pharmacy, provides durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS or TCM provider. For specific information, refer to OAR chapter 410, division 121, Pharmaceutical Services Program; OAR chapter 410, division 122, DMEPOS Program; and OAR chapter 410, division 138, TCM Program.

(3) To enroll with the Division as an AI/AN provider, a health center must be one of the following:

(a) An IHS direct health care services facility established, operated, and funded by IHS; or

(b) A Tribally-owned and operated facility funded by Title I or V of the Indian Self Determination and Education Assistance Act (Public Law 93-638) and is referenced throughout these rules as a “Tribal 638” provider;

(A) A Tribal 638 facility that has administrative control, operation, and funding for health programs transferred to AI/AN tribal governments under a Title I contract with IHS;

(B) A Tribal 638 facility that assumes autonomy for the provision of the tribe’s own health care services under a Title V compact with IHS.

(4) Eligible IHS and Tribal 638 providers who want to enroll with the Division as an AI/AN provider must submit the following information:

(a) Completed Oregon Health Authority (Authority) provider enrollment forms with attachments;

(b) A Tribal facility must submit documentation verifying they are a 638 provider:

(A) A letter from IHS, applicable-Area Office or Central Office, indicating that the facility (identified by name and address) is a 638 facility;

(B) A written assurance from the Tribe that the facility (identified by name and site address) is owned or operated by the Tribe or a Tribal organization with funding directly obtained under a 638 contract or compact. A copy of the relevant

provision of the Tribe's current 638 contract or compact must accompany the written assurance;

(c) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, licensed professional counselor or licensed marriage and family therapist is providing mental health services;

(d) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services;

(e) A list of all Prepaid Health Plan (PHP) contracts;

(f) A list of all practitioners contracted with or employed by the IHS or Tribal 638 Facility including names, legacy Division provider numbers, National Provider Identifier (NPI) numbers and associated taxonomy codes; and

(g) A list of all clinics affiliated or owned by the IHS or Tribal 638 Facility including business names, legacy Division provider numbers, National Provider Numbers (NPI) and associated taxonomy codes.

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: ORS 414.065 and 430.010

410-146-0040 – ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes

(1) The Division of Medical Assistance Program (Division) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The appropriate ICD-10-CM code must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-10-CM. The Division considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) The Division requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(a) For dental services, use codes that are in effect for the date the services(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT)

codes in effect for the date the services(s) was provided. These services include, but are not limited to, the following:

(A) Physician services;

(B) Physical and occupational therapy services;

(C) Radiology procedures;

(D) Clinical laboratory tests;

(E) Other medical diagnostic procedures;

(F) Hearing and vision services.

(6) The Division maintains unique coding and claim submission requirements for administrative exams and Death With Dignity services. Refer to OAR 410 division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services for specific requirements.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-146-0060 Prior Authorization

(1) Some covered services or items require prior authorization (PA) by the Division of Medical Assistance Programs (Division) before the service can be provided or before payment will be made. Refer to Oregon Administrative Rule (OAR) 410-120-1320, Authorization of Payment.

(2) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a Prepaid Health Plan (PHP) (refer to OAR 410-120-1140, Verification of Eligibility).

(3) An OHP client who is a Native American or Alaska Native with proof of Indian heritage is exempt from mandatory enrollment in a PHP, and can request disenrollment from a PHP if mandatorily enrolled. An American Indian/Alaska Native Program (AI/AN) OHP client can choose to remain in the Medicaid fee-for-service (FFS) delivery system for physical, dental and/or mental (including alcohol and chemical dependency) health care and receive services from an Indian Health Service facility, tribal health clinic/program or urban clinic. Refer to OAR 410-141-0060 (4)..

(4) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. It is the AI/AN providers' responsibility to contact the PHP prior to providing services to any:

(a) Non-AI/AN OHP client enrolled in a PHP and with whom the AI/AN provider has a contract, to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP. The AI/AN provider needs to contact the client's PHP for specific instructions;

(b) AI/AN OHP client enrolled in a PHP with whom the AI/AN provider does not have a contract, to comply with PA requirements in these rules, the General Rules and applicable Division program rules.

(5) If a client receives services on a FFS basis or is an AI/AN PHP-enrolled client with whom the AI/AN provider does not have a contract and plans to bill the Division directly FFS, a PA may be required from the Division for certain services. An AI/AN provider assumes full financial risk in providing services to a client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules.

(6) If the service or item is subject to PA, the AI/AN provider must follow and comply with PA requirements in these rules, the Division's General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in

the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with the services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 413.042 and 414.065; Stats. Implemented: ORS 414.065

12-1-08 7-1-10 (Hk) 3-1-11 (Hk)

410-146-0075 Client Copayments

(1) Division of Medical Assistance Programs' (Division) American Indian/Alaska Native (AI/AN) Program clients who are members of a Federally recognized Indian Tribe or Tribal Organization and receive Medicaid-covered services rendered through an AI/AN provider or an Urban Tribal Health Clinic are exempt from copayments (refer to OAR 410-120-1230, Client Copayment).

(2) AI/AN providers may not charge copayments to eligible non-AI/AN Division clients receiving care at their facility.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0080 Professional Ambulatory Services

(1) Professional Ambulatory services for American Indian/Alaska Native (AI/AN) providers include medical, diagnostic, screening, dental, vision, physical therapy, occupational therapy, podiatry, mental health, alcohol and chemical dependency, maternity case management, speech, hearing, and home health services.

(2) Providers must use the following guidelines in conjunction with all individual program-specific Division of Medical Assistance Programs' (Division) administrative rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages:

(a) AI/AN Services Program administrative rules (OAR chapter 410, division 146);

(b) General Rules Program (OAR chapter 410, division 120);

(c) OHP Administrative Rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520); and

(d) The Health Services Commission's Prioritized List of Health Services.

(3) IHS and Tribal 638 facilities are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification (see also AI/AN OAR 410-146-0085).

(4) The date of service determines the appropriate version of the AI/AN Services Rules, General Rules, and the HSC Prioritized List that AI/AN providers should use to determine coverage.

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: ORS 414.065

410-146-0085 – Encounter and Recognized Practitioners

(1) The Division of Medical Assistance Programs (Division) will reimburse enrolled American Indian/Alaska Native (AI/AN) providers as follows:

(a) For services, items and supplies that meet the criteria of a valid encounter in sections (5) through (7) of this rule;

(b) Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Division.

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon administrative rule (OAR) 410-147-0120, Encounter and Recognized Practitioners, in the Division's Federally Qualified Health Centers and Rural Health Clinics Program.

(3) AI/AN providers reimbursed according to the IHS rate are subject to the requirements of this rule.

(4) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) and Qualified Medicare Beneficiary (QMB) only clients are not billed according to encounter criteria and not reimbursed at the IHS encounter rate (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System).

(5) For the provision of services defined in Titles XIX and XXI, and provided through an IHS or Tribal 638 facility, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (7) of this rule outlines limitations for telephone contacts that qualify as encounters.

(6) An encounter includes all services, items and supplies provided to a client during the course of an office visit, and "incident-to" services (except as excluded in section (15) of this rule). The following services are inclusive of the visit with the core provider meeting the criteria of a reimbursable valid encounter and are not reimbursed separately:

(a) Drugs or medication treatments provided during the clinic visit, with the exception of contraception supplies and medications as costs for these items are excluded from the IHS encounter rate calculation (refer to OAR 410-146-0200, Pharmacy);

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace); and

(c) Venipuncture for laboratory tests.

(7) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and OAR 410-130-0190, Tobacco Cessation (refer to OAR 410-120-1200). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(8) The following services may be Medicaid-covered services according to an OHP client's benefit package as a stand-alone service; however, when furnished as a stand-alone service, are not reimbursable:

(a) Case management services for coordinating care for a client;

(b) Sign language and oral interpreter services;

(c) Supportive rehabilitation services including, but not limited to, environmental intervention, supported employment, or skills training and activity therapy to promote community integration and job readiness.

(9) AI/AN providers may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment and that require separate enrollment (see OAR 410-146-0021, AI/AN Provider Enrollment). These services include:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (DMEPOS) (e.g. diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS);

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to the Division through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services);

(c) Targeted case management (TCM) services. For specific information, refer to OAR chapter 410, division 138, TCM.

(10) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, see OAR 410-146-0086 for reporting multiple encounters.

(11) For claims that require a procedure and diagnosis code the provider must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure Code Set established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided (refer to OARs 410-120-1280,

Billing and 410-146-0040, ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes).

(12) Services furnished by AI/AN enrolled providers that may meet the criteria of a valid encounter (refer to individual program administrative rules for service limitations.):

(a) Medical (OAR chapter 410, division 130);

(b) Diagnostic: The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Oregon Health Evidence Review Commission's Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-130-0190);

(d) Dental (OAR 410-146-0380 and OAR chapter 410, division 123);

(e) Vision (OAR chapter 410, division 140);

(f) Physical Therapy (OAR chapter 410, division 131);

(g) Occupational Therapy (OAR chapter 410, division 131);

(h) Podiatry (OAR chapter 410, division 130);

(i) Mental Health (refer to the Division of Addiction and Mental Health (AMH) for appropriate OARs);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 410-146-0021). Requires a letter or licensure of approval by AMH (refer to AMH for appropriate OARs);

(k) Maternity Case Management (OAR 410-146-0120);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) The Division considers a home visit for assessment, diagnosis, treatment or maternity case management (MCM) as an encounter. The Division does not consider home visits for MCM as home health services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid and CHIP State Plan Amendments and the Division's administrative rules.

(13) The following practitioners are recognized by the Division:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed physician assistants;

(c) Nurse practitioners;

(d) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon's Board of Nursing OARs;

(e) Nurse midwives;

(f) Dentists;

(g) Dental hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits in Oregon Revised Statute (ORS) 680.200 and the appropriate Oregon Board of Dentistry OARs;

(h) Pharmacists;

(i) Psychiatrists;

(j) Licensed Clinical Social Workers;

(k) Clinical psychologists;

(l) Acupuncturists — refer to OAR chapter 410, division 130 for service coverage and limitations;

(m) Licensed professional counselor;

(n) Licensed marriage and family therapist; and

(o) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(A) Their individual provider's certification or license; or

(B) A clinic's mental health certification or alcohol and other drug program approval or licensure by AMH (see OAR 410-146-0021).

(14) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (including drugs and biologicals) furnished on a part-time or intermittent basis to home-bound AI/AN clients residing on tribal land and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-146-0080).

(15) The Division reimburses the following services fee-for-service outside of the IHS all-inclusive encounter rate and according to the physician fee schedule:

(a) Laboratory and/or radiology services;

(b) Contraception supplies and medications (see OAR 410-146-0200, Pharmacy);

(c) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);

(d) Death with Dignity services (refer to OAR 410-130-0670); and

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).

(16) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140, Verification of Eligibility).

(17) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280, Billing and 410-120-1340, Payment).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-146-0086 Multiple Encounters

(1) An “encounter” is defined in Oregon Administrative Rule (OAR) 410146-0085.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (see OAR 410-146-0085 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (section (3) of this rule, and OAR chapter 410, division 130);

(b) Dental (OAR 410-146-0380 and OAR chapter 410, division 123);

(c) Mental Health - f a client is also seen for a medical office visit and receives a mental health diagnosis, then the client contacts are a single encounter (refer to the Division of Addictions and Mental Health (AMH) for the appropriate OARs);

(d) Addiction, Alcohol and Chemical Dependency - If a client is also seen for a medical office visit and receives an addiction diagnosis, then the client’s contacts are a single encounter (refer to the Division of Addictions and Mental Health (AMH) for the appropriate OARs);

(e) Ophthalmology - fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR chapter 410, division 140);

(f) Maternity Case Management (MCM) (OAR 410-146-0120);

(g) Physical or occupational therapy (PT/OT) - If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR chapter 410, division 131);

(h) Immunizations – if no other medical office visit occurs on the same date of service; and

(i) Tobacco cessation – if no other medical, dental, mental health or addiction service encounter occurs on the same date of service (OAR 410130-0190).

(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit

with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in section (2) of this rule.

(4) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(5) Similar services, even when provided by two different health care practitioners are considered a single encounter, and not multiple encounters. Services that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist; and

(f) Any time a client receives only a partial service with one provider and partial service from another provider.

(6) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service.

(7) Clinics may not “unbundle” services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient’s record.

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: 414.065

410-146-0100 Vaccines for Children

(1) The Vaccines for Children (VFC) Program supplies federally purchased free vaccines for immunizing eligible client's ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC Program, contact the Oregon Health Authority's (Authority) Immunization Program. Refer to the American Indian/Alaska Native (AI/AN) Supplemental Information for instructions and OAR 410-130-0255, Immunizations and Immune Globulins, section (4), VFC Program.

(2) The Division of Medical Assistance Programs (Division) will reimburse for the administration of vaccines to eligible clients according to the AI/AN provider's IHS or cost-based rate.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0120 Maternity Case Management Services

(1) The Division of Medical Assistance Programs (Division) will reimburse American Indian/Alaska Native (AI/AN) providers for maternity case management (MCM) services according to their encounter rate.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill the Division directly per the clinic's encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, and services were furnished to a:

(A) Non-AI/AN client, the provider needs to request the necessary authorizations from the PHP;

(B) AI/AN client enrolled with a PHP with which the AI/AN provider does not have an agreement, the AI/AN provider can bill the Division directly.

(3) Clients records' must clearly document all MCM services provided including all mandatory topics. For specific requirements, refer to the Medical-Surgical Services Program OAR 410-130-0595, Maternity Case Management.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation prior to the day of delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day do not qualify as multiple encounters.

(6) A medical/prenatal visit encounter and an MCM encounter can qualify as two separate encounters when furnished on the same day only when the MCM service is:

(a) The initial evaluation to receive MCM services; or

(b) A nutritional counseling MCM service provided after the initial evaluation visit. See section (7) of this rule for limitations.

(7) MCM Services limitations:

(a) The Division reimburses the initial evaluation one time per pregnancy per provider;

(b) The Division reimburses nutritional counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595 (14); and

(c) The Division will reimburse a maximum of ten MCM services/visits in addition to (a) and (b) above, providing visits/services are furnished in compliance with OAR 410-130-0595.

(8) Case management services must not duplicate services for case management activities or direct services provided under the State Plan or the Oregon Health Plan (OHP), through fee for service, managed care, or other contractual arrangement, that meet the same need for the same client at the same point in time. This includes the Division's Maternity Case Management Program (OAR chapter 410, division 130) and any Targeted Case Management (TCM) Program outlined in OAR chapter 410, division 138.

(9) Community health representatives may be eligible to provide specific MCM services, with the exclusion of the initial assessment (G9001), while working under the supervision of a licensed health care practitioner listed in OAR 410-130-0595 (7) (a). Refer to OAR 410-130-0595(7) (d).

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: 414.065

410-146-0130 Modifiers

(1) The Division of Medical Assistance Programs (Division) uses Health Insurance Portability and Accountability Act (HIPAA) compliant modifiers for many services.

(2) The following services require the use of a modifier for all services for all procedures:

(a) Family planning service -- FP, Refer to OAR 410-130-0585, Family Planning Services;

(b) Vaccine for children -- SL or 26, Refer to OAR 410-130-0255.

(3) When billing for services that are reimbursed outside an American Indian/Alaska Native (AI/AN) Program provider's cost-based or IHS rate, a clinic must use the required modifier(s) listed in the individual program-specific administrative rules.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0160 Administrative Medical Examinations and Reports

(1) The Division of Medical Assistance Programs (Division) does not reimburse administrative medical examinations and reports at an American Indian/Alaska Native (AI/AN) Program provider's IHS encounter rate. Administrative medical examinations and reports are not eligible under the Memorandum of Agreement (MOA). The Division reimburses providers for administrative examinations and reports on a fee-for-service basis outside the IHS or cost-based encounter rate.

(2) AI/AN health care facilities can be reimbursed for administrative medical examinations and reports when requested by a Department of Human Services' branch office, or approved by the Division. The branch office may request an Administrative Medical Examination/Report Authorization (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) Refer to OAR chapter 410, division 150, Administrative Examination and Report Billing Services, for specific requirements. See Administrative Exams Supplemental Information guide for more detailed information on procedure codes and descriptions.

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

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-146-0200 Pharmacy

(1) As defined by the Division of Medical Assistance Programs (Division), a valid encounter excludes pharmaceutical or biologicals not generally provided during a clinic visit (refer to OAR 410-1460085, Encounter and Recognized Practitioners):

(a) Because the Division includes the costs for drugs or medication treatments dispensed by a clinic to treat a client during an office visit in the calculation of the all-inclusive encounter rate for the office visit, providers cannot bill separately for the cost of drugs or medication treatments;

(b) Because pharmacy services are not eligible under the Memorandum of Agreement (MOA) for reimbursement at the IHS or a cost-based encounter rate prescriptions are not included in the calculation of the encounter rate. To bill for filled prescriptions, the AI/AN facility's qualified enrolled pharmacy must bill the Division through the pharmacy program.

(2) AI/AN providers may directly bill the Division only for contraceptive supplies and contraceptive medications outside of the pharmacy program:

(a) For clients enrolled with a Prepaid Health Plan (PHP): AI/AN providers must bill the PHP first. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill the Division fee-for-service at the clinic's acquisition cost (see OAR 410-130-0585, Family Planning Services);

(b) For clients not enrolled with a PHP: AI/AN providers can directly bill the Division fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications (see OAR 410130-0585, Family Planning Services.

(3) Refer to OAR chapter 410, division 121, Pharmaceutical Services Program Rulebook for specific information.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0220 Death With Dignity

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) All Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a prepaid health plan. Death With Dignity services are not part of the Division's American Indian/Alaska Native (AI/AN) Program encounter rate.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0240 Transportation

(1) The Division of Medical Assistance Programs (Division) may reimburse American Indian/Alaska Native (AI/AN) providers for medically appropriate sedan car or wheelchair van transportation services to Oregon Health Plan (OHP) AI/AN clients who receive medical services through an AI/AN provider (refer to the Division's Medical Transportation Program (OAR chapter 410, division 136).

(2) Federal regulations in 42 CFR 431.53 require the State to ensure necessary transportation for Medicaid recipients to and from providers. The AI/AN provider must ensure that:

(a) The service to be provided is the most cost-effective method that meets the medical needs of the client; and

(b) The service to be provided at the point of origin and/or destination is a Division Medicaid-covered service according to a client's Oregon Health Plan (OHP) benefit package.

(c) In addition, AI/AN OHP clients may be transported to the nearest Tribal health facility, and are not restricted to the nearest (non-tribal) facility able to meet the client's medical needs.

(3) For the purpose of this rule the most "cost effective" method is a transportation service that cannot, in the judgment of the Division, be provided through a less expensive alternative while meeting the medical needs of the client. Reimbursement by the Division to an AI/AN Program provider will not exceed the most cost-effective method and is the lesser of:

(a) The providers costs for furnishing transportation services; or

(b) The amount reimbursed by the Division to non-emergency transportation providers under the Division's Medical Transportation Program (OAR chapter 410, division 136).

(4) The Division reimburses transportation services fee-for-service, and outside of the IHS encounter rate, when the AI/AN provider meets the following conditions:

(a) The AI/AN provider owns or leases the sedan car or wheelchair van; and

(b) The individual providing the service is an employee of the AI/AN provider.

(5) AI/AN providers do not need to enroll separately as a transportation provider if they furnish either sedan car or wheelchair van transportation. As used in this rule transportation services by AI/AN providers are defined as follows:

(a) Sedan car transport: Transportation provided by a 4-door sedan or mini-van motor vehicle having a seating capacity of not less than 4 and not more than 7 passengers;

(b) Wheelchair van transport: Transportation provided by a wheelchair lift equipped vehicle for a client who uses a wheelchair. Transportation is generally a "door to door" service. At times, an individual being transported must be picked up inside their residence and taken inside their destination (escort by the driver);

(6) Under the following conditions, an AI/AN provider is required to separately enroll with the Division as a provider of medical transportation services:

(a) The AI/AN provider serves all clients as a whole, and does not limit services to the AI/AN community (e.g. Native American clients);

(b) The AI/AN provider owns and operates a taxi service; or

(c) The AI/AN provider owns and operates an ambulance service.

(7) Non-emergency ambulance, air ambulance, commercial air, bus, or train are not reimbursed under this rule to AI/AN providers and requires advance arrangement and prior authorization (PA) through the local Seniors and People with Disabilities Division (SPD) or Children, Adults and Families (CAF) branch office.

(8) For all claims submitted to the Division, the provider records must contain completed documentation (pertinent to the service provided) that includes but is not limited to:

(a) Trip information including:

(A) Date of service;

(B) If one way, round trip, or three-way and if transportation needs are ongoing;

(C) Physical address of the point of origin, e.g., client address, nursing home name and address, etc.;

(D) Number of actual patient miles traveled; and

(E) Physical address and name of the destination point, e.g., hospital name, doctor name, address, etc.;

(b) Client information including:

(A) Client name;

(B) ID number; and

(C) Medical assistance needs (e.g. for example, requires wheelchair, walker, cane, needs assistance, requires portable oxygen, etc.); and

(c) Justification for extra attendant beyond one if wheelchair van;

(9) All required documentation must be retained in the provider files for the period of time specified in the Division's General Rules (OAR chapter 410, division 120).

(10) Medical transportation services must be billed in the professional claim format using the billing instructions and procedure codes in this rule and in conjunction with the Division's Medical Transportation Program (OAR chapter 147, division 136).

(11) Additional client transport. If two or more Medicaid clients are transported by the same mode (e.g., wheelchair van) at the same time, the Division will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more Division clients are transported by mixed mode (e.g., wheelchair van and ambulatory) at the same time, the Division will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client. Reimbursement will not be made for duplicated miles traveled. If more than one client is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. The first 10 miles is included in the base rate and should be included in the total number of miles on the CMS-1500 (OAR 410-136-0080, Additional Client Transport).

(12) Tribal facility owned/leased sedan car:

(a) S0215 -- Non-emergency transportation; mileage, per mile;

(b) Not eligible for base rate or extra attendant reimbursement;

(13) Tribal facility owned/leased wheelchair car/van. The Division's reimbursement of the first ten miles of a transport is included in the payment for the base rate. A service from point of origin to point of destination (one-way) is considered a "transport."

(14) Tribal facility owned/leased wheelchair van:

(a) If a client is able to transfer from wheelchair to car/van, the Division will not make payment for wheelchair services for transportation of ambulatory (capable of walking) clients (e.g. base rate, extra attendant);

(b) Wheelchair van -- Bill using the following procedure codes:

(A) A0130 -- Non-emergency transportation, wheelchair car/van base rate;

(B) S0209 -- Wheelchair van, ground mileage, per statute mile;

(C) T2001 -- Extra attendant (each).

(15) When billing transportation services use the appropriate place of service (POS) codes and modifiers as listed in the Medical Transportation Services Supplemental Information document to indicate the type of transportation service, and point(s) of origin and destination.

(16) The Division may recoup such payments if, on subsequent review, it is found that the provider did not comply with the Division's administrative rules. Non-compliance includes, but is not limited to, failure to adequately document the service and the need for the service.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0440 Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (Division) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP). American Indian/Alaska Native (AI/AN) Program providers that are not FQHCs, and that elect to receive payment under Title XIX and XXI according to the Indian Health Services (IHS) rate under the Memorandum of Agreement (MOA) effective July 11, 1996 will also be eligible to receive supplemental payments in the same manner as an FQHC under 1902(bb)(5).

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon administrative rule (OAR) 410-147-0460, Prepaid Health Plan Supplemental Payments.

(3) The PHP supplemental payment represents the difference, if any, between the payment received by the AI/AN provider from the PHP for treating the PHP enrollee and the payment to which the AI/AN provider would be entitled if they had billed the Division directly for these encounters according to the clinic's IHS rate (refer to OAR 410146-0020).

(4) In accordance with federal regulations, the provider must take all reasonable measures to ensure that in most instances, with the exception of IHS, Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP (refer to OAR 410120-1140, Verification of Eligibility).

(5) When any other coverage is known to the provider, the provider must bill the other resource prior to billing the PHP. When a provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field (see OAR 410-120-1280, Billing and 410-120-1340, Payment).

(6) Supplemental payment by the Division for encounters submitted by AI/AN providers for purposes of this rule is reduced by any and all payments received by the AI/AN provider from outside resources, including Medicare, private insurance or any other coverage. AI/AN providers are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third party resources (TPR).

(7) The Division shall calculate the PHP supplemental payment in the aggregate of the difference between total payments received by the AI/AN provider, to include payments as listed in section (6) of this rule and the payment to which the AI/AN provider would have been eligible to claim as an encounter if they had billed the Division directly according to the IHS encounter rate.

(8) AI/AN providers must submit their clinic's data using the Managed Care Data Submission Template developed by the Division to report all PHP encounter and payment activity.

(9) To facilitate the Division processing PHP supplemental payments, the AI/AN must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The AI/AN National Provider Identifier (NPI) number and applicable associated taxonomy code registered with the Division for the health center must be used when submitting all claims to the PHPs;

(b) To the Division:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template coversheet;

(C) Payments must be reported at the detail line level on the Managed Care Data Submission Template worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (medical, dental, mental health, or alcohol and chemical dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the IHS or Tribal 638 facility or the total detail lines submitted on the Managed Care Data Submission Template worksheet;

(E) A list of individual practitioners with active Division enrollment including, names, legacy Division provider number and NPI number assigned to practitioners associated with the IHS or Tribal 638 facility. “Associated” refers o a practitioner who is either subcontracted or employed by the AI/AN provider.

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to the Division no later than October 31 of each year.

(10) PHP supplemental payment process:

(a) The Division processes PHP supplemental payments on a quarterly basis. The quarterly settlement includes a final reconciliation for the reported time period.

(b) Upon processing a clinic’s data and the PHP supplemental payment, the Division shall:

(A) Send a check to the AI/AN provider for PHP supplemental payment calculated from clinic data the Division was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by the Division;

(c) The AI/AN provider is responsible for reviewing the data the Division was unable to process for accuracy and completeness. The clinic has 30 days, from the date of the Division’s cover letter under section (9) of this rule, to make any corrections to the data and resubmit to the Division for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by the Division prior to expiration of the 30 days, and must:

(A) Be in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing the Division the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of the Division’s receipt of the re-submitted data, the Division shall:

(A) Review the data and issue a check for all encounters the Division verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The AI/AN provider must submit data to the Division within the timelines provided by the Division.

(11) Clinics must carefully review in a timely fashion the data that the Division was unable to process and returns to the AI/AN provider. If clinics do not bring any incomplete, inaccurate or missing data to the Division's attention within the time frames outlined, Division may not process an adjustment.

(12) The Division encourages AI/AN providers to request PHP supplemental payment in a timely manner.

(13) Clinics must exclude from a clinic's data submission for PHP supplemental payment, services provided to a PHP-enrolled non-AI/AN client denied by the PHP because the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP supplemental payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP supplemental payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to the Division (see OAR 410-146-0060).

(14) If a PHP denies payment to a contracted AI/AN provider for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-146-0085, for the reason that all services, items and supplies are non-covered by the plan, the Division may or may not make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(15) The Division will not reimburse some Medicaid-covered services that are only reimbursed by PHPs, and are not reimbursed by the Division. The Division will not make PHP supplemental payment for these services, as the Division does not reimburse these services when billed directly to the Division.

(16) It is the responsibility of the AI/AN provider to refer PHP-enrolled non-AI/AN clients back to their PHP if the AI/AN provider does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The provider assumes full financial risk in serving a person not confirmed by the Division as eligible on the date of service. See OAR 410-120-1140, Verification of Eligibility. The provider must verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an “open card” or fee-for-service basis.

Stat. Auth.:ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

410-146-0460 Compensation for Outstationed Outreach Workers

(1) The Division of Medical Assistance Programs (Division) may provide reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices.

(2) The Division may provide reasonable compensation to eligible AI/AN providers for outreach activities performed by Outstationed Outreach Workers (OSOW) equal to 100% of direct costs.

(3) American Indian/Alaska Native (AI/AN) Program providers must submit a budget each December 1st to the Division for review of the clinic OSOW costs for approval before any OSOW compensation is made each January 1st.

(4) AI/AN providers must be compliant with OAR 410-120-0045 Applications for Medical Assistance at provider locations, to be eligible for compensation under this rule.

(5) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percent of time spent performing OSOW services and maintain adequate documentation to support the percentage of time claimed. The percent must be used to calculate personnel expenses incurred by an AI/AN provider as outlined in section (7) of this rule and that are directly attributed to outreach activities performed by the employee.

(6) Case management is excluded from OSOW reimbursement. If an OSOW also does case management, calculate the OSOW expense as outlined in section (5) above.

(7) Direct cost expenses allowed for OSOW reimbursement:

(a) Personnel costs for OSOWs:

(A) Salary/wages;

(B) Taxes;

(C) Fringe benefits provided to OSOW;

(D) Premiums paid by the AI/AN Program provider for private health insurance;

(b) Travel expenses incurred by the AI/AN provider for the Division training on OSOW activities;

(c) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(d) Reasonable equipment necessary to perform outreach activities. A Tribal 638 provider reimbursed according to a cost-based rate will not include expenses for replacing equipment if the original cost of the equipment was reported on the cost statement when the clinic's initial cost-based encounter rate was calculated;

(e) Rent or space costs. A Tribal 638 provider reimbursed according to a cost-based rate will not include rent or space costs if 100% of facility costs were reported on the cost statement when the clinic's initial cost-based encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(8) The Division excludes indirect costs relating to OSOW activities to Tribal 638 providers reimbursed according to a cost-based rate. Excluded indirect costs include and are not limited to the following:

(a) Any costs included in the initial calculation of a Tribal 638 clinic's cost-based encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs; and

(d) Operating expenses including utilities, building maintenance and repair, and janitorial services

(9) IHS and Tribal 638 Facilities that have a Medicaid Administrative Match contract that includes outreach costs are not eligible for separate outreach payments. IHS and Tribal 638 facilities cannot participate in the Medicaid Administrative Claiming (MAC) program if they are receiving OSOW compensation according to this rule.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065