Division of Medical Assistance Programs
Policy and Planning Section

Federally Qualified Health Centers and Rural Health Clinics Services Administrative Rulebook

Chapter 410, Division 147

Effective June 27, 2013

Table of Contents

410-147-0000 – Foreword 1
410-147-0020 – Professional Ambulatory Services 2
410-147-0040 – ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes 3
410-147-0060 – Prior Authorization 5
410-147-0080 – Prepaid Health Plans 7
410-147-0085 – Client Copayments 10
410-147-0120 – Encounter and Recognized Practitioners 11
410-147-0125 – OHP Standard Emergency Dental Benefit 17
410-147-0140 – Multiple Encounters 18
410-147-0160 – Modifiers 20
410-147-0180 – Vaccines for Children Program 21
410-147-0200 – Maternity Case Management Services 22
410-147-0260 – Death With Dignity 24
410-147-0280 – Drugs 25
410-147-0320 – Federally Qualified Health Center Rural Health Clinics Enrollment 26
410-147-0340 – Federally Qualified Health Centers and Rural Health Clinics Provider Numbers 31
410-147-0360 – Encounter Rate Determination (T) 33
410-147-0362 – Change in Scope of Services 38
410-147-0365 – Rural Health Clinic Obstetrics Care Delivery Procedures Reimbursement 44
410-147-0380 – Accounting and Record Keeping 45
410-147-0400 – Compensation for Outstationed Outreach Activities 48
410-147-0420 – Re-basing 52
410-147-0440 – Medicare Economic Index 53

410-147-0460 – Prepaid Health Plan Supplemental Payments 54
410-147-0480 – Cost Statement Instructions 59
410-147-0500 – Total Encounters for Cost Reports 64
410-147-0520 – Depreciation 68
410-147-0540 – Related Party Transactions 69
410-147-0560 – Sanctions 71

410-147-0000 – Foreword

(1) The Division of Medical Assistance Programs (Division) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage.

(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.

(3) It is the clinic's responsibility to understand and follow all Division rules that are in effect on the date services are provided.

(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All provider rules can be found on the Division web site.

(5) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other provider rules unless specifically directed in rules contained in the FQHC and RHC rules. The General Rules and the Oregon Health Plan (OHP) administrative rules are intended to be used in conjunction with all program rules including the FQHC and RHC provider rules.

(6) The Health Services Commission's Prioritized List of Health Services is found in the OHP administrative rules (OAR 410-1410520) and defines the services covered under the Division.

(7) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.

(8) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0020 – Professional Ambulatory Services

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: medical, EPSDT, diagnostic, dental, vision, physical therapy, occupational therapy, podiatry, mental health, alcohol and chemical dependency, maternity case management, speech, hearing, and home health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR chapter 410, division 147), General Rules (OAR chapter 410, division 120), OHP administrative rules (OARs 410-141-0480, 410-141-0500, and 410-1410520), and the Health Services Commission's (HSC) Prioritized List of Health Services (List), and the Oregon Health Authority (Authority) general rules related to provider enrollment and claiming (OARs 943-120-0300 through 0380).

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may be reimbursed for covered professional services provided within the scope of the clinic and within the individual practitioner’s scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:

(a) For FQHCs only, services must be provided in accordance with the FQHC’s scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and

(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).

(3) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and HSC List to determine coverage.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0040 – ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The appropriate ICD-9-CM diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(2) 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.

(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-9-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. 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 service(s) was provided that is found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(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 service(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 chapter 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 and 414.065

Stats. Implemented: ORS 414.065

410-147-0060 – Prior Authorization

(1) 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). Client's who are not enrolled in a PHP receive services on an "open card" or "fee-for-service" (FFS) basis.

(2) The provider must verify whether a PHP or the Division of Medical Assistance Programs (Division) is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) If a client is enrolled in a PHP there may be prior authorization (PA) requirements for some services that are provided through the PHP. The Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) must comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP client enrolled in a PHP. The FQHC or RHC needs to contact the client's PHP for specific instructions.

(4) Clients who are enrolled in a PHP may receive family planning services, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without PA from the PHP as provided under the terms of Oregon's Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with a PHP, and the PHP denies payment, the Division shall reimburse for these services per a clinic's encounter rate (see OAR 410-147-0120(12)(b)).

(5) If a client receives services on a FFS basis, the Division may require a PA for certain covered services or items before the service can be provided or before payment will be made. An FQHC or RHC assumes full financial risk in providing services to a FFS client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OARs). See OAR 410120-1320 Authorization of Payment and any applicable program rules.

(6) If the service or item is subject to prior authorization, the FQHC or RHC must follow and comply with PA requirements in these rules, the 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 those services provided; and

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-147-0080 – Prepaid Health Plans

(1) 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). Clinics serving eligible OHP clients who are enrolled in a PHP must secure authorization from the PHP prior to providing PHP-covered services or case management services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or referral from the PHP before providing any services to clients enrolled in a PHP unless the FQHC or RHC have contracted with the PHP to provide PHP-covered services. If an FQHC or RHC has an arrangement or contract with a PHP, the clinic is responsible to follow PHP rules and prior authorization requirements. See OAR chapter 410, division 141 for OHP Program rules and; OAR 410-147-0060, Prior Authorization.

(2) The Division of Medical Assistance Programs (Division) encourages FQHCs and RHCs to contact each PHP in their local service area for the purpose of requesting inclusion in their panel of providers.

(3) PHPs contracting with FQHCs or RHCs, for the provision of providing services to their members, are required by 42 USC 1396b(m)(2)(A)(ix) to provide payment to the FQHC or RHC that is not less than the level and amount of payment which the PHP would make for services furnished by a non-FQHC/RHC provider.

(4) Payment for services provided to PHP-enrolled clients (PHP members) is a matter between the FQHC or RHC and the PHP authorizing the services except as otherwise provided in OAR 410-141-0410, OHP Primary Care Managers. If a PHP denies payment to an FQHC or RHC because arrangements were not made with the PHP prior to providing the service, the Division will not reimburse the FQHC or RHC under the encounter rate, except as outlined in Section (5) of this rule (see OAR 410-141-0120, OHP PHP Provision of Health Care Services).

(5) FQHCs and RHCs can provide family planning services or Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome prevention services to eligible PHP members without authorization or a referral from the PHP. The FQHC and RHC must bill the PHP first. If the PHP will not reimburse for the service, then the clinic may bill the Division. Refer to ORS 414.153, Authorization for payment for certain point of contact services.

(6) PHPs will execute agreements with publicly funded providers, unless cause can be demonstrated to the Division’s satisfaction why such an agreement is not feasible for authorization of payment for point of contact services in the following categories (refer to ORS 414.153):

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(7) PHPs are responsible to ensure the provision of qualified sign language and oral interpreter services for covered medical, mental health or dental care visits, for their enrolled PHP Members with a hearing impairment or who are non-English speaking. Services must be sufficient for the FQHC or RHC provider to be able to understand the PHP Member's complaint; to make a diagnosis; respond to the PHP Member's questions and concerns; and to communicate instructions to the PHP Member. See OAR 410-141-0220(7), Oregon Health Plan Prepaid Health Plan Accessibility.

(8) The provider assumes full financial risk in serving a person not confirmed by the Division as eligible on the date(s) of service. It is the responsibility of the provider to verify a client's eligibility. Refer to OAR 410-120-1140 Verification of Eligibility:

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

(b) Whether an OHP client receives services on a fee-for-service (open card) basis or is enrolled with a PHP; and

(c) Whether the service is covered by a third party resource (TPR), a PHP, or if the Division reimburses on a fee-for-service basis.

(9) The Division requires the following of a FQHC or RHC under contract with a PHP:

(a) Clinic must maintain reimbursement and documentation records that will permit calculation of supplemental payments according to OAR 410-147-0460. According to OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan

Record Keeping, a PHP's participating providers shall maintain a clinical record keeping system with sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the PHP member. See also OAR 410-120-1360, Requirements for Financial, Clinical and Other Records;

(b) Clinics are subject to ongoing performance review by the PHP. According to OAR 410-141-0200, Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System, PHPs must maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division members. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(c) Clinics are subject to program review by the Division, the Authority's Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity and:

(A) Compliance with Oregon Revised Statutes, Oregon Administrative Rules and Federal laws and regulations;

(B) Use of accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation, for calculating PHP supplemental payments and compensation for out-stationed outreach workers;

(C) Adequate records maintenance for cost reimbursed services to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0085 – Client Copayments

(1) The Division of Medical Assistance Programs (Division) Medical Care Identification will indicate which Oregon Health Plan (OHP) clients are responsible for copayments for services.

(2) The Division requires copayments from clients with certain benefit packages. See OAR 410-120-1230, Client Copayment, and Table 120-1230-1 for specific details.

(3) A client may owe more than one copayment during a 24-hour period. The Division may require copayments for each medical, dental, mental health or alcohol and chemical dependency encounter on the same date of service. Refer to OAR 410-147-0140, Multiple Encounters.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-147-0120 – Encounter and Recognized Practitioners

(1) The Division of Medical Assistance Programs (Division) reimburses Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services according to the Prospective Payment System (PPS) as follows:

(a) When the service(s) meet the criteria of a valid encounter as defined in Sections (2) through (4) 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) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, 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 (4) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) An encounter includes all services, items and supplies provided to a client during the course of an office visit (except as excluded in Sections (6) and (12) of this rule) and those services considered "incident-to." These services are inclusive of the visit with the core provider meeting the criteria a valid encounter and reimbursed at the PPS all-inclusive encounter rate. These services include:

(a) Drugs or medication treatments provided during a clinic visit are inclusive of the encounter, with the exception of contraception supplies and medications as costs for these items are excluded from the PPS encounter rate calculation (see OAR 410-147-0280 Drugs and OAR 410-147-0480 Cost Statement (DMAP 3027) Instructions);

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) are inclusive of an office visit;

(c) Laboratory and/or radiology services (even if performed on another day);

(d) Venipuncture for lab tests. The Division does not deem a visit for lab test only to be a clinic encounter;

(4) 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 (see also 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.

(5) Extended care services furnished under a contract between a county Community Mental Health Program (CMHP) of the FQHC and Addictions and Mental Health Division (AMH) are reimbursed outside of the PPS. Extended care services are those services provided under AMH's licensure requirements and reimbursed under AMH's terms and conditions...

(6) Some Division Medicaid-covered services are not reimbursable when furnished according to Oregon Health Plan (OHP) client's benefit package as a stand alone service. Although costs incurred for furnishing these services are inclusive of the PPS all-inclusive rate calculation, visits where these services were furnished as a stand-alone service were excluded from the denominator for the PPS rate calculation (see OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions). The following services when furnished as a stand-alone service are not reimbursable:

(a) Case management services, including case management by a Primary Care Manager (PCM) as defined in OHP administrative rules (OAR 410-141-0700) and previously provided under a PCM contract;

(b) Sign language and oral interpreter services;

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

(7) FQHCs and RHCs may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment, and requires separate enrollment (see OAR 410-147-0320(1) (b) Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) 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 (refer to OAR chapter 410, division 138).

(8) 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 encounter. For exceptions to this rule, see OAR 410-147-0140 for reporting multiple encounters.

(9) Providers are advised to include all services that can appropriately be reported using a procedure code on the claim and bill as instructed in the appropriate Division program rules and must use the appropriate Health Insurance Portability and Accountability Act (HIPAA) procedure code set such as Current Procedural Terminology (CPT), Health Care Common Procedure Coding System (HCPCS), International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), American Dental Association (ADA) Current Dental Terminology (CDT), National Drug Code (NDC), established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual provider rules (refer to OAR 410-120-1280 Billing and see OAR 410-147-0040 ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes).

(10) FQHC and RHC services that may meet the criteria of a valid encounter are (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 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 (see to OAR 410-147-0125, and refer to 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 (see also OAR 410147-0320). Requires a letter or licensure of approval by AMH (refer to AMH for appropriate OARs);

(k) Maternity Case Management (MCM) (OAR 410-147-0200);

(l) Speech (OAR chapter 410, division 129);

(m) Hearing (OAR chapter 410, division 129);

(n) The Division considers a home visit for assessment, diagnosis, treatment or 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; and

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

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

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) 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, ORS 680.200 and the appropriate Oregon Board of Dentistry OARs;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) 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;

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists - Refer to OAR chapter 410, division 130 for service coverage and limitations;

(n) Licensed professional counselor;

(o) Licensed marriage and family therapist; or

(p) 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 the Addictions and Mental Health Division (AMH) (see OAR 410-147-0320).

(12) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies -- Code of Federal Regulations 42 § 405.2417), and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(13) FQHCs and RHCs may furnish services that are reimbursed outside of the PPS all-inclusive encounter rate and according to the physician fee schedule. These services include:

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

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

(c) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients (refer to OARs 410-120-1210, 461-135-1070 and 410-130-0240);

(d) Services provided to Qualified Medicare Beneficiary (QMB) only clients (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). Specific billing information is located in the FQHC and RHC Supplemental Information billing guide; and

(e) Comprehensive environmental lead investigation (refer to OAR 410-1300245, Early and Periodic Screening, Diagnostic and Treatment Program).

(14) OHP benefit packages and delivery system are described in OAR 410-1201210. Most OHP clients have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or "fee-for-service" (FFS) basis.

(a) The Division is responsible for making payment for services provided to open card clients. The provider will bill the Division the clinic's encounter rate for Medicaid-covered services provided to these clients according to their OHP benefit package (see OAR 410-147-0360, Encounter Rate Determination).

(b) A PHP is responsible to provide, arrange and make reimbursement arrangements for covered services for their Division members (refer to OAR 410-120-0250, and OAR chapter 410, division 141, OHP administrative rules governing PHPs). The provider must bill the PHP directly for services provided to an enrolled client (See also OARs 410-147-0080, Prepaid Health Plans, and 410-147-0460, PHP Supplemental Payment). Clinics must not bill the Division for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(A) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(B) Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(15) 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).

(16) 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 410-1201280 Billing and 410-120-1340 Payment).

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065 and 430.010

410-147-0125 – OHP Standard Emergency Dental Benefit

(1) Clients with the Oregon Health Plan (OHP) Standard benefit package have a limited dental benefit. The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Services are limited to the treatment of conditions listed in Oregon Administrative Rule (OAR) 410-123-1670(2).

(2) Hospital dentistry is not a covered benefit for the OHP Standard population, except for clients specified in OAR 410-123-1670(3).

(3) Dental services for the OHP standard population are limited to those procedures listed in the Covered and Non-Covered Dental Services document. Refer to the document in effect for the date the dental service was furnished, found at web site http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html Refer to OAR 410-123-1670(2).

(4) Any limitations or prior authorization requirements for services listed in OARs 410-123-1160 and 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an FQHC or RHC.

Stat. Auth.: ORS 413.042 and 414.065

Other Authority: 42 USC 1396a(bb), Title 42 Public Health of the Code of Federal Regulations

Stats. Implemented: ORS 414.065

410-147-0140 – Multiple Encounters

(1) An encounter is defined in Oregon Administrative Rule (OAR) 410-147-0120.

(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 410-147-0120 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 410-147-0125, and OAR chapter 410, division 123);

(c) Mental Health - If 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 and Alcohol and Chemical Dependency - If a client is also seen for a medical office visit and receives an addiction diagnosis, then the client contacts area single encounter (Refer to AMH's OARs);

(e) Ophthalmologic services - 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 410-147-0200);

(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 (refer to OAR 410-130-0190).

(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 not considered multiple encounters. Situations 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;

(f) Any time a client receives only a partial service with one provider and partial service from another provider, this would be considered a single encounter.

(6) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service. A recipient may obtain medical, dental or other health services from any provider approved by the Division, and/or contracts with the recipient's PHP, if the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) is not the recipient's primary care manager.

(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.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: 414.065

410-147-0160 – Modifiers

(1) The Division of Medical Assistance Programs (Division) uses HIPAA compliant modifiers for many services.

(2) The following conditions require the use of a modifier for all codes:

(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(4)

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in the individual program administrative rules.

(a) Enhanced Care Services (including extended care) – HK, Refer to OAR 410-147-0120;

(b) Assist surgeon for cesarean deliveries for Citizen Alien Waived Emergency Medical (CAWEM) clients – 80, 81, 82 or AS.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065 12-1-08

410-147-0180 – Vaccines for Children Program

(1) The Division of Medical Assistance Programs (Division) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible clients.

(2) The 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 (Authority) Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.

Stat. Auth: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0200 – Maternity Case Management Services

(1) The Division of Medical Assistance Programs (Division) will reimburse federally qualified health centers (FQHCs) and rural health clinics (RHCs) for maternity case management (MCM) services.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to a client enrolled in a 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 Prospective Payment System (PPS) 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, the provider needs to request the necessary authorizations from the PHP.

(3) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management for specific requirements.

(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 the day before 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 service; 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 Maternity Case Management, and any Targeted Case Management (TCM) Programs outlined in OAR chapter 410, division 138.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0260 – 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 claims for Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a managed care plan. Death With Dignity services are not part of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter rate.

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

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0280 – Drugs

(1) As defined by the Division of Medical Assistance Programs (Division), a valid Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter excludes pharmaceutical or biologicals not generally provided during a clinic visit. Refer to OAR 41-147-0120 DMAP Encounter and Recognized Practitioners.

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

(b) Prescriptions are not included in the PPS encounter rate. To bill for filled prescriptions, the FQHC or RHC's qualified enrolled pharmacy must bill the Division using its pharmacy provider number.

(2) Clinics may directly bill the Division using their clinic provider number for contraceptive supplies and contraceptive medications only for:

(a) Clients enrolled in a Prepaid Health Plan (PHP): Clinics 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 also OAR 410-130-0585, Family Planning Services;

(b) Fee-for-service clients: Clinics can directly bill the Division fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications. See also OAR 410-130-0585, 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

410-147-0320 – Federally Qualified Health Center Rural Health Clinics Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (Division) enrollment requirements for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) (Refer also to OAR 410-120-1260 and 943-120-0320, Provider Enrollment).

(a) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act (Public Law 93-638), providers should refer to the program rules for American Indian/Alaska Native (AI/AN) Services, OAR chapter 410, division 146, for enrollment details;

(b) An FQHC or RHC 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; OAR chapter 410, division 122, DMEPOS; and OAR chapter 410, division 138, TCM.

(c) A county Community Mental Health Program (CMHP) furnishing extended care services under contract with the Oregon Health Authority (Authority) Addictions and Mental Health Division (AMH) should refer to AMH for licensure and reimbursement requirements.

(2) To enroll with the Division as an FQHC, a health center must comply with one of the following:

(a) Receive Public Health Service (PHS) grant funds under the authority of Section 330;

(b) Have received FQHC Look-Alike designation from the Centers for Medicare and Medicaid Services (CMS), based on the recommendation of the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC); or

(c) Be an Urban Indian Health Program (UIHP) clinic (under Title V of the Indian Health Care Improvement Act, Public Law 94-437). In the Omnibus Reconciliation Act (OBRA) of 1993, Title V programs were added to the list of specific programs automatically eligible for FQHC designation.

(3) Eligible FQHCs who want to enroll with the Division as an FQHC and receive reimbursement under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed Authority provider enrollment forms with attachments as required in OAR 943-120-0300 through 0320);

(b) National Provider Identifier (NPI) number and associated taxonomy code obtained for the FQHC with the provider enrollment form (refer to OAR 943-120-0320);

(c) Completed Cost Statement (DMAP 3027):

(A) One each for medical, dental and mental health (including addiction, alcohol and chemical dependency) (see also OAR 410147-0360);

(B) One for each FQHC-designated site, unless specifically exempted in writing by the Division to file a consolidated cost report (see also OAR 410-147-0340 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) provider numbers);

(d) Completed copy of the grant proposal submitted to HRSA/BPHC detailing the clinic's service and geographic scope;

(e) Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC;

(f) A copy of the clinic's trial balance (see OAR 410-147-0500, Total Encounters for Cost Reports);

(g) Audited financial statements (refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations");

(h) Depreciation schedules;

(i) Overhead cost allocation schedule;

(j) A copy of the clinic's 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;

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

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

(m) A list including names and NPI numbers of individual practitioners enrolled with the Division and contracted with or employed by the FQHC; and

(n) A list including business names, addresses and facility NPI numbers for all Division-enrolled clinics affiliated or owned by the FQHC including any clinics that do not have FQHC status.

(4) For enrollment with the Division as an RHC, a clinic must:

(a) Be designated by CMS as an RHC.

(b) Maintain Medicare certification and be in compliance with all Medicare requirements for certification.

(5) Eligible RHCs who want to enroll with the Division as an RHC, and be eligible for payment under the Prospective Payment System

(PPS) encounter rate methodology, must submit the following information:

(a) Completed the Authority provider enrollment forms with attachments as required in OAR 943-120-0300 through 0320;

(b) National Provider Identifier (NPI) number and any associated taxonomy codes obtained for the RHC with the provider enrollment form (refer to OAR 943-120-0320);

(c) Copy of Medicare's letter certifying the clinic as an RHC;

(d) Medicare Cost Report for RHC or completed Cost Statement (DMAP 3027) (see OAR 410-147-0360). Complete a cost statement for each RHC-designated site, unless specifically exempted in writing by the Division to file a consolidated cost report (see OAR 410-1470340):

(A) The Division will accept an uncertified Medicare Cost Report;

(B) If the clinic's Medicare Cost Report, provided to the Division, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. The Division shall include these costs when determining the PPS encounter rate;

(C) An RHC may submit the Cost Statement (DMAP 3027) as a substitute to the Medicare Cost Report.

(e) A copy of the clinic's trial balance (see OAR 410-147-0500, Total Encounters for Cost Reports only if completing Cost Statement DMAP 3027);

(f) Audited financial statements (refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" if completing Cost Statement DMAP 3027);

(g) Depreciation schedules (only if completing Cost Statement DMAP 3027);

(h) Overhead cost allocation schedules (only if completing Cost Statement DMAP 3027);

(i) A copy of the clinic's 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;

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

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

(l) A list including names and NPI numbers of individual practitioners enrolled with the Division and contracted with or employed by the RHC; and

(m) A list including business names, addresses and facility NPI numbers for all Division-enrolled clinics affiliated or owned by the RHC including any clinics that do not have RHC status.

(6) The FQHC/RHC Program Manager, upon receipt of the required items as listed in section (3) of this rule for FQHCs and section (5) of this rule for RHCs, shall review all documents for compliance with program rules, completeness and accuracy.

(7) The Division prohibits an established, enrolled FQHC or RHC that adds or opens a new clinic site from submitting claims for services rendered at the new site under their FQHC or RHC Division enrollment, and according to the PPS encounter rate, prior to the Division's acknowledgment. An FQHC or RHC is required to immediately submit to the attention of the FQHC/RHC Program Manager, Division:

(a) For FQHCs only, a copy of the recent HRSA Notice of Grant Award including the new site under the main FQHC's scope;

(b) For RHCs only, a copy of Medicare's letter certifying the new clinic as an RHC;

(c) A recent list of all PHP contracts; and

(d) A recent list of names and NPI numbers for all individual practitioners enrolled with the Division and contracted with or employed by the new FQHC or RHC site.

(8) If an established and enrolled RHC or FQHC changes ownership, the new owner must submit:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated; or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership (see OAR 410-147-0360);

(b) Notice of a change in tax identification number;

(c) A recent list of all PHP contracts;

(d) A recent list of names and NPI numbers for all individual practitioners enrolled with the Division and contracted with or employed by the FQHC or RHC; and

(e) A recent list including business names, addresses, NPI numbers and associated taxonomy codes for all Division-enrolled clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status.

(9) FQHCs that are involved with a sub-recipient must provide documentation. Sub-recipient contracts with an FQHC must enroll as an FQHC and submit the same required documentation as outlined under the enrollment sections of this rule.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065 and 430.010

410-147-0340 – Federally Qualified Health Centers and Rural Health Clinics Provider Numbers

(1) Pursuant to National Provider Identifier (NPI) requirements in 45 CFR Part 162 providers must use a NPI, and in specific situations associated taxonomy code(s), when billing the Division of Medical Assistance Programs (Division).

(2) A Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) shall register the NPI number and associated taxonomy code, obtained for the FQHC or RHC at the time of enrollment. Multiple sites are not separately enrolled, unless each site has a different tax identification number.

(3) The Division may grant an exception to section (2) of this rule upon written request to the Division of Medical Assistance Programs – Attn: FQHC/RHC Program Manager. The request must include a detailed explanation describing the:

(a) Need for separate enrollment of an additional site; and

(b) Mechanisms in place to assure no duplication of billings.

(4) If the Division finds evidence of duplicate or inappropriate billing resulting from provider misuse under multiple enrollments, the Division may terminate the exception upon written notice to the clinic.

(5) If the Division grants an exception to section (2) of this rule, the Division shall separately enroll each clinic site. When granted multiple provider enrollments, clinics must register:

(a) A separate NPI number for each clinic; or

(b) One NPI number and separate taxonomy codes for each clinic.

(6) If an FQHC or RHC has several clinic sites and one or more of the clinics are not designated as an FQHC or RHC, the non-FQHC or non-RHC (each individual clinic) must:

(a) Enroll as a billing provider; and

(b) Each practitioner must individually enroll.

(7) Upon enrollment and each October thereafter, FQHCs and RHCs must submit to the Division:

(a) A list including names and NPI numbers of individual practitioners associated with the FQHC/RHC; and

(b) A list including business names, addresses and facility NPI numbers for all Division-enrolled clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status

(8) An FQHC or RHC that operates a retail pharmacy, provides durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS), must enroll separately as a pharmacy and/or DMEPOS provider. Refer to OAR chapter 410, division 121, Pharmaceutical and OAR chapter 410, division 122, DMEPOS; for specific information. These services are not billed under FQHC or RHC enrollment.

(9) The Division shall coincide registration of a clinic's NPI number and associated taxonomy codes if applicable, effective the date of enrollment with the Division as an FQHC or RHC, and after the encounter rate is established.

(10) Prepaid Health Plans (PHP) are required to report all PHP encounters using the FQHC/RHC's NPI and associated taxonomy code, if required, and not individual practitioner NPI numbers and taxonomy codes.

Stat. Auth.: ORS 413.042 and 414.065

Stat. Implemented: ORS 414.065

410-147-0360 – Encounter Rate Determination (T)

(1) The Division of Medical Assistance Programs (Division) will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:

(a) DMAP will enroll a clinic as an FQHC or RHC effective the date DMAP determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with the Division and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled providers can submit claims to the Division for providing specific care, item(s), or service(s) to Division clients. A clinic or individual provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with DMAP, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical, Dental and Mental Health (including Addiction, Alcohol and Chemical Dependency) Services.

(a) Effective October 1, 2004, for FQHCs only, the Division will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with the Division:

(i) Medical;

(ii) Dental; and

(iii) Mental Health, to include addiction, alcohol and chemical dependency services.

(b) FQHCs enrolled with the Division prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate calculated if the clinic adds a service category listed in either Section (2)(a)(ii) or (iii) of this rule. Refer also to Section (16) of this rule.

(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.

(a) The Division will accept an uncertified Medicare Cost Report;

(b) If the clinic's Medicare Cost Report, provided to the Division, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. The Division will include these costs when determining the PPS encounter rate.

(c) The Division will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;

(d) An RHC can submit the Division cost statement form 3027 as a substitute to the Medicare Cost Report.

(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by the Division. If exempted from this requirement by the Division, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding separate enrollment for multiple sites.

(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.

(6) FQHCs and RHCs cannot include costs associated with non-covered Medicaid services. The Division does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.

(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid covered services provided at clinic sites serving Division clients when completing the Cost Statement (DMAP 3027). For RHCs only, the Medicare Cost Report can only include financial documents for Medicaid-covered services provided at clinic sites that see Division clients. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve Division clients in the Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs.

(8) At any time, if the Division determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, the Division may:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate(s); and

(b) Impose sanctions as defined in OARs 410-120-1400 Provider Sanctions, 410-120-1460 Type and Conditions of Sanctions; and 407-120-360 Consequences of Non-Compliance and Provider Sanctions.

(9) Effective January 1, 2001, DMAP determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid covered services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.

(10) Clinics existing in 1999 and 2000, and enrolled with the Division as a FQHC or RHC as of January 1, 2001, receive payment from the Division for services rendered to

Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.

(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from the Division for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC. Coinciding with enrollment as an FQHC or RHC with the Division, a clinic will have a PPS encounter rate:

(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or

(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.

(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).

(13) For established, enrolled clinics with a change of ownership, the new owner can submit:

(a) A Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by the Division to determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic’s tax identification number;

(c) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.

(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to the Division for review.

(15) The Division may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health (including addiction, and alcohol and chemical dependency) services.

A separate PPS encounter rate will be calculated by the Division for the added service element if:

(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;

(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;

(c) The FQHC is certified by the Addictions and Mental Health Division (AMH) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by Addictions and Mental Health Division (AMH) former Office of Mental Health and Addictions Services (OMHAS) to provide addiction, and alcohol and chemical dependency services;

(i) Certification by AMH of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements

(iii) A letter of licensure or approval by AMH is required for FQHCs providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(16) If an FQHC meets the criteria as outlined in Section (15) of this rule for the addition of Dental or Mental Health (including addiction, and alcohol and chemical dependency) services, after the initial encounter rate determination, the Division will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

(17) When an FQHC shares the same space for multiple services, then the Division will use square footage to determine the percent of the indirect cost associated with each encounter rate.

(18) A clinic may be exempt from this requirement if an FQHC has minimal utilization for a particular service such as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to the Division FQHC Program Manager for consideration.

(19) Alternate Payment Methodology (APM): After one calendar year of payment at the PPS rate, clinics may request a transfer to an Alternate Payment Methodology (APM).

(a) APM converts the clinics current PPS rate into an equivalent per member per month rate using the clinic's historical patient utilization and the clinic's PPS cost base rate.

The purpose of APM is to reimburse clinics an amount no less than what the clinic would have received if paid with PPS. The Division shall process quarterly reconciliations and if the APM issued is less than what the clinic would have received if paid using PPS, the Division shall reimburse the clinic the difference.

(c) The Division shall have a memorandum of understanding to establish an effective date with each participating clinic.

(d) A clinic may request to return to its PPS rate by submitting written request to the Division. The Division shall return the clinic to their PPS rate within 30 business days after a clinics request has been received.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-147-0362 – Change in Scope of Services

(1) As required by 42 USC § 1396a(bb)(3)(B), the Division of Medical Assistance Programs (Division) must adjust Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payment System (PPS) encounter rates based on any increase or decrease in the scope of FQHC or RHC services, as defined by 42 USC §§ 1396d(a)(2)(B-C).

(2) The Centers for Medicare and Medicaid Services (CMS) defines a “change in scope of services” as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS’ broad definition of change in scope of services allows the Division the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the elements “type,” “intensity,” “duration,” and “amount” and procedures for implementing these adjustments. This rule defines the Division’s policy for implementing FQHC and RHC PPS rate adjustments based on a change in scope of services.

(3) A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC §§ 1396d(a)(2)(B-C).

(4) A change in the cost of a service is not considered in and of itself a change in the scope of services. An FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers’ services.

(5) The following examples are offered as guidance to FQHCs and RHCs to facilitate understanding the types of changes that may be recognized as part of the definition of a change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

(a) A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples of eligible changes in scope of services include, but are not limited to:

(A) Changes within medical, dental or mental health (including addiction, alcohol and chemical dependency services) service areas (e.g. vision, physical/occupation therapy, internal medicine, oral surgery, podiatry, obstetrics, acupuncture, or chiropractic);

(B) Services that do not require a face-to-face visit with an FQHC or RHC provider will be recognized (e.g. laboratory, radiology, case management, supportive rehabilitative services, and enabling services.)

(b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of services does not constitute an eligible change. Examples of eligible changes include but are not limited to:

(A) A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center;

(B) The addition or removal of specialty providers (e.g., pediatric, geriatric or obstetric specialists) with a corresponding change in scope of services provided by the health center (e.g. delivery services);

(i) If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services;

(ii) If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services;

(c) A change in service intensity or service delivery model attributable to a change in the types of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the health center;

(d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services. (e.g. the addition of a radiology department);

(e) A change in applicable technologies or medical practices:

(A) Maintaining electronic medical records (EMR);

(B) Updating or replacing obsolete diagnostic equipment (which may also necessitate personnel changes); or

(C) Updating practice management systems;

(f) A change in overall health center costs due to changes in state or federal regulatory or statutory requirements. Examples include but are not limited to:

(A) Changes in laws or regulations affecting health center malpractice insurance;

(B) Changes in laws or regulations affecting building safety requirements; or

(C) Changes in laws or regulations relating to patient privacy.

(6) The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as described in sections (3) - (5):

(a) A change in office hours;

(b) Adding staff for the same service-mix already provided;

(c) Adding a new site for the same service-mix provided;

(d) A change in office location or office space; or

(e) A change in the number of patients served.

(7) Threshold change in cost per visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over the course of several years (e.g. health centers would use the cost report for the year in which all changes were implemented and the 5% cost/visit was met, as described in sections (13) and (14) of this rule). A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a health center, as defined in sections (3) - (5) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

(8) If a FQHC or RHC has experienced an increase or decrease in the health center's scope of services, as described in sections (3)-(5) of this rule and that meets the threshold requirement of section (7) of this rule, the FQHC or RHC must submit to the Division a written application as outlined below. The Division may also initiate a review of whether a change in scope of services has occurred at a health center:

(a) A written narrative describing the specific changes in health center services, and how these changes relate to a change in the health center's overall picture of services;

(b) An estimate of billable Medicaid encounters for the forthcoming 12-month period so the financial impact to the Division can be accounted for;

(c) A cost statement. All costs and expenses reported must be in agreement with the principles of reasonable cost reimbursement as found at 42 CFR 413, Centers for Medicare and Medicaid Services Publication 15-1 (Provider Reimbursement Manual), and any other regulations mandated by the Federal government. Any situations not covered will be based on Generally Accepted Accounting Principals (GAAP). See Change in Scope Cost Report Instructions;

(d) Certification by the Addiction and Mental Health Division (AMH) of a health center's outpatient mental health program is required if mental health services are provided by

non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements; and

(e) A letter of licensure or approval by AMH is required for health centers providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3)(j) and (5)(i); and

(f) The clinic is responsible for providing complete and accurate copies of the above documentation. Health centers may submit a maximum of one change in scope application per year.

(9) Upon receipt of a health center's written change in scope of services request, the FQHC/RHC Program manager will:

(a) Review all documents for completeness, accuracy and compliance with program rules. An incomplete application will result in a delay in the Division's review until the complete application is received; and

(b) Respond to the health center with a decision within 90 days of receipt of a complete application.

(10) Providers may appeal this decision in accordance with the provider appeal rules set forth in OAR 410-120-1560.

(11) Approved change in scope of service requests will result in PPS rate adjustments:

(a) A separate mental health or dental PPS encounter rate will be calculated if a FQHC or RHC adds dental or mental health (including addiction, and alcohol and chemical dependency) services, and costs associated with these service categories were not included in the original cost statements used to determine the baseline PPS encounter rate;

(b) If costs associated with dental or mental health services were included in the original cost statements, whether negligible or significant, health centers have the option of having an adjusted single encounter rate, or requesting a separate dental or mental health rate.

(12) The new rate will be effective beginning the first day of the quarter immediately following the date the Division approves the change in scope of services adjustment (e.g. January, April, July, or October 1):

(a) The Division will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;

(b) It is a health center's responsibility to request a timely change in scope of service rate adjustment.

(13) For changes occurring on or after October 1, 2008, the effective date of this policy, FQHCs and RHCs are required to:

(a) For anticipated changes, health centers should submit prospective costs for the Division to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by the Division. Health centers may later request a subsequent rate adjustment based on actual costs;

(b) For gradual or unanticipated changes, health centers must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met, or beginning in the calendar year of the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met. For example, a health center implements a change in scope of services in 2008, but the additional costs incurred do not meet the 5% threshold criteria. In 2009 the health center implements additional scope of service changes. Additional costs incurred in 2009 together with the costs incurred for 2008 meet the 5% threshold. The health center would report costs for 2009;

(c) Health centers may submit both actual costs (for prior changes) as well as projected costs (for anticipated changes). Prior to submitting both actual and projected costs, health centers should work with the Division's FQHC/RHC Program manager to confirm the appropriate time periods of costs to submit.

(14) For changes that occurred prior to the effective date of this policy, October 1, 2008, FQHCs and RHCs are required to:

(a) Submit cost reports for either:

(A) The first year of actual costs beginning the date on which a change in the cost per visit threshold is met; or

(B) The calendar year or the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met;

(b) For changes that occurred over multiple and overlapping time periods, FQHC/RHCs will submit actual costs for the time period beginning when all changes were in effect. For example, if changes occurred in 2003 and 2004, health centers would submit their 2004 cost report that would include costs for changes implemented in both 2003 and 2004;

(c) Rate adjustments calculated using costs from prior fiscal years will be adjusted by the Medicare Economic Index (MEI) to present.

(15) FQHC and RHCs clinics that choose to participate in the Patient Centered Primary Care Home (PCPCH) Program must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through OAR 409-055-0080 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. Providers who choose to participate and meet all related requirements shall receive a separate payment per the PMPM payment established by OAR 410-141-0860;

(b)If a provider has a PPS rate that includes costs for operating a medical home or health home but would like to participate as a PCPCH, then they must submit a change in scope for a change in service delivery method.

(c) Becoming a PCPCH does not qualify as a change in scope.

Stat. Auth.: ORS 413.042 and 414.065 and 413.032

Other Authority: None

Stats. Implemented: ORS 414.065 and 413.032

410-147-0365 – Rural Health Clinic Obstetrics Care Delivery Procedures Reimbursement

Reimbursement for obstetric delivery procedures by the Division of Medical Assistance Programs (Division) to eligible Medicare-certified Independent Rural Health Clinics will be according to the physician fee schedule and outside of the Prospective Payment System (PPS).

Statutory Authority: ORS 413.042 and 414.065

Statutes Implemented: ORS 414.065

410-147-0380 – Accounting and Record Keeping

(1) General requirements:

(a) The following rules and regulations apply to clinics reimbursed under the Federally Qualified Health Center (FQHC) and Rural Health Clinic Program;

(b) In cases of conflict between the rules contained in section (2) and

(3) of this rule, section (2) will prevail over section (3);

(c) FQHCs and RHCs must use the cost principles contained in Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. Use the circular appropriate to your clinic;

(d) Must adhere to acceptable accounting standards.

(2) Rules and regulations:

(a) FQHC and RHC administrative rules;

(b) The Division of Medical Assistance Programs (Division) General Rules;

(c) Oregon Health Plan (OHP) administrative rules;

(d) All other applicable Division provider rules.

(3) Cost Principles for State and Local Governments, OMB Circular A-87 and A-122.

(4) Each FQHC and RHC shall:

(a) Maintain internal control over and accountability for all funds, property and other assets;

(b) Maintain complete client documentation;

(c) Adequately safeguard from duplicate billings or other routine billing errors;

(d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;

(e) Prepare Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs in conformance with:

(A) Generally accepted accounting principles;

(B) The provisions of the FQHC and RHC administrative rules; and

(C) All other applicable rules listed in sections (2) and (3).

(f) Maintain for a period of not less than five years from the end of the fiscal the year:

(A) Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs;

(B) Cost Statement Worksheet (DMAP 3032);

(C) A copy of the clinic's trial balance;

(D) Audited financial statements;

(E) Depreciation schedules;

(F) Overhead cost allocation schedules; and

(G) Financial and clinical records for the period covered by the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs.

(g) Maintain adequate records to thoroughly explain how the amounts reported on the Cost Statement (DMAP 3027) were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;

(h) Adequately document expenses reported as allowable costs in the records of the clinic or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee stating the purpose of the trip or activity, the dates, name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over $25;

(i) Prepare special work papers or reports to support or explain data reported on the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs for current or previous periods at the Division’s request. These work papers/reports must be completed within 30 days of the Division’s request. An extension of up to 30 days may be granted if the request is made before the end of the original 30 day period. Extensions must be requested in writing;

(j) Ensure that the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs is reconcilable to the audited financial records and encounters must be reconcilable to the Uniform Data Set (UDS) form or other reasonable data the Division may request. If the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs cannot be reconciled, the UDS numbers will be used or other appropriate data sets as determined by the Division;

(k) Do not submit financial documentation to the Division for FQHC or RHC sites that:

(A) Are not designated as an FQHC or RHC, and/or;

(B) Do not serve Medical Assistance Program clients.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0400 – Compensation for Outstationed Outreach Activities

(1) This rule provides 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) A federally qualified health center (FQHC) eligible in accordance with OAR 410-120-0045, will be eligible for compensation under this rule.

(3) ‘‘Initial processing’’ includes the following activities:

(a) Taking applications;

(b) Assisting applicants in completing the application;

(c) Providing information as outlined in OAR 410-120-0045;

(d) Obtaining required documentation to complete processing of the application;

(e) Ensuring that the information contained on the application form is complete; and

(f) Conducting any necessary interviews.

(4) “Initial processing” does not include evaluating the information contained on the application and the supporting documentation or making a determination of eligibility or ineligibility.

(5) At locations that are infrequently used by the designated low-income eligibility groups, the Division may use the following resources:

(a) Volunteers, provider or contractor employees; or

(b) Its own eligibility staff, or

(c) Telephone assistance by:

(A) The FQHC as outlined in section (12); or

(B) Prominently displaying a notice that includes the telephone number for the state OHP Application Center or the local branch office that applicants may call for assistance.

(6) Eligible FQHCs may be able to receive reasonable compensation for outreach activities performed by Outstationed Outreach Workers (OSOW) that is equal to 100% of direct costs.

(7) Allowable direct cost expenses for OSOW reimbursement include:

(a) Travel expenses incurred by the FQHC for Division training on OSOW activities;

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

(c) OSOW personnel costs:

(A) Wages shall be the lesser of:

(i) Wages reported by the FQHC; or

(ii) Wages paid by the State of Oregon to an employee of the state providing enrollment assistance to individuals applying for OHP;

(iii) Wage reimbursement may not exceed the highest salary issued by the State of Oregon to a Human Services Specialist 2;

(B) Taxes;

(C) Fringe benefits provided to OSOW;

(D) Premiums paid by the FQHC for private health insurance.

(d) Reasonable costs for equipment necessary to perform outreach activities, which does include expenses for replacing equipment if the original equipment cost was reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(e) Rent or space costs only if 100% of facility costs were not reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

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

(g) Postage.

(8) The Division may not include indirect costs in the OSOW reimbursement rate. Indirect costs include but are not limited to the following:

(a) Any costs included in the initial calculation of a clinic's PPS encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs;

(d) Supervision costs; and

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

(9) Clinics must submit to the Division a cost statement for the preceding calendar year between October 1, and October 31, of each year for Division review and approval of the clinic's OSOW direct costs.

(10) If a clinic fails to submit the OSOW cost statement by October 31 of the required year, the clinic may not be eligible for reimbursement of OSOW costs as of January 1 for the following year.

(11) Any change to the OSOW rate, based on the October cost statement submission, shall be effective January 1 of the following year; The Division shall make payment to the clinic for the reviewed and accepted OSOW costs in four equal installments at the beginning of each calendar quarter; January 1, April 1, July 1, and October 1.

(12) Clinic locations with limited operating hours, or that limit access to the general public during their regular operating hours must calculate the actual time an OSOW meets face-to-face with the general public for receipt and the initial processing of applications. For example, if a clinic employs an OSOW at a satellite school-based health center (SBHC), and the SBHC can only be accessed by the general public outside of the school's normal hours of operation, use the percent of time an OSOW is available to meet face-to-face with potential applicants when reporting compensation as outlined in section (11)(c) of this rule.

(a) Clinics must display a notice in a prominent place that advises potential applicants when an OSOW will be available;

(b) The notice must include a telephone number that applicants may call for assistance.

(13) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percentage of time spent performing OSOW activities and maintain adequate documentation to support the time claimed. The percentage must be used to calculate personnel expenses incurred by an FQHC that are directly attributed to outreach activities performed by the employee. Outreach activities:

(a) May include assisting individuals with completing applications for other Department of Human Services (Department) and Authority-administered programs where eligibility is determined by staff at local branch offices;

(b) Does not include assisting individuals with applying for non-Department and non-Authority-administered programs.

(14) A clinic shall not claim reimbursement for costs associated with personnel positions where 100% of costs were included in the FQHC's PPS encounter rate calculation.

(15) A Public Health Department designated as an FQHC or a School Based Health Center (SBHC) within the scope of an FQHC designation cannot participate in the Medicaid Administrative Claiming (MAC) program.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

DMAP 35-2013, f. & cert. ef. 6-27-13

410-147-0420 – Re-basing

(1) Determination of encounter rates effective January 1, 2001 as directed by the Balanced Budget Act (BBA) of 1997 and the Budget Refinement Act of 1999 Prospective Payment System (PPS) was changed for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) clinics. PPS eliminates annual cost reports and retrospective settlements except for managed care organization (MCO) supplemental payments.

(2) As directed by the BBA and PPS, the federal government will notify states when clinics can re-base clinic rates. No specific date has been determined by the federal government at this time.

Stat. Auth.: ORS 413.432 and 414.065

Other Authority: 42 USC 1396a(bb), Title 42 Public Health of the Code of Federal Regulations

Stat. Implemented: ORS 414.065

410-147-0440 – Medicare Economic Index

Effective January 1, 2001, as directed by the Balanced Budget Act of 1997, the Budget Refinement Act of 1999 Prospective Payment System (PPS), BIPA all-encounter rates must be adjusted annually by the Medicare Economic Index (MEI) for the current year. The encounter rate will be adjusted by the MEI effective January 1st of the current year.

Stat. Auth.: ORS 413.042 and 414.065

Other Authority: 42 USC 1396a(bb), Title 42 Public Health of the Code of Federal Regulations

Stat. Implemented: ORS 414.065

410-147-0460 – 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).

(2) The PHP supplemental payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP(s) for treating the PHP enrollee and the payment to which the FQHC/RHC would be entitled if they had billed the Division directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.

(3) In accordance with federal regulations the provider must take all reasonable measures to ensure that in most instances 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 410-147-0120(14).

(4) When any other coverage is known to the provider, the provider must bill the other resource(s) 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 also OAR 410-1201280 Billing and OAR 410-120-1340 Payment.

(5) Supplemental payment by the Division for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs 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 resource(s) (TPR).

(6) The Division will calculate the PHP supplemental payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed the Division directly per their PPS encounter rate.

(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with dates of service January 1, 2006 and after, using the Managed Care Data Submission Template developed by the Division to report all PHP encounter and payment activity.

(8) To facilitate the Division processing PHP supplemental payments, the FQHC or RHC 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 National Provider Identifier (NPI) number and associated taxonomy code, registered by the FQHC or RHC clinic with the Division 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 are to 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 FQHC or RHC or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) All individual NPI numbers and taxonomy codes assigned to practitioners associated with the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain individual active enrollment with the Division in limited situations. Refer to OAR 410147-0340(3).

(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.

(9) PHP supplemental payment process:

(a) The Division will process PHP supplemental payments on a quarterly basis:

(A) Quarterly processing of PHP supplemental payments includes a final reconciliation for the reported time period;

(B) For an FQHC or RHC approved by the Division to participate in a pilot project, PHP supplemental payments will be processed at the discretion of the Division in collaboration with health centers;

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

(A) Send a check to the clinic 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 FQHC or RHC 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)(b) 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 requested 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 will:

(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 FQHC or RHC should submit data to the Division within the timelines provided by the Division.

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

(11) The Division encourages FQHCs and RHCs to request PHP supplemental payment in a timely manner.

(12) Clinics must exclude from a clinic's data submission for PHP supplemental payment, clinic services provided to a PHP-enrolled client when the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (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 also OAR 410-147-0060).

(13) If a PHP denies payment to an FQHC or RHC 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 410-1470120, for the reason that all services, items and supplies are non-covered by the plan, the Division is not required to 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.

(14) If an FQHC or RHC has been denied payment by a PHP because the clinic does not have a contract or agreement with the PHP, the Division is not required to make a supplemental payment to the clinic. The Division is only required to make a PHP supplement payment when the FQHC or RHC has a contract with a 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 FQHC or RHC to refer PHP-enrolled clients back to their PHP if the FQHC or RHC 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(s) of service. See OAR 410-120-1140. It is the responsibility of the provider to 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

Stat. Implemented: ORS 414.065

410-147-0480 – Cost Statement Instructions

(1) The Division of Medical Assistance Programs (Division) requires federally qualified health centers (FQHC) to submit Cost Statements (DMAP 3027).

(2) Rural health clinics (RHCs) can choose to submit either their Medicare Cost Report or the Cost Statement (DMAP 3027). If the RHC files a Medicare Cost Report, the Division may request additional information.

(3) The Division reimburses some services, items and supplies fee-for-service, outside of a FQHC or RHC's Prospective Payment System (PPS) encounter rate. For this reason, clinics must exclude the costs for the following items from the cost statement:

(a) Contraceptive supplies and contraceptive medications (see OAR 410-147-0280);

(b) Pharmacy. Requires separate enrollment, refer to OAR chapter 410, division 121, Pharmaceutical Services Program Rulebook for specific information;

(c) Durable medical equipment and supplies. Requires separate enrollment, refer to OAR chapter 410, division 122, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS);

(d) Targeted case management (TCM) services. Requires separate enrollment, see OAR 410-147-0610, and refer to OAR chapter 410, division 138, Targeted Case Management for specific information; and.

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

(4) Payment for services provided by FQHCs and RHCs is in accordance with 42 USC 1396a (bb). In general, a Prospective Payment System (PPS) encounter rate is calculated on a per visit basis that is equal to the average of reasonable and allowable costs incurred by a clinic for furnishing services included in the State Plan under Title XIX and XXI of the Social Security Act. The rate is calculated by dividing the total costs incurred by an FQHC or RHC for furnishing services by the total number of clinic encounters as defined in OAR 410-147-0500. A clinic must submit a Cost Statement (DMAP 3027) to the Division:

(a) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinic services (see OAR 410-1470360);

(b) For new clinics (see OAR 410-147-0360); or

(c) If there is a change of ownership, the new owner can submit the Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of

ownership to have a new PPS encounter rate calculated (see also OAR 410-147-0320 (8).

(5) The Cost Statement (DMAP 3027) must include all documents required by OAR 410-147-0320.

(6) Each section must be completed if applicable.

(7) Page 1 -- Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, legacy Division provider number, current National Provider Identifier (NPI) numbers and associated taxonomy code(s); the name of the persons or organizations having legal ownership of the FQHC or RHC; and all provider and health care practitioners as defined on the DMAP 3027 Cost Statement.

(b) The Cost Statement (DMAP 3027) must be prepared, signed and dated by both the FQHC or RHC accountant and an authorized responsible officer.

(8) Page 2 -- Part A -- FQHC or RHC Practitioner Staff and Visits:

(a) Full Time Equivalent (FTE) Personnel: List the total number of staff by position;

(b) Encounters: List the number of on-site and off-site encounters by staff (see OAR 410-147-0500, Total Encounters for Cost Reports). Exclude the following types of encounters from your total encounters:

(A) Out-stationed outreach workers;

(B) Administration; and

(C) Support staff, or any staff members who do not meet the criteria of OAR 410-147-0120(6) or the qualification or certification requirements under a clinic’s mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH) (see OAR 410-147-0320).

(9) Pages 3-4 -- Reclassification and adjustment of trial balance of expenses:

(a) Record the expenses for covered health care costs, nonreimbursable program costs, allowable overhead costs, and nonreimbursable overhead costs:

(A) Covered health care (program) costs include all necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Whether the Division allows the costs is subject to the regulations prescribing the

treatment of specific items under the Medicaid program (see OAR 410-147-0020 Professional Services).Covered health care (program) and direct health care costs include but are not limited to:

(i) Personnel costs, including Medical record and medical receptionist costs;

(ii) Administrative costs;

(iii) Employee pension plan costs;

(iv) Normal standby costs;

(v) Medical practitioner salaries; and

(vi) Malpractice insurance costs;

(B) Non-reimbursable program costs are costs that are not related to patient care and which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs that are not necessary include costs that usually are not common or accepted occurrences in the field of the provider's activity. Non-reimbursable program costs include, but are not limited to:

(i) Women, Infants and Children (WIC);

(ii) Community services/housing projects (refer to OAR 410-1201200);

(iii) Environmental external maintenance costs (e.g. landscaping, pesticide application);

(iv) Research;

(v) Public education; and

(vi) Outside services;

(C) Allowable overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs:

(i) Administrative costs;

(ii) Billing department expenses;

(iii) Audit costs;

(iv) Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

(v) Space costs (rent and utilities); and

(vi) Liability insurance costs;

(D) Non-reimbursable overhead costs:

(i) Entertainment;

(ii) Fines and penalties;

(iii) Fundraising;

(iv) Goodwill;

(v) Gifts and contributions;

(vi) Political contributions;

(vii) Bad debts;

(viii) Other interest expense;

(ix) Advertising;

(x) Membership dues for public relations purposes, including country or fraternal club memberships;

(xi) Cost of personal use of motor vehicles;

(xii) Cost of travel incurred in connection with non-patient care related purposes; and

(xiii) Costs applicable to services, facilities, and supplies furnished by a related organization (related party transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity (see OAR 410-147-0540);

(b) Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used;

(c) Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC administrative rules on allowable costs. A schedule of any reported reclassification of trial balance expense, whether an increase or decrease, must include:

(A) A reference to the line number on either page 3 or 4;

(B) A description of the reclassification or adjustment;

(C) The amount of the debit or credit; and

(D) The total for each debit and credit;

(d) Net expenses must equal the combined reclassified trial balance taking into account the adjustment amount on each detail line;

(e) Enter the totals from each column in the “Total” fields.

(10) Page 5 -- Determinations -- Determination of overhead applicable to FQHC and RHC services:

(a) Parts A and B: Enter all totals from the previous pages of the Cost Statement (DMAP 3027) as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate;

(b) Part C: If applicable, complete by entering the wages for Out-stationed Outreach Workers on line C1, divide the wages by the number of billable Division encounters to determine the rate per encounter (see also OAR 410-147-0400).

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

410-147-0500 – Total Encounters for Cost Reports

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively.

(2) In general, the Division of Medical Assistance Programs (Division) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter.

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ALL:

(a) Encounters for all clients regardless of payor;

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, third party payor or other party, but otherwise have an associated cost for providing the service whether billed to the client (e.g. uninsured, signed waiver on file) or absorbed by the clinic; and;

(c) Encounters regardless of line placement on the Health Services Commission's (HSC) Prioritized List of Health Services. For the purpose of reporting encounters according to this rule, encounters are not subject to the HSC Prioritized List, or service limitations and benefit reductions implemented by the Division.

(4) FQHCs and RHCs must report all encounters furnished to all client populations irrespective of coverage or payor source. Examples of client populations include, but are not limited to:

(a) Oregon Health Plan (OHP) clients (includes both fee-for-service and prepaid health plan (PHP) clients). Refer to OAR 410-147-0120 for more information regarding OHP encounters;

(b) Citizen/Alien-Waived Emergency Medical (CAWEM) clients. Refer also to OAR 410-120-1210(3)(f).

(c) Family Planning Expansion Program (FPEP) Title X, clients;

(d) Uninsured and/or self-pay clients;

(e) Medicare clients;

(f) Third party or private pay insurance clients;

(g) County- and/or clinic-pay clients (services paid or funded by the county or clinic); and

(h) Clients funded by federal, state, local or other grants.

(5) FQHCs and RHCs must exclude from the total number of reported encounters:

(a) Encounters attributed to non-allowable costs:

(A) Services performed under the auspices of a Women, Infant and Children (WIC) Program or a WIC contract;

(B) Services performed and reimbursed under separate enrollment (e.g. targeted case management);

(C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC; and

(E) Health services provided as part of a large-scale “free to the public” or “nominal fee” effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair);

(b) Encounters for specific services outlined in 42 USC 1396d (a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Cost for furnishing these services is an allowed administrative program cost and should be reported on a clinic’s cost statement for calculating a clinic’s PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to:

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

(B) Enabling services, including but not limited to, sign language and oral interpreter services;

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

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis);

(E) Prescription refills; and

(F) Services provided without the client present, except for telephone contacts as specified in this rule section (6)(c).

(6) FQHCs and RHCs are required to include encounters for services furnished by practitioners recognized by the Division in OAR 410-147-0120(6). Examples of encounters that may be overlooked but should be included are:

(a) Encounters below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement;

(b) Encounters outside of the clinic by primary care practitioners (e.g. services furnished in a hospital or residential treatment setting);

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), OAR 410-130-0595, programs. See also OAR 410-120-1200(2)(y);

(d) Medication management-only encounters by a behavioral health practitioner;

(e) Encounters by Registered and Licensed Practical Nurses:

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of home health agencies (OAR 410-147-0120(10));

(B) Administration of immunizations/vaccinations encounters;

(C) "99211" encounters; and

(D) MCM encounters.

(7) Global procedures require attention for accurate reporting of encounters:

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter;

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-0040(5) ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information;

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information:

(A) Services within a surgical package and “included” in a given CPT surgical code are reported as a single encounter. Refer to OAR 410130-0380, Surgical Guidelines, for more information; and

(B) The initial consultation or evaluation of the problem by the provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter.

(8) A surgical procedure furnished to an OHP client and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CAWEM client. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC may be eligible as multiple encounters if medically necessary.

(9) When two or more services are provided on the same date of service:

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or

(b) With similar diagnoses, a clinic must report one encounter.

(10) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027):

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Stat. Auth.: ORS 413.042 and 414.065

Other Authority: 42 USC 1396a (bb), Title 42 Public Health of the Code of Federal Regulations

Stats. Implemented: ORS 414.065

410-147-0520 – Depreciation

Office of Management and Budget (OMB) Circular A-87 and A-122, Section 13 is applicable with the following exception: depreciation and amortization must be calculated on a straight line basis less the estimated salvage value. The clinic must use the American Hospital Association guidelines "Estimated Useful Lives of Depreciable Hospital Assets" for determining asset lives when computing depreciation. For assets not covered by the guidelines and with costs of more than $500 individually and $500 aggregate, the lives established by the clinic are subject to approval by the Division of Medical Assistance Programs (Division) depreciation and amortization schedules must be maintained.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-147-0540 – Related Party Transactions

(1) A “related party” is an individual or organization that is associated or affiliated with, or has control of, or is controlled by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:

(a) “Common ownership” exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;

(b) “Control” exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(2) The Division of Medical Assistance Programs (Division) allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent they:

(a) Relate to Title XIX and Title XXI client care;

(b) Are reasonable, ordinary, and necessary; and

(c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.

(3) The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.

(4) Clinics must disclose a related party who is separately enrolled as a provider with the Division and furnish the provider’s National Provider Identifier (NPI) and associated taxonomy code(s).

(5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by the Division. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(6) The Division will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC administrative rules.

(7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC’s cost statement report.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-147-0560 – Sanctions

(1) Providers are directed to Division of Medical Assistance Programs' (Division) general rules Oregon Administrative Rules (OAR) 410-120-1400 Provider Sanctions and 410-120-1460 Type and Conditions of Sanctions; and the Oregon Health Authority (Authority) general rule 943-120-0360 Consequences of Non-Compliance and Provider Sanctions.

(2) OAR 410-120-1510 and 943-120-0380 govern fraud and abuse. The Department is authorized to take the actions necessary to investigate and respond to substantiated allegations of fraud and abuse, including but not limited to suspending or terminating the provider from participation in the medical assistance programs

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065