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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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RULE CAPTION

Elimination of Oregon Health Plan Standard Benefit Plan Effective January 1, 2014
Not more than 15 words

RULEMAICING ACTION

ADOPT:

AMEND:

410-120-0030,410-120-1210,410-120-1230,410-125-0020,410-125-0080,410-125-0085,410-130-0240,410-131-0120,410-138-0000,410-138-0007,410-138-0009,410-141-0860,410-142-0040

REPEAL:

410-120-0030 (T) , 410-120-1210 (T) , 410-120-1230 (T) ,410-125-0020 (T) , 410-125-0080 (T) , 410-1250085 (T) 410-130-0240 (T) , 410-131-0120 (T) 410-138-0007 (T) , 410-138-0009 (T) , 410-141-0860 (T) , 410-142-0040(T),410-122-0055,410-123-1670,410-125-0047,410-127-0055,410-129-0195,410-130-0163,410-132-0055,410-146-0022,410-146-0380,410-147-0125,410-148-0090

RENUMBER:

AMEND & RENUMBER:

Stat.Aw114:413.042, 414.065

Other Auth.:

StasAmplemented::414.025, 414.065, 414.329, 414.706, 414.707, 414.708, 414.710, 688.135

RULE SUMMARY

The Affordable Care Act (ACA) set forth a series of changes for Medicaid and CHIP eligibility including the expansion to the new adult category. This adult group includes the adults that were known as the OHP standard population. Effective January 1, 2014, the current OHP Standard benefit package will be eliminated, and those clients receiving this benefit package will receive the OHP Plus benefit. Additionally, the ACA added new exemptions to copayments; all changes are pending approval by the Centers for Medicare and Medicaid services (CMS). Other non-substantive changes include moving the CAWEM Plus benefit description from OAR 410-120-0030 to 410-120-1210, correcting or clarifying grammatical or wording revisions, acronyms and OAR references.

Judy Mohr Peterson

Judy Mohr-Peterson 3/28/14

Authorized Signer Printed Name

Date

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410-120-0030

Children's Health Insurance Program

(1) The Children's Health Insurance Program (CHIP) is a federal non-entitlement program. The Oregon Health Authority (Authority), Division of Medical Assistance Program (Division) administers two programs funded under CHIP in accordance with the Oregon Health Plan (OHP) waiver and the CHIP state plan:

(a) CHIP: Provides health coverage for uninsured, low-income children who are ineligible for Medicaid;

(b) CHIP Pre-natal care expansion program.

(2) The General Rules Program (OAR 410-120-0000 et. seq.) and the OHP Program rules (OAR 410-141-0000 et. seq.) applicable to the Medicaid program are also applicable to the Authority's CHIP program.

(3) Children under 19 years of age who meet the income limits, citizenship requirements and eligibility criteria for medical assistance established in OAR chapter 410 through the program acronym OHP-CHIP receive the OHP benefit package. (For benefits refer to OAR 410-120-1210.)

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

410-120-1210

Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any Division chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;

(C) Coverage includes:

(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Mental health services based on the Prioritized List to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services.

(D) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140).

(b) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes: Services covered by Medicare and OHP Plus as described in this rule;

(D) Limitations:

(i) The same as OHP Plus, as described in this rule;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

(I) Over-the-counter (OTC) drugs;

(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;

(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services; however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.

(c) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code MED;

(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(d) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM;

(B) Eligibility criteria: Eligible clients are non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070;

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

(e) CAWEM Plus:

(A) Benefit Package identifier code CWX;

(B) Eligibility criteria: As defined in federal regulations and in the Children's Health Insurance Program (CHIP) state plan eligible clients are CAWEM pregnant women not eligible for Medicaid at or below 185 percent of the Federal Poverty Level (FPL);

(C) Coverage includes: Services covered by OHP Plus as described above;

(D) Exclusions: The following services are not covered for this program:

(i) Postpartum care (except when provided and billed as part of a global obstetric package code that includes the delivery procedure);

(ii) Sterilization;

(iii) Abortion;

(iv) Death with dignity services;

(v) Hospice.

(E) The day after pregnancy ends, eligibility for medical services shall be based on eligibility categories established in OAR chapter 461.

(5) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the Division's Hospital Services Program rule (OAR chapter 410, Division 125).

(d) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO, PHP or PCO;

(B) Subject to limitations and restrictions in the Division's individual program rules, the client can receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.706, 414.708, 414.710

410-120-1230

Client Co-payment

(1) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. A co-payment applies regardless of location of services rendered, i.e., provider's office or client's residence.

(2) The following services are exempt from co-payment:

(a) Emergency medical services, as defined in OAR 410-120-0000;

(b) Family planning services and supplies;

(c) Prescription drug products for nicotine replacement therapy (NRT);

(d) Prescription drugs ordered through the Division of Medical Assistance Programs' (Division's) Mail Order (a.k.a., Home-Delivery) Pharmacy program;

(e) Services to treat "health care-acquired conditions" (HCAC) and "other provider preventable conditions" (OPPC) services as defined in OAR 410-125-0450.

(3) The following clients are exempt from co-payments:

(a) Pregnant women;

(b) Children under age 19;

(c) Young adults in Substitute Care and in the Former Foster Care Youth Medical Program;

(d) Clients receiving services under the home and community based waiver and developmental disability waiver;

(e) Inpatients in a hospital, nursing facility, or Intermediate Care Facility for Intellectually or Developmentally Disabled (ICF/IDD);

(f) American Indian/Alaska Native (AI/AN) clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), tribal organization or services provided at an Urban Tribal Health Clinic as provided under Public Law 93-638;

(g) Individuals receiving hospice care;

(h) Individuals eligible for the Breast and Cervical Cancer Program.

(4) Co-payment for services is due and payable at the time the service is provided unless exempted in sections (2) and (3) above. Services to a client may not be denied solely because of an inability to pay an applicable co-payment. This does not relieve the client of the responsibility to pay the applicable co-payment, nor does it prevent the provider from attempting to collect any applicable co-payments from the client; the co-payment is a legal debt and is due and payable to the provider of service.

(5) Except for prescription drugs, one co-payment is assessed per provider/ per visit/ per day unless otherwise specified in other Divisions' program administrative rules.

(6) Fee-for-service co-payment requirements:

(a) The provider may not deduct the co-payment amount from the usual and customary billed amount submitted on the claim. Except as provided in section (2) and (3) of this rule, the Division shall deduct the co-payment from the amount the Division pays to the provider (whether or not provider collects the co-payment from the client);

(b) If the Division's payment is less than the required co-payment, then the co-payment amount is equal to the Division's lesser required payment, unless the client or services are exempt according to exclusions listed in section (2) and (3) above. The client's co-payment shall constitute payment-in-full;

(c) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 1001.951 – 1001.952, the Division does not require providers to bill or collect a co-payment from the Medicaid client. The provider may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the provider.

(7) CCO, PHP or PCO co-payment requirements:

(a) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 447.58 and 447.60, the Division does not require CCOs, PHP or PCOs to bill or collect a

co-payment from the Medicaid client. The CCO, PHP or PCO may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the CCO, PHP or PCO;

(b) When a CCO, PHP or PCO is operating within the scope of the safe harbor regulation outlined in 42 CFR 1001.952(l), a CCO, PHP or PCO may elect to assess a co-payment on some of the services outlined in table 120-1230-1 but not all. The CCO, PHP or PCO must assure they are working within the provisions of 42 CFR 1003.102(b) (13).

(8) Services that require co-payments are listed in Table 120-1230-1.

(9) Table 120-1230-1.

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 414.025 and 414.065

Table 120-1230-1

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH, BMD, BMM)
Acupuncture services	\$3
Ambulance services (emergency)	\$0
Ambulatory Surgical Center	\$3
Audiology services	\$3
• Hearing Aids	\$0
Chemical Dependency services	
• Outpatient services	\$3
• Medication dosing/dispensing, case management	\$0
• Inpatient hospital detoxification	\$0
Chiropractic services	\$3
Dental services	
• Diagnostic – (D0100-D0999) oral examinations used to determine changes in the patient’s health or dental status, including x-rays, laboratory services and tests associated with making a diagnosis and/or treatment.	\$0
• Preventive services (D1000-D1999) routine cleanings fluoride, sealants	\$0
• Restorative treatment or other dental services (D2000-D9999)	\$3
DME and supplies	\$0
Home visits for	
• Home health	\$3
• Private duty nursing	\$3
	\$3

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH, BMD, BMM)
<ul style="list-style-type: none"> • Enteral/Parenteral 	
Hospital <ul style="list-style-type: none"> • Inpatient care • Outpatient surgery • Emergency room services • Outpatient, other • Non-emergent visit performed in the ER 	\$0 \$3 \$0 \$3 \$3
Laboratory test	\$0
Mental Health services <ul style="list-style-type: none"> • Inpatient hospitalization - includes ancillary, facility and professional fees (DRG 424-432); • Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90791, 90792); • Outpatient hospital- Electroconvulsive (ECT) treatment (Revenue code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104); • Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887) 	\$3 \$3 \$3 \$0
Naturopathic services	\$3
Podiatry services	\$3
Prescription drugs <ul style="list-style-type: none"> • Non-preferred PDL or generics in non-PDL classes costing >\$10 • Preferred PDL generic or generics in non-PDL classes costing <\$10 • Preferred PDL brand • All other brands Refer to OAR 410-121-0030 for PDL list PDL list is not applicable to those enrolled in MCO, contact the MCO for details.	\$1 \$0 \$0 \$3
Professional visits for <ul style="list-style-type: none"> • Primary care, including urgent care by a Physician, Physician Assistant, Certified Nurse Practitioner • Specialty care • Office medical procedures • Surgical procedures • PT/OT/Speech 	\$3 \$3 \$0 \$0 \$3
Radiology <ul style="list-style-type: none"> • Diagnostic procedures • Treatments 	\$0 \$0
Vision services	

OHP Benefit Package Client Co-payment Requirements (Benefit Identifier)	OHP Plus (BMH, BMD, BMM)
<ul style="list-style-type: none"> • Exams- for medical purposes or solely for glasses • Frames, contracts, corrective devices 	<p style="text-align: center;">\$3</p> <p style="text-align: center;">\$0</p>

410-125-0020

Retroactive Eligibility

(1) The Division of Medical Assistance Programs (Division) may pay for services provided to an individual who does not have Medicaid coverage at the time services are provided if the individual is made retroactively eligible for medical assistance and eligibility is extended back to the date services were provided. Contact the local branch concerning possible retroactive eligibility. In some cases, the date of branch contact may be considered the date of application for eligibility.

(2) Authorization for payment may be given after the service is provided under limited circumstances. For prior authorization information see OAR 410-125-0124 (Hospital Services Program).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0080

Inpatient Services

(1) Elective (not urgent or emergent) hospital admission:

(a) Coordinated Care Organization (CCO), Fully-Capitated Health Plan (FCHP), and Mental Health Organization (MHO) clients: Contact the client's CCO, FCHP, or MHO. The health plan may have different prior authorization (PA) requirements than the Division of Medical Assistance Programs (Division);

(b) Medicare clients: The Division does not require PA for inpatient services provided to clients with Medicare Part A or B coverage;

(c) Division clients: Oregon Health Plan (OHP) clients covered by the OHP Plus Benefit Package:

(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, rules OAR chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401;

(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1.

(2) Transplant services:

(a) Complete rules for transplant services are in the Division's Transplant Services Program rules, OAR chapter 410, division 124;

(b) Clients are eligible for transplants covered by the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria. For clients enrolled in a FCHP, contact the plan for authorization. Clients not enrolled in a FCHP, contact the Division's Medical Director's office.

(3) Out-of-State non-contiguous hospitals:

(a) All non-emergent and non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;

(b) Contact the Division's Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-State contiguous hospitals: The Division prior authorizes services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, following the same rules and procedures governing in-State providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA. Contact the Division-contracted Quality Improvement Organization (QIO);

(b) For transfers to a long-term, acute-care hospital, skilled nursing facility, intermediate care facility or swing bed, contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO and FCHP clients, transfers require authorization and payment (for first 20 days) from the CCO or FCHP;

(c) For transfers for the same or lesser level inpatient care to a general acute-care hospital, the Division shall cover transfers, including back transfers that are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or psychological benefit to the patient:

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;

(B) Payment for transfers not meeting these guidelines may be denied on the basis of post-payment review.

(d) Exceptions:

(A) Emergency transfers do not require PA;

(B) In-State or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;

(C) All non-urgent transfers to out-of-State, non-contiguous hospitals require PA.

(6) Dental procedures provided in a hospital setting:

(a) For prior authorization requirements, see the Division's Dental Services Program rules; specifically OAR 410-123-1260 and 410-123-1490;

(b) Emergency dental services do not require PA;

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, <http://www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html>;

(d) For clients enrolled in a CCO or FCHP, contact the client's health plan.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-125-0085

Outpatient Services

(1) Outpatient services that may require prior authorization (PA) include (see the individual program in the Division of Medical Assistance Programs (Division), Oregon administrative rules (OARs or rules) :

(a) Physical Therapy (chapter 410, division 131);

(b) Occupational Therapy (chapter 410, division 131);

(c) Speech Therapy (chapter 410, division 129);

(d) Audiology (chapter 410, division 129);

- (e) Hearing Aids (chapter 410, division 129);
 - (f) Dental Procedures (chapter 410, division 123);
 - (g) Drugs (chapter 410, division 121);
 - (h) Apnea monitors, services, and supplies (chapter 410, division 131);
 - (i) Home Parenteral/Enteral Therapy (chapter 410, division 148);
 - (j) Durable Medical Equipment and Medical supplies (chapter 410, division 122);
 - (k) Certain hospital services.
- (2) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.
- (3) Outpatient surgical procedures:
- (a) Coordinated Care Organization (CCO) and Fully-Capitated Health Plan (FCHP) clients: Contact the client's health plan. The health plan may have different PA requirements than the Division. Some services are not covered under FCHP contracts and require PA from the Division, or the Division's Dental Program analyst;
 - (b) Medicare clients enrolled in a CCO or an FCHP: These services must be authorized by the plan even if Medicare is the primary payer. Without this authorization, the provider shall not be paid beyond any Medicare payments (see also OAR 410-125-0103);
 - (c) For Division clients on the OHP Plus benefit package:
 - (A) Surgical procedures listed in OAR 410-125-0080 require PA when performed in an outpatient or day surgery setting, unless they are urgent or emergent;
 - (B) Contact the Division for PA (unless indicated otherwise in OAR 410-125-0080).
 - (d) Out-of-State services: Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require prior authorization unless specified in the Division's Hospital Services Program rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require PA. For clients enrolled in a CCO or an FCHP, contact the health plan for authorization. For clients not enrolled in a health plan, contact the Division's Medical Unit.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-130-0240

Medical Services

- (1) Coverage of medical and surgical services is subject to the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List). Medical and surgical services requiring prior authorization (PA) are listed in Oregon administrative rule (OAR or rule) 410-130-0200, PA Table 130-0200-1, and medical and surgical services that are Not Covered/Bundled services are listed in OAR 410-130-0220, Table 130-0220-1.
- (2) Coverage for acupuncture services by an enrolled acupuncture provider are subject to the HERC Prioritized List and the client's benefit plan.
- (3) Coverage for chiropractic services provided by an enrolled chiropractor is subject to the HERC Prioritized List and benefit plan for:
 - (a) Diagnostic visits, including evaluation and management services;
 - (b) Chiropractic manipulative treatment;
 - (c) Laboratory and radiology services.
- (4) Maternity care and delivery:
 - (a) The Division may consider payment for delivery within a clinic, birthing center or home setting;
 - (b) Within the home setting the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, newborn screening cards, and local or anesthetics;
 - (c) The Division may consider payment for physician-administered medications associated with delivery except for local or topical anesthetics;
 - (d) When labor management conducted by a LDEM does not result in a delivery and the client is appropriately transferred, the provider shall code for labor management only. Bill code 59899 and attach a report;
 - (e) For multiple births, use the appropriate CPT code for the first vaginal or cesarean delivery that includes antepartum and postpartum care, and the subsequent births under the respective delivery only code. For example, for total obstetrical care with cesarean delivery of twins, bill code 59510 for the first delivery and code 59514 for the second delivery.
- (5) Neonatal Intensive Care Unit (NICU) procedures:

(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;

(b) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use appropriate CPT ECMO codes.

(6) Neurology/Neuromuscular—Payment for polysomnograms and multiple sleep latency tests (MSLT) are each limited to two in a 12 month period.

(7) Oral health services provided by medical practitioners may include an oral assessment and application of topical fluoride varnish during a medical visit to children under the age of seven years. Refer to OAR 410-123-1260 Dental Services Program rule.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-131-0120

Limitations of Coverage and Payment

(1) Oregon Health Plan (OHP) Plus clients shall be responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. See OAR 410-120-1230, Client Co-payment, and Table 120-1230-1 for specific details:

(2) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services must be supported by a therapy plan of care signed and dated by the prescribing practitioner (see OAR 410-131-0080).

(3) PT/OT initial evaluations and re-evaluations do not require Prior Authorization (PA), but are limited to:

(a) Up to two initial evaluations in any 12-month period; and

(b) Up to four re-evaluation services in any 12-month period;

(4) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day.

(5) All other occupational and physical therapy treatments require PA. See also OAR 410-131-0160 and Table 131-0160-1.

(6) A licensed occupational or physical therapist, or a licensed occupational or physical therapy assistant under the supervision of a therapist, must be in constant attendance while therapy treatments are performed:

(a) Duration—Therapy treatments may not exceed one hour per day each for occupational and physical therapy;

(b) Modalities:

(A) Require PA;

(B) Up to two modalities may be authorized per day of treatment;

(C) Need to be billed in conjunction with a therapeutic procedure code; and

(D) Each individual supervised modality code may be reported only once for each client encounter. See Table 131-0160-1.

(c) Massage therapy is limited to two units per day of treatment and shall only be authorized in conjunction with another therapeutic procedure or modality.

(7) Supplies and materials for the fabrication of splints must be billed at the acquisition cost, and reimbursement may not exceed the Division's maximum allowable in accordance with the physician fee schedule. Acquisition cost is purchase price plus shipping. Off-the-shelf splints, even when modified, are not included in this service.

(8) The following services are not covered:

(a) Services not medically appropriate;

(b) Services that are not paired with a funded diagnosis on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services pursuant to OAR 410-141-0520;

(c) Work hardening;

(d) Back school/back education classes;

(e) Hippotherapy (e.g. horse or equine-assisted therapy);

(f) Services included in OAR 410-120-1200 Excluded Services Limitations;

(g) Durable medical equipment and medical supplies other than those splint supplies listed in Table 131-0120-1, OAR 410-131-0280; and

(h) Maintenance therapy (see OAR 410-131-0100).

(9) Physical capacity examinations are not a part of the PT/OT program but may be reimbursed as administrative examinations when ordered by the local branch office. See the Division's OARs 410, division 150 for information on administrative examinations and report billing.

(10) Table 131-0120-1.

Stat. Auth.: ORS 413-042

Stats. Implemented: ORS 688.135, 414.065

Table 131-0120-1 Services That Do Not Require Payment Authorization

This table is arranged to improve clarity and is not intended to provide complete guidance on service coverage. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on covered services.

Application of splints

29105
29125
29126
29130
29131

Supplies to create splints

Q4017
Q4018
Q4019
Q4020
Q4021
Q4022
Q4023
Q4024
Q4049
Q4051

410-138-0000

Targeted Case Management Definitions

The following definitions apply to OAR 410-138-0000 through 410-138-0420:

(1) Assessment means the act of gathering information and reviewing historical and existing records of an eligible client in a target group to determine the need for medical, educational, social, or other services. To perform a complete assessment, the case manager shall gather information from family members, medical providers, social workers, and educators, if necessary.

(2) Care Plan means a Targeted Case Management (TCM) Care Plan that is a multidisciplinary plan that contains a set of goals and actions required to address the medical, social, educational,

and other service needs of the eligible client based on the information collected through an assessment or periodic reassessment.

(3) Case Management means services furnished by a case manager to assist individuals eligible under the Medicaid State plan in gaining access to and effectively using needed medical, social, educational, and other services (such as housing or transportation) in accordance with 42 CFR 441.18. See also definition for Targeted Case Management.

(4) Centers for Medicare and Medicaid Services (CMS) means the federal agency under the U.S. Department of Health and Human Services that provides the federal funding for Medicaid and Children's Health Insurance Program (CHIP).

(5) Department means the Department of Human Services (Department).

(6) Division means the Division of Medical Assistance Programs.

(7) Duplicate payment means more than one payment made for the same services to meet the same need for the same client at the same point in time.

(8) Early intervention (EI) means services for preschool children with disabilities from birth until three years of age, including Indian children and children who are homeless and their families.

(9) Early childhood special education (ECSE) means free, specially designed instruction to meet the unique needs of a preschool child with a disability, three years of age until the age of eligibility for public school, including instruction in physical education, speech-language services, travel training, and orientation and mobility services. Instruction is provided in any of the following settings: home, hospitals, institutions, special schools, classrooms, and community childcare or preschool settings.

(10) Early Intervention/Early Childhood Special Education (EI/ECSE) services means services provided to a preschool child with disabilities, eligible under the Individuals with Disabilities Education Act (IDEA), from birth until they are eligible to attend public school, pursuant to the eligible child's Individualized Family Service Plan (IFSP).

(11) EI/ECSE Case manager (i.e., service coordinator) means an employee of the EI/ECSE contracting or subcontracting agency meeting the personnel standards requirements in OAR 581-015-2900. The EI/ECSE case manager serves as a single point-of-contact and is responsible for coordinating all services across agency lines for the purpose of assisting an eligible client to obtain needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) identified in the eligible client's care plan in coordination with the client's IFSP.

(12) EI/ECSE TCM Program means a service under the State plan and includes case management services furnished to eligible EI/ECSE preschool children age 0-5 with disabilities, assisting them to gain access to needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) in coordination with their IFSP.

EI/ECSE TCM providers must meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for State reimbursement under OAR 581-015-2710 EI/ECSE and must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be sub-contractors with such a contractor. Medicaid reimbursement for EI/ECSE TCM services is available only to eligible clients in the target group and does not restrict an eligible client's free choice of providers.

(13) Eligible client means an individual who is found eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Oregon Health Authority (Authority) and eligible for case management services (including TCM services) as defined in the Medicaid State plan at the time the services are furnished.

(14) Federal Financial Participation (FFP) means the portion paid by the federal government to states for their share of expenditures for providing Medicaid services. FFP was created as part of the Title XIX, Social Security Act of 1965. There are two objectives that permit claims under FFP. They are:

(a) To assist individuals eligible for Medicaid to enroll in the Medicaid program; and

(b) To assist individuals on Medicaid to access Medicaid providers and services. The second objective involves TCM.

(15) Federal Medical Assistance Percentage (FMAP) means the percentage of federal matching dollars available to a state to provide Medicaid services. The FMAP is calculated annually based on a three-year average of state per capita personal income compared to the national average. The formula is designed to provide a higher federal matching rate to states with lower per capital income. No state receives less than 50 percent or more than 83 percent.

(16) Individualized Family Service Plan (IFSP) means a written plan of early childhood special education, related services, early intervention services, and other services developed in accordance with criteria established by the State Board of Education for each child eligible for services. (See OAR 581-015-2700 to 581-015-2910, Early Intervention and Early Childhood Special Education Programs.)

(17) Medical Assistance Program means a program administered by the Division that provides and pays for health services for eligible Oregonians. The Medical Assistance Program includes TCM services provided to clients eligible under the Oregon Health Plan (OHP) Title XIX, and the Children's Health Insurance Program (CHIP) Title XXI.

(18) Monitoring means ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision makers, family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the care plan is effectively implemented.

(19) Oregon Health Plan (OHP) means the Medicaid program in Oregon that is known as the OHP and governed by a series of laws passed by the Oregon Legislature with the intention of

providing universal access to healthcare to Oregonians. OHP is also governed by many federal laws.

(20) Reassessment means periodically re-evaluating the eligible client to determine whether or not medical, social, educational, or other services continue to be adequate to meet the goals and objectives identified in the care plan. Reassessment decisions include those to continue, change, or terminate TCM services. A reassessment must be conducted at least annually or more frequently if changes occur in an eligible client's condition; or when resources are inadequate or the service delivery system is non-responsive to meet the client's identified service needs.

(21) Referral means performing activities such as scheduling appointments that link the eligible client with medical, social, or educational providers, or other programs and services, and follow-up and documentation of services obtained.

(22) Targeted Case Management (TCM) Services means case management services furnished to a specific target group of eligible clients under the Medicaid State plan to gain access to needed medical, social, educational, and other services (such as housing or transportation).

(23) Unit of Government means a city, a county, a special purpose district, or other governmental unit in the State.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-138-0007

Targeted Case Management — Covered Services

(1) Targeted case management (TCM) services shall be furnished only to assist individuals eligible under the Medicaid State plan in gaining access to and effectively using needed medical, social, educational, and other services (such as housing or transportation) in accordance with 42 CFR 441.18.

(2) TCM services billed to Medicaid must be for allowable activities and include one or more of the following components:

(a) Assessment of an eligible client in the target group to determine the need for medical, educational, social, or other services as follows:

(A) Taking client history;

(B) Identifying the needs of the client, and completing related documentation;

(C) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible client;

(D) Periodically reassessing a client to determine if the client's needs or preferences have changed. A reassessment must be conducted at least annually or more frequently if changes occur in an individual's condition;

(b) Development of a care plan based on the information collected through the assessment or periodic reassessment, specifying the goals and actions to address the medical, social, educational, and other services needed by the eligible client. This may include:

(A) Active participation of the eligible client in the target group; or

(B) Working with the eligible client or the eligible client's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the eligible client;

(c) Referral, linking and coordination of services and related activities including but not limited to:

(A) Scheduling appointments for the eligible client in the target group to obtain needed services; and

(B) Activities that help link the eligible client with medical, social, or educational providers, or other programs and services (e.g., food vouchers, transportation, child care, or housing assistance) that address identified needs and achieve goals specified in the care plan. The case management referral activity is completed once the referral and linkage have been made;

(C) Reminding and motivating the client to adhere to the treatment and services schedules established by providers.

(d) Monitoring or ongoing face-to-face or other contact:

(A) Monitoring and follow-up activities include activities and contacts:

(i) To ensure the care plan is effectively implemented;

(ii) To help determine if the services are being furnished in accordance with the eligible client's care plan;

(iii) To determine whether the care plan adequately addresses the needs of the eligible client in the target group;

(iv) To adjust the care plan to meet changes in the needs or status of the eligible client.

(B) Monitoring activities may include contacts with:

(i) The participating eligible client in the target group;

(ii) The eligible client's healthcare decision makers, family members, providers, or other entities or individuals when the purpose of the contact is directly related to the management of the eligible client's care.

(3) TCM services billed to Medicaid must be documented in individual case records for all individuals receiving case management. The documentation must include:

(a) The name of the individual;

(b) The dates of the case management services;

(c) The name of the provider agency (if relevant) and the person providing the case management service;

(d) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

(e) Whether the individual has declined services in the care plan;

(f) The need for, and occurrences of, coordination with other case managers;

(g) A timeline for obtaining needed services;

(h) A timeline for reevaluation of the plan.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-138-0009

Targeted Case Management—Services Not Covered

(1) Targeted Case Management (TCM) services do not cover:

(a) Direct delivery of an underlying medical, educational, social, or other service to which the eligible client has been referred;

(b) Providing transportation to a service to which an eligible client is referred;

(c) Escorting an eligible client to a service;

(d) Providing child care so that an eligible client may access a service;

(e) Contacts with individuals who are not categorically eligible for Medicaid or who are categorically eligible for Medicaid but not included in the eligible target population when those

contacts relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care;

(f) Assisting an individual who has not yet been determined eligible for Medicaid to apply for or obtain eligibility;

(g) TCM services provided to an individual if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or State funded parole and probation, or juvenile justice programs;

(h) Activities for which third parties are liable to pay.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-141-0860

Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment

(1) Definitions:

(a) ACA-qualified conditions will be posted on the agency website. The types of conditions include a mental health condition, substance use disorders, asthma, diabetes, heart disease, BMI over 25 or for patients under the age of 20 (The equivalent measure would be BMI equal or greater than 85 percentile.), HIV/AIDS, hepatitis, chronic kidney disease and cancer;

(b) An ACA-qualified patient is a patient who meets the criteria described in these rules as authorized by Section 2703 of the Patient Protection and Affordable Care Act;

(c) ACA-qualified patients are individuals with:

(A) A serious mental health condition; or

(B) At least two chronic conditions proposed by the state and approved by CMS; or

(C) One chronic condition and at risk of another qualifying condition as described above:

(i) Providers and plans are to use information published by the US Preventive Services Task Force, Bright Futures, and HRSA Women's Preventive Services when making decisions about the particular risk factors for an additional chronic condition that may lead a patient with one chronic condition to meet the criteria of one chronic condition and at risk of another;

(ii) The conditions and risk factors shall be documented in the patient's medical record.

(d) Core services are defined as:

(A) Comprehensive Care Management is identifying patients with high risk environmental or medical factors, including patients with special health care needs who will benefit from additional care planning. Care management activities may include but are not limited to population panel management, defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and developing end-of-life care plans when appropriate;

(B) Care coordination is an integral part of the PCPCH. Care coordination functions will include the use of the person-centered plan to manage such referrals and monitor follow up as necessary. The Division shall assign clients to a provider, clinic, or team to increase continuity of care and ensure responsibility for individual client care coordination functions, including but not limited to:

(i) Tracking ordered tests and notifying all appropriate care-givers and clients of results;

(ii) Tracking referrals ordered by its clinicians including referral status and whether consultation results have been communicated to clients and clinicians; and

(iii) Directly collaborating or co-managing clients with specialty mental health and substance abuse and providers of services and supports to people with developmental disabilities and people receiving long-term care services and supports. (The Division strongly encourages co-location of behavioral health and primary care services.)

(C) Health promotion is demonstrated when a PCPCH provider supports continuity of care and good health through the development of a treatment relationship with the client, other primary care team members and community providers. The PCPCH provider shall promote the use of evidence-based, culturally sensitive wellness and prevention by linking the client with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. The PCPCH shall use health promotion activities to promote patient and family education and self-management of their ACA-qualifying conditions;

(D) Comprehensive transitional care is demonstrated when a PCPCH emphasizes transitional care with either a written agreement or procedures in place with its usual hospital providers, local practitioners, health facilities and community-based services to ensure notification and coordinated, safe transitions, as well as improve the percentage of patients seen or contacted within one (1) week of facility discharges;

(E) Individual and family support services are demonstrated when a PCPCH has processes in place for:

(i) Patient and family education;

(ii) Health promotion and prevention;

(iii) Self-management supports; and

(iv) Information and assistance to obtain available non-health care community resources, services and supports.

(F) Referral to community and social support services is demonstrated through the PCPCH's processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.

(e) Patient Centered Primary Care Home (PCPCH) pursuant to OAR 409-055-0010(7) is defined as a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to 409-055-0040;

(f) A PCPCH "team" is interdisciplinary and inter-professional and must include non-physician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, community health workers, personal health navigators and peer wellness specialists authorized through State plan or waiver authorities. (Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized.) These PCPCH professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics and facilities;

(g) Person-centered plan is defined as the plan that shall be developed by the PCPCH and reflect the client and family/caregiver preferences for education, recovery and self-management as well as management of care coordination functions. Peer supports, support groups and self-care programs shall be utilized to increase the client and caregivers knowledge about the client's health and health-care needs. The person-centered plan shall be based on the needs and desires of the client including at least the following elements:

(A) Options for accessing care;

(B) Information on care planning and care coordination;

(C) Names of other primary care team members when applicable; and

(D) Information on ways the team member participates in this care coordination.

(h) Primary Care Managers (PCM) must be trained and certified or licensed, as applicable under Oregon statutes and administrative rules in one of the following disciplines:

(A) Doctors of medicine;

(B) Doctors of osteopathy;

(C) Naturopathic physicians;

(D) Nurse Practitioners;

(E) Physician assistant;

(F) Naturopaths who have a written agreement with a physician sufficient to support the provision of primary care, including prescription drugs, and the necessary referrals for hospital care.

(2) Enrollment requirements:

(a) To enroll as a PCM, all applicants must:

(A) Be enrolled as Oregon Division of Medical Assistance Programs (Division) providers;

(B) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;

(C) Complete and sign the PCM Application (DMAP 3030 (7/11));

(D) If the Division determines that the PCM or an applicant for enrollment as a PCM does not comply with the OHP administrative rules pertaining to the PCM program or the Division's General Rules, or if the Division determines that the health or welfare of Division clients may be adversely affected or in jeopardy by the PCM, the Division may:

(i) Deny the application for enrollment as a PCM;

(ii) Close enrollment with an existing PCM; or

(iii) Transfer the care of those PCM clients enrolled with that PCM until such time as the Division determines that the PCM is in compliance.

(E) The Division may terminate their agreement without prejudice to any obligations or liabilities of either party already accrued prior to termination, except when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members. The PCM shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members.

(b) To enroll as a PCPCH with the Division, all applicants must:

(A) Apply to and be "recognized" as a PCPCH by the Oregon Health Authority (Authority) as organized in accordance with relevant Oregon Office of Health Policy and Research (OHPR) administrative rules (OAR 409-055-0000 to 409-055-0090), the Division administrative rules (chapter 410, division 141), and OHPR's Oregon Patient Centered Primary Care Home Model, dated October 2011 and found at www.primarycarehome.oregon.gov. The Authority grants

PCPCH recognition only when a practice, site, clinic or individual provider is successful in the application process with the Authority;

(i) The type of practice, site, clinic or individual provider that may apply to become a PCPCH includes physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine), Certified Nurse Practitioner and Physician Assistants, clinical practices or clinical group practices (FQHCs; RHCs; Tribal clinics; Community health centers; Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers);

(ii) PCPCH services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

(B) PCPCH providers must complete the enrollment process in order to receive reimbursement (OAR 410-120-1260), except as otherwise stated in OAR 410-120-1295. The Provider Enrollment Attachment (attachment to the Provider Enrollment Agreement) sets forth the relationship between the Division and the PCPCH site (recognized clinic or provider) to receive payment for providing PCPCH services under OHP OAR 410-141-0860;

(C) New PCPCH enrollment shall be effective on or after October 1, 2011 or the date established by the Division upon receipt of required information; (Note: PCPCH tier enrollment changes shall be effective the first of the next month or a date approved by the Division.)

(D) The PCPCH enrollment process requires the PCPCH submit a list of fee-for-service (FFS) clients to the Division in a format approved by the Division. The PCPCH must identify current OHP clients being treated within their practice. The PCPCH shall identify that patients are ACA qualified or not as defined in these rules;

(E) PCPCHs serving clients enrolled in a managed care organization (MCO, FCHP or PCO) must consult the MCO on the procedures for developing an OHP client list. The MCO shall submit the list of their identified clients to the Division. Identified client lists are submitted to the Division so that the Division can assign the appropriate clients to the PCPCH and begin making payments for services rendered, all in accordance with relevant OARs;

(F) Termination of PCPCH enrollment shall be the date established by the Authority. All providers shall comply with Provider Sanctions as outlined in OAR 410-120-1400.

(3) Payment: The Division shall make per member per month (PMPM) payments based on the PCPCH clinic's recognized tier and on the patient's ACA status.

(a) PCPCH payments are made as follows:

(A) For fee-for-service (FFS) ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

(i) \$ 10 for tier 1;

(ii) \$15 for tier 2 and;

(iii) \$24 for tier 3.

(B) For FFS non-ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

(i) \$2 for tier 1;

(ii) \$4 for tier 2 and;

(iii) \$6 for tier 3.

(b) For MCO enrolled ACA-qualified members, MCOs are responsible for payment to PCPCH providers assigned to the PCPCH. MCOs shall make payments to PCPCH clinics in accordance with OAR 409-055-0030. If an MCO retains any portion of the PCPCH payment, that portion shall be used to carry out functions related to PCPCH and is subject to approval and oversight by the Division;

(c) MCOs that wish to use PCPCH payment methodology and amount different from the Division must receive Division approval;

(d) The Division shall not provide additional PMPM payment to the MCOs for non-ACA-qualified members. For MCO enrolled non-ACA-qualified members, PCPCH payment responsibility will be integrated into MCOs capitation payments and covered services at the next opportunity to revise capitation rates expected on or near July 1, 2012;

(e) MCOs must use an alternative payment methodology that supports the Division's goal of improving the efficiency and quality of health services for primary care homes by decreasing the use of FFS reimbursement models. PMPM payment is an alternative methodology;

(f) It is the Division's intention that the PCPCH Program will not duplicate other similar services or programs such as PCM and medical case management, and the Authority shall not make PCPCH payments for patients who participate in these programs. The Division may review on a program to program basis if care coordination programs are complimentary with PCPCH.

(4) Client Assignment:

(a) OHP clients' participation with PCPCH is voluntary. OHP clients can opt out at any time from a PCPCH;

(b) The Division will provide client notice of PCPCH assignment including information about benefits of PCPCH and how to notify the Division if they wish to opt out.

(c) The Division shall remove PCPCH assignment from clients who choose not to participate in a PCPCH Program.

(d) Upon completion of PCPCH enrollment process and approval from CMS, the Division will implement PMPM payments for non-ACA patients who are not enrolled in an FCHP or PCO. The Division will integrate this service into rate setting and managed care responsibilities at the first available opportunity. This provision only affects the start-up phase of the program and is acknowledgment of a more gradual implementation than was originally intended;

(e) Clients assigned must have full medical eligibility with either Oregon Health Plan (OHP) Plus (BMH, BMP, BMM or BMD) benefit plans. This excludes CAWEM Plus (CWX) and QMB (MED) only.

(5) Documentation Requirements:

(a) The PCPCH must coordinate the care of all assigned clients who do not choose to opt out of the PCPCH Program to ensure they have a “person-centered plan” that has been developed with the client or the client’s caregiver. The PCPCH must provide an assigned client with at least one of the six “core” services as defined in Oregon State Medicaid Plan each quarter and document the service(s) in the medical record in order to be eligible for payment;

(b) PCPCHs shall assure that the patient’s engagement, education and agreement to participate in the PCPCH program are documented within six months of initial participation;

(c) PCPCHs shall assure that for each patient, providers are working with the patient to develop a person-centered plan within six months of initial participation and revise as needed;

(d) For ACA-qualified patients, PCPCH clinics shall provide one of the six core services or an activity that is defined in the service definition at least quarterly. Documentation of the services provided must be kept in the patient’s medical record;

(e) PCPCHs shall assure that they notify the Division when a patient moves out of the service area, terminates care, or no longer receives primary care from the PCPCH clinic as stated in OAR 410-141-0080 and 410-141-0120. Patient assignment shall be terminated at the end of the month for which PCPCH services terminated, unless a move to another PCPCH provider begins primary care before the end of the month. In this situation, the disenrollment and payment will be prorated;

(f) PCPCH clinics and MCOs must report to the Division a complete list of their Medicaid PCPCH patients, no less than quarterly. The Division will not make payments for patients that are not reported on these quarterly reports or for patients where documentation requirements are not met. PCPCH clinics and MCOs may provide the Division information on new member assignments or termination member assignments on a more frequent basis if they desire;

(g) PCPCH clinics must log on to the PCPCH provider portal, which will be available at www.primarycarehome.oregon.gov, no less than quarterly. In conjunction with submission of the quarterly patient list, logging on to the PCPCH provider portal serves as evidence that the clinic has complied with the service and documentation requirements. Clinics will have the opportunity to track quality measures through the portal and use this as a panel management tool;

(h) PCPCH clinics that have their own information technology system can use their own system as an alternative to the PCPCH provider portal. To do this, PCPCH clinics must:

(A) Be able to document quarterly usage of the system for panel management purposes; and

(B) Submit a request in writing to the Division to utilize their system as an alternative. The Division will respond to each request in writing.

(i) MCOs, no later than the 15th of January, April, July and October shall provide the Division with the following information for the preceding quarter:

(A) Number of clinics or sites that meet PCPCH standards;

(B) Number of Primary Care Providers in those service delivery sites;

(C) Number of patients receiving primary care in those sites; and

(D) Number of ACA-qualified patients receiving primary care at those sites.

(j) PCPCH shall provide their Division PCPCH clinic number when referring a patient to another provider to ensure it is added to the claim as a referring provider. The PCPCH will also need to document the referral in the patient's medical record.

Stat. Auth.: ORS 413.042, 414.065;

Stats. Implemented: ORS 414.065

410-142-0040

Eligibility for the Hospice Services

(1) Hospice services are covered for clients who have:

(a) Been certified as terminally ill in accordance with OAR 410-142-0060; and

(b) Have Oregon Health Plan (OHP) Plus benefit package coverage.

(2) Providers must bill Medicare for hospice services for clients with Medicare Part A coverage. Medicare's payment is considered payment in full.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065