XX-XXX

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division) | 410
Agency and Division | Administrative Rules Chapter Number

Sandy Cafourek, 500 Summer St Ne, Salem, OR 97301 | 503-945-6430
Rules Coordinator | Address | Telephone

RULE CAPTION

Add definitions, Change chemical dependency to substance use disorder, detox services available in other settings

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

December 17, 2013	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: The proposed amendment of OAR 410-120-0000, 410-120-0045, 410-120-1160, 410-120-1200, 410-120-1210, 410-120-1855

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth. : ORS 413.042

Other Auth.:

Stats. Implemented: **ORS 414.025, 414.041, 414.065, 414.329, 414.705, 414.706, 414.707, 414.708, 414.710**

RULE SUMMARY

The Authority needs to amend these rules to replace "chemical Dependency" with "Substance Use Disorder" as it is considered to be the standard terminology in the industry and to reflect that detox services is not restricted to a particular settings.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

December 19, 2013 by 5:00 p.m.
Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Rhonda Busek | Rhonde Busek | 11-13-13
Signature | Printed name | Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410

Agency and Division Administrative Rules Chapter Number

Add definitions, Change chemical dependency to substance use disorder, detox services available in other settings

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: **The proposed amendment of OAR 410-120-0000, 410-120-0045, 410-120-1160, 410-120-1200, 410-120-1210, 410-120-1855**

Statutory Authority: **ORS 413.042**
Other Authority:
Stats. Implemented: **ORS 414.025, 414.041, 414.065, 414.329, 414.705, 414.706, 414.707, 414.708, 414.710**

Need for the Rule(s): **The Authority needs to amend these rules to replace "chemical Dependency" with "Substance Use Disorder" as it is considered to be the standard terminology in the industry and to reflect that detox services is not restricted to a particular settings.**

Documents Relied Upon, and where they are available:

Fiscal and Economic Impact: **None**

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

Amending these rules will have no fiscal impact on the Authority other state agencies, local government, clients, the public, or businesses, including small businesses.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

The Division has approximately 63,000 enrolled providers. These enrolled providers range from large hospital affiliates, national Durable Medical Equipment or Pharmacy chains to individually owned physician offices. The Division's fee-for-services providers serve approximately 10% of the total OHP population. The Division does not have available information to estimate the percentage of these medical practices that are small businesses, but it is likely that there is a significant number of them.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

Amending these rules will not add additional reporting, record keeping or other administrative activities.

c. Equipment, supplies, labor and increased administration required for compliance:

Amending these rules will not impose any new equipment, supplies, labor and increased administration requirements on small or large businesses.

How were small businesses involved in the development of this rule? N/A

Administrative Rule Advisory Committee consulted?: **Yes. Approximately two weeks prior to the rules advisory committee meeting a public notice was posted on the agency website, an invitation was emailed to more than 250 people that had**

expressed interest in the rule making process in meetings referenced above. Those invited are made up of large and small providers groups and associations.

If not, why?:

Rhonda Busek 11-15-18

Signature | Printed name | Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 925-2007

410-120-0000

Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) or the Addictions and Mental health Division (AMH) administrative rules applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions, OAR 410-141-0300, and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 407 administrative rules, or contact the Division.

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Authority.

(2) "Acupuncturist" means a person licensed to practice acupuncture by the relevant state licensing board.

(3) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(4) "Acute" means a condition, diagnosis or illness with a sudden onset and that is of short duration.

(5) "Acquisition Cost" means unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.

(6) "Addiction and Mental Health Division (AMH)" means a division within the Authority that administers mental health and addiction programs and services.

(7) "Adequate Record Keeping" means documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

(8) "Administrative Medical Examinations and Reports" mean examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.

(9) "Advance Directive" means an individual's instructions to an appointed individual specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(10) "Adverse Event" means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(11) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (DHS) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)".

(12) "All-Inclusive Rate" or "Bundled rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340, Payment.

(13) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(14) "Alternative Care Settings" mean sites or groups of practitioners that provide care to members under contract with a PHP or CCO, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities and outpatient surgical centers.

(15) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(16) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).

(17) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.

(18) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims

Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(19) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(20) "Ancillary Services" mean services supportive of or necessary for providing a primary service, such as, anesthesiology, which is an ancillary service necessary for a surgical procedure.

(21) "Anesthesia Services" mean administration of anesthetic agents to cause loss of sensation to the body or body part.

(22) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.

(23) "Atypical Provider" means entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but which does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(24) "Audiologist" means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(25) "Audiology" means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(26) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone or Web-based response.

(27) "Benefit Package" means the package of covered health care services for which the client is eligible.

(28) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

(29) "Billing Provider (BP)" means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.

(30) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up).

(31) "By Report (BR): means services designated, as BR require operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature, and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(32) "Case Management Services" mean services provided to ensure that CCO members obtain health services necessary to maintain physical, mental and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, ~~chemical dependency~~ substance use disorder and/or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency or dental services, referring members to community services and supports which may include referrals to Allied Agencies. (33) "Children, Adults and Families Division (CAF)" means a division within the Department, responsible for administering self-sufficiency and child-protective programs.

(34) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.

(35) "Chiropractor" means a person licensed to practice chiropractic by the relevant state licensing board.

(36) "Chiropractic Services" mean services provided by a licensed chiropractor within the scope of practice, as defined under state law and Federal regulation.

(37) "Citizen/Alien-Waived Emergency Medical (CAWEM)" means aliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210 (3)(f).

(38) "Claimant" means a person who has requested a hearing.

(39) "Client" means an individual found eligible to receive OHP health services. "Client" is inclusive of members enrolled in PHPs, PCMs and CCOs.

(40) "Clinical Nurse Specialist" means a registered nurse who has been approved and

certified by the Board of Nursing to provide health care in an expanded specialty role.

(41) "Clinical Social Worker" means a person licensed to practice clinical social work pursuant to State law.

(42) "Clinical Record" means the medical, dental or mental health records of a client or member.

(43) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

(44) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an action:

(a) A client or member or their representative;

(b) A PHP or CCO member's provider; or

(c) A PHP or CCO.

(45) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.

(46) "Contiguous Area Provider" means a provider practicing in a contiguous area.

(47) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.

(48) "Co-Payments" mean the portion of a claim or medical, dental or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment).

(49) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.

(50) "Cover Oregon" means the state's health insurance exchange that will help individuals find out if they qualify for Medicaid, CHIP or health insurance coverage for themselves, their families and their employees.

(51) "Covered Services" means medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the Legislature funds, based on the Prioritized List of Health Services.

(52) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(53) "Current Procedural Terminology (CPT)" means the physicians' CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(54) "Date of Receipt of a Claim" means the date on which the Authority receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(55) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(56 "Dental Emergency Services" mean dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(57) "Dental Services" mean services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(58) "Dentist" means a person licensed to practice dentistry pursuant to state law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

(59) "Denturist" means a person licensed to practice denture technology pursuant to State law.

(60) "Denturist Services" mean services provided, within the scope of practice as defined under State law, by or under the personal supervision of a denturist.

(61) "Dental Hygienist" means a person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(62) "Dental Hygienist with an Expanded Practice Permit" means a person licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to State law.

(63) "Dentally Appropriate" means services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the client or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a client.

(64) "Department of Human Services (Department or DHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.

(65) "Department Representative" means a person who represents the Department and presents the position of the Department in a hearing.

(66) "Diagnosis Code" means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), the primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(67) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-9-CM.

(68) "Division of Medical Assistance Programs (Division)" means a division within the Authority; the Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs.

(69) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" mean equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces. Medical supplies are non-

reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

(70) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)" mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(71) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

(72) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(73) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.

(74) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(75) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(3)(f)(B)).

(76) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition, as defined in this rule, and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

(77) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.

(78) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)).

(79) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading or omitted information and such inaccurate, misleading or omitted information would result, or has resulted, in an overpayment.

(80)"Family Health Insurance Assistance Program (FHIAP)" means a program in which the State subsidizes premiums in the commercial insurance market for uninsured individuals and families with income below 185% of the Federal Poverty Level.

(81) "Family Planning Services" mean services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(82) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the Public Health Service Act; or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

(83) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of a Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP) . A medical provider participating in a PHP or a CCO may be

considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

(84) "Flexible Service" means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the mental condition, ~~chemical dependency~~ substance use disorder condition, or physical condition as documented in the Member's Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Services, and other non-Traditional Services identified.

(85) "Flexible Service Approach" means the delivery of any Coordinated Care Service in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering Coordinated Care Services at alternative sites such as schools, residential facilities, nursing facilities, Members' homes, emergency rooms, offices of DHS, OHA, other community settings; offering flexible clinic hours; offering Coordinated Care Services through outreach or a home-based approach; and using peers, paraprofessionals, Community Health Workers, Peer Wellness Specialists, or Personal Health Navigators who are Culturally Competent to engage difficult-to-reach Members.

(86) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(87) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Department for full medical assistance coverage.

(88) "General Assistance (GA)" means medical assistance administered and funded 100% with State of Oregon funds through OHP.

(89) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(90) "Health Care Professionals" mean individuals with current and appropriate licensure, certification or accreditation in a medical, mental health or dental profession who provide health services, assessments and screenings for clients within their scope of practice, licensure or certification.

(91) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority, from the most to the least important, representing the comparative benefits of each service to the population served.

(92) "Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(93) "Health Maintenance Organization (HMO)" means a public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(94) "Health Plan New/noncategorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet all eligibility requirements to become an OHP client.

(95) "Hearing Aid Dealer" means a person licensed by the Board of Hearing Aid Dealers to sell, lease or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(96) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract, as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

(97) "Home Health Agency" means a public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by the Authority as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(98) "Home Health Services" mean part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(99) "Home Intravenous Services" mean services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(100) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(101) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(102) "Hospital" means a facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as long-term care hospitals, long-term acute care hospitals or religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state, and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(103) "Hospital-Based Professional Services" mean professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (Division 42) report for the Division.

(104) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(105) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services, in a hospital setting, as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.

(106) "Indian Health Care Provider" means an Indian health program or an urban Indian organization.

(107) "Indian Health Program" means any Indian Health Service (IHS) facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(108) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives.

(109) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602) indigent has the meaning: Individuals with out health insurance coverage, public or private and meet standards for indigence adopted by the federal government as defined in ORS 813.602 (5).

(110) "Individual Adjustment Request Form (DMAP 1036)" means form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(111) "Inpatient Hospital Services" mean services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(112) "Institutional Level of Income Standards (ILIS)" mean three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' (SPD) Home and Community Based Waiver.

(113) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing and/or hospital care for a period of 30 days or more.

(114) "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)" mean a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(115) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory, under the Clinical Laboratory Improvement Act (CLIA).

(116) "Laboratory Services" mean those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his/her scope of practice as defined under State law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

(117) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery by the Public Health Division.

(118) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(119) "Managed Care Organization (MCO)" means contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(120) "Maternity Case Management" means a program available to pregnant clients. The purpose of Maternity Case Management is to extend prenatal services to include non-medical services, which address social, economic and nutritional factors. For more information refer to the Division's Medical-Surgical Services Program administrative rules.

(121) "Medicaid" means a federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Authority.

(122 "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

(123) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project, and Medicaid and CHIP services under the State Plan.

(124) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients. (called the Oregon Health ID starting Aug. 1, 2012).

(125) "Medical Services" mean care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

(126) "Medical Transportation" means transportation to or from covered medical services.

(127) "Medically Appropriate" means services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;

(c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to a Division client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(128) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for Inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and

(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;

(c) Prescription drug coverage (Part D) means covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.

(129) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(130) "Medicheck for Children and Teens" mean services also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate

health care services and to help Authority clients and their parents or guardians effectively use them.

(131) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(132) "Mental Health Case Management" means services provided to CCO members who require assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the CCO member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring CCO members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services.

(133) " National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

(134) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.

(135) "National Provider Identification (NPI)" means federally directed provider number mandated for use on HIPAA covered transactions; individuals, provider organizations and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(136) "Naturopathic physician" means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(137) "Naturopathic Services" means services provided within the scope of practice as defined under State law and by rules of the Oregon Board of Naturopathic Medicine..

(138) "Non-covered Services" mean services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:

(a) OAR 410-120-1200, Excluded Services and Limitations; and

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) Any other applicable Division administrative rules.

(139) "Non-Emergent Medical Transportation Services (NEMT) "means transportation to or from a source of covered service, which does not involve a sudden, unexpected occurrence that creates a medical crisis requiring emergency medical services, as defined in OAR 410-120-0000(49), and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(140) "Non-Paid Provider" means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).

(141) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.

(142) "Nurse Practitioner" means a person licensed as a registered nurse and certified by the Board of Nursing to practice as a Nurse Practitioner pursuant to State law.

(143) "Nurse Practitioner Services" mean services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

(144) "Nursing Facility" means a facility licensed and certified by the Department SPD and defined in OAR 411-070-0005.

(145) "Nursing Services" mean health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by State law.

(146) "Nutritional Counseling" means counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(147) "Occupational Therapist" means a person licensed by the State Board of Examiners for Occupational Therapy.

(148) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, aging process, or psychological disability; the treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(149) "Ombudsman Services" mean advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of or limitations on the health services provided.

(150) "Oregon Health ID" means a card the size of a business card that lists the client name, client ID (prime number) and the date it was issued.

(151) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project which expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations, and Medicaid and CHIP services under the State Plan

(152) "Optometric Services" mean services provided, within the scope of practice of optometrists as defined under State law.

(153) "Optometrist" means a person licensed to practice optometry pursuant to State law.

(154) "Oregon Health Authority (Authority or OHA)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the OHA are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(155) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(156) "Out-of-State Providers" mean any provider located outside the borders of the State of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

(157) "Outpatient Hospital Services" mean services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules found in chapter 410, division 125.

(158) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

(159) "Overpayment" means payment(s) made by Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(160) "Overuse" means use of medical goods or services at levels determined by Authority medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(161) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(162) "Panel" means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(163) "Payment Authorization" means authorization granted by the responsible agency, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(164) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the State to review services ordered or furnished by other practitioners in the same professional field.

(165) "Pharmaceutical Services" mean services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

(166) "Pharmacist" means a person licensed to practice pharmacy pursuant to state law.

(167) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(168) "Physical Therapist" means a person licensed by the relevant State licensing authority to practice Physical Therapy.

(169) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis or treatment of a human being. Physical Therapy shall not include radiology or electrosurgery.

(170) "Physician" means a person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the

federal government. A physician may be an individual licensed under ORS 677 or ORS 685.

(171) "Physician Assistant" means a person licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(172) "Physician Services" mean services provided, within the scope of practice as defined under state law, by or under the personal supervision of a physician.

(173) "Podiatric Services" mean services provided within the scope of practice of podiatrists as defined under state law.

(174) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to state law.

(175) "Post-Payment Review" means review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(176) "Practitioner" means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(177) "Premium Sponsorship" means premium donations made for the benefit of one or more specified Division clients (See 410-120-1390).

(178) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(179) "Primary Care Dentist (PCD)" means a dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.

(180) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005. (181) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority

staff, or its contracted agencies prior to provision of the service. A physician referral is not a PA.

(182) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.

(183) "Private Duty Nursing Services" mean nursing services provided within the scope of license by a registered nurse or a licensed practical nurse, under the general direction of the patient's physician to an individual who is not in a health care facility.

(184) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP(s) unless otherwise specified.

(185) "Provider Organization" means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility or organization;

(e) If such entity solely submits billings on behalf of providers and payments are made to each provider, then the entity is an agent. (See Subparts of Provider Organization).

(186) "Public Health Clinic" means a clinic operated by a county government.

(187) "Public Rates" mean the charge for services and items that providers, including Hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.

(188) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary, as defined by the Social Security Act and its amendments.

(189) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.

(190) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.

(191) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.

(192) "Radiological Services" mean those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, Hospital, or independent radiological facility.

(193) "Recipient" means a person who is currently eligible for medical assistance (also known as a client).

(194) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(195) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

(196) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.

(197) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

(198) "Request for Hearing" means a clear expression, in writing, by an individual or representative that the person wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

(199) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(200) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.

(201) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance

(202) "Rural" means a geographic area that is 10 or more map miles from a population center of 30,000 people or less.

(203) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse or abuse of Division requirements.

(204) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program which addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(205) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

(206) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(207) "Social Worker" means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(208) "Speech-Language Pathologist" means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(209) "Speech-Language Pathology Services" mean the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(210) "State Facility" means a Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(211) "Subparts (of a Provider Organization)" mean for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically, or has an entity do so on its behalf, could be components of an organization or separate physical locations of an organization.

(212) "Subrogation" means Right of the State to stand in place of the client in the collection of third party resources (TPR).

(213) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(214) "Surgical Assistant" means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(215) "Suspension" means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(216) "Targeted Case Management (TCM)" means activities that will assist the client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by Allied Agency providers.

(217) "Termination" means a sanction prohibiting a provider's participation in the Division's programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Authority at the time of termination.

(218) "Third Party Liability (TPL), Third Party Resource (TPR) or Third party payer" means a medical or financial resource which, under law, is available and applicable to pay for medical services and items for a Authority client.

(219) "Transportation" means Medical Transportation.

(220) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.

(221) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services and regulatory programs for the elderly or the elderly and disabled.

(222) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(223) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.

(224) "Urban" means a geographic area that is less than 10 map miles from a population center of 30,000 people or more.

(225) "Urgent Care Services" mean health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.

(226) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.

(227) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(228) "Valid Claim" means an invoice received by the Division or the appropriate Authority/Department office for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(229) "Vision Services" mean provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(230) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of DHS who is providing services on behalf of DHS in a non-paid capacity except for incidental expense reimbursement under the DHS Volunteer Program authorized by ORS 409.360

Stat. Auth.: ORS 413.042 414.065

Stats. Implemented: ORS 414.065

410-120-0045

Applications for Medical Assistance at Provider locations

(1) The Oregon Health Authority (Authority) allows Division enrolled providers the opportunity to assist patients applying for public and private health coverage offered through OHA and Cover Oregon at the provider's practice site. Once the provider is determined eligible by the Authority, providers will receive an approval letter, unique assister identification number, training requirements and other information.

(2) For purposes of this rule, the provider's practice will be referred to as a site. Sites can be, but are not limited, to the following:

(a) Hospitals;

(b) Federally qualified health centers/rural health clinics (FQHC/RHCs);

(c) County health departments;

(d) ~~Adult and youth alcohol and drug treatment centers~~ Substance Use Disorder adult and adolescent treatment and recovery centers;

(e) Tribal health clinics;

(f) Family Planning clinics;

(g) Other primary care clinics as approved by the Authority.

(3) The site shall send all employees that will be assisting to a mandatory Authority training session for application assistance certification. Employees must pass a test provided at that training session before initiating application assistance service. At least one trained employee must be a permanent employee of the site. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Authority. For purposes of this rule, certified staff will be referred to as "application assisters."

(4) Application assisters will log in to the Cover Oregon portal to provide enrollment assistance. In the event that the client needs require the use of a paper application, the Application assister will write the date the application was started and the assister's assigned assister identification number in the appropriate space on the application. Assistance will support patients potentially eligible for public and private health coverage offered through OHA and Cover Oregon. Sites are not under an obligation to provide medical program or Cover Oregon application assistance to individuals other than those they are providing care to. The application assister shall establish a date of request for applicants by logging into the Cover Oregon portal or writing the assister's identification number on the paper application in the appropriate place with the date the applicant requests an application. Once written on the application, the date can never

be changed, altered or backdated. The inscription must include the provider's assigned application assister site code number, in addition to the date.

(5) The application assister shall encourage applicants to provide accurate and truthful information, assist in completing the application and enrollment process and shall assure that the information contained on the application is complete. The application assister shall not attempt to pre-determine applicant eligibility or make any assurances regarding the eligibility for public or private health coverage offered through OHA and Cover Oregon.

(6) The application assister shall provide information to applicants about public medical programs and Cover Oregon private insurance products so applicant can make an informed choice when enrolling into a health insurance product. Language (including sign language) translators must be available if requested by applicants.

(a) The information given to the applicant shall, at a minimum, include an explanation of the significance of the date of request on the hard copy application, review of public medical programs and Cover Oregon private insurance products that are available, provide unbiased health coverage choices using filters embedded in the online application and information provided by OHA or Cover Oregon during enrollment process,, answer questions and assist in filling out online or paper application forms. The information provided at these sessions may include, but is not limited to the following:

(A) General eligibility criteria for public and private coverage accessible through OHA and Cover Oregon;

(B) Health plan choices, criteria and how to enroll in public medical programs or Cover Oregon private insurance product choices.

(b) The application assister must make copies of the original eligibility verification documentation required to accompany the application, but not uploaded to the Cover Oregon portal.

(7) The site shall log into Cover Oregon portal to track applications with which they have assisted. If site uses a hard copy application, site will use reporting process provided by Authority.

(8) Providers, staff, contracted employees and volunteers are subject to all applicable provisions under General Rules OAR chapter 410, division 120.

(a) The application assister shall treat all information they obtain for public medical programs and Cover Oregon private insurance as confidential and privileged communications. The application assister shall not disclose such information without the written consent of the individual, his or her delegated authority, attorney, or responsible parent of a minor child or child's guardian. Nothing prohibits the disclosure of

information in summaries, statistical or other form, which does not identify particular individuals;

(b) The Authority and sites will share information as necessary to effectively serve public medical programs and Cover Oregon eligible or potentially eligible individuals;

(c) Personally identifiable health information about applicants and recipients will be subject to the transaction, security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the administrative rules there under. Sites will cooperate with the Authority in the adoption of policies and procedures for maintaining the privacy and security of records and for conducting transactions pursuant to HIPAA requirements.

(9) The Authority will be responsible for the following:

(a) The Authority will provide training to application assisters on public medical programs and Cover Oregon private insurance products, eligibility and enrollment, application procedures and documentation requirements. The Authority will set dates and times for these additional training classes as needed, following changes in policy or procedure;

(b) The Authority will make available public medical programs and Cover Oregon application forms online and in hard copy (in English, translated languages and alternative formats), health insurance coverage options, assister identification number instructions, reporting guidance and other necessary forms;

(c) The Authority and Cover Oregon will process all applications in accordance with Authority and Cover Oregon standards;

(d) The Authority and Cover Oregon will process completed applications, which have satisfactory verification information, within the time requirements set forth in Authority and Cover Oregon policy. In the event of a change in policy, the time for completion of processing shall be changed to the new time requirements.

(10) The Authority and Cover Oregon will provide all necessary forms and applications as referenced above at no cost to the site. There are no monetary provisions in this rule for any payment for the performance of work by the site, except for those costs provided under OAR 410-147-0400 and 410-146-0460. However, the parties acknowledge the exchange and receipt of other valuable considerations in the spirit of cooperation to the benefit of all by collaborating and authorizing the performance of the work. The Authority does not guarantee a particular volume of business under these rules.

(11) The provider may terminate enrollment at any time as outlined in OAR 410-120-1260(14).

Stat. Auth.: 413.042
Statutes Implemented: 414.041

410-120-1160 - Medical Assistance Benefits and Provider Rules

(1) Providers enrolled with and seeking reimbursement for services through the Division of Medical Assistance Programs (Division) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) Web page for the division and its medical assistance programs. It is the provider's responsibility to become familiar with, and abide by, these rules.

(2) The following services are covered to the extent included in the Division client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of Medical Services:

(a) Acupuncture services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(b) Administrative examinations, as described in the Administrative Examinations and Billing Services Program provider rules (OAR chapter 410, division 150);

(c) ~~Alcohol and drug abuse~~ Substance Use Disorder treatment services:

(A) The Division covers ~~alcohol and drug~~ substance use disorder inpatient treatment services for medically managed intensive inpatient detoxification when provided in an acute care hospital and when hospitalization is considered medically appropriate. The Division covers Medically Monitored detoxification and Clinically Managed detoxification provided in a free standing detoxification center or an appropriately licensed SUDs residential treatment facility when considered medically appropriate;

~~(B) The Division does not cover residential level of care provided in an inpatient hospital setting for alcohol and drug abuse treatment;~~

(B~~C~~) The ~~Addictions and Mental Health~~ Division ~~(AMH)~~ covers non-hospital ~~alcohol and drug~~ substance use disorder treatment and recovery services on a residential or outpatient basis ~~through direct contracts with counties or providers~~. For information to access these services, contact the client's PHP or CCO if enrolled, the community mental health program (CMHP), an outpatient ~~alcohol and drug~~ substance use disorder treatment provider, the residential treatment program or the Addictions and Mental Health Division AMH~~;~~.

(C~~B~~) The Division does not cover residential level of care provided in an inpatient hospital setting for ~~alcohol and drug abuse~~ substance use disorder treatment and recovery;

(d) Ambulatory surgical center services, as described in the Medical-Surgical Services Program provider rules (OAR 410 division 130);

(e) Anesthesia services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(f) Audiology services, as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Program provider rules (OAR chapter 410, division 129);

(g) Chiropractic services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(h) Dental services, as described in the Dental/Denturist Services Program provider rules (OAR chapter 410, division 123);

(i) Early and periodic screening, diagnosis and treatment services (EPSDT, Medicheck for children and teens), are covered for individuals under 21 years of age as set forth in the individual program provider rules. The Division may authorize services in excess of limitations established in the OARs when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;

(j) Family planning services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(k) Federally qualified health centers and rural health clinics, as described in the Federally Qualified Health Center and Rural Health Clinic Program provider rules (OAR chapter 410, division 147);

(l) Home and community-based waiver services, as described in the Authority and the Department's OARs of Children, Adults and Families Division (CAF), Addictions and Mental Health Division (AMH), and Seniors and People with Disabilities Division (SPD);

(m) Home enteral/parenteral nutrition and IV services, as described in the Home Enteral/Parenteral Nutrition and IV Services Program rules (OAR chapter 410, division 148), and related Durable Medical Equipment. Prosthetics, Orthotics and Supplies Program rules (OAR chapter 410, division 122) and Pharmaceutical Services Program rules (OAR chapter 410, division 121);

(n) Home health services, as described in the Home Health Services Program rules (OAR chapter 410, division 127);

(o) Hospice services, as described in the Hospice Services Program rules (OAR chapter 410, division 142);

(p) Indian health services or tribal facility, as described in The Indian Health Care Improvement Act and its Amendments (Public Law 102-573), and the Division's American Indian/Alaska Native Program rules (OAR chapter 410, division 146);

(q) Inpatient hospital services, as described in the Hospital Services Program rules (OAR chapter 410, division 125);

(r) Laboratory services, as described in the Hospital Services Program rules (OAR chapter 410, division 125) and the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(s) Licensed direct- entry midwife services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(t) Maternity case management, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(u) Medical equipment and supplies, as described in the Hospital Services Program, Medical-Surgical Services Program, DMEPOS Program, Home Health Care Services Program, Home Enteral/Parenteral Nutrition and IV Services Program and other rules;

(v) When a client's Benefit Package includes mental health, the mental health services provided will be based on the Oregon Health Services Commission's Prioritized List of Health Services.;

(w) Naturopathic services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(x) Nutritional counseling as described in the Medical/Surgical Services Program rules (OAR chapter 410, division 130);

(y) Occupational therapy, as described in the Physical and Occupational Therapy Services Program rules (OAR chapter 410, division 131);

(z) Organ transplant services, as described in the Transplant Services Program rules (OAR chapter 410, division 124);

(aa) Outpatient hospital services, including clinic services, emergency department services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital, as described in the Hospital Services Program rules (OAR chapter 410, division 125);

(bb) Physician, podiatrist, nurse Practitioner and licensed physician assistant services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(cc) Physical therapy, as described in the Physical and Occupational Therapy and the Hospital Services Program rules (OAR chapter 410, division 131);

(dd) Post-hospital extended care benefit, as described in OAR chapter 410, division 120 and 141 and Seniors and People with Disabilities (SPD) program rules;

(ee) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services Program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services Program (OAR chapter 410, division 148) and the Hospital Services Program rules (OAR chapter 410, division 125);

(ff) Preventive services, as described in the Medical-Surgical Services (OAR chapter 410, division 130) and the Dental/Denturist Services Program rules (OAR chapter 410, division 123) and prevention guidelines associated with the Health Service Commission's Prioritized List of Health Services (OAR 410-141-0520);

(gg) Private duty nursing, as described in the Private Duty Nursing Services Program rules (OAR chapter 410, division 132);

(hh) Radiology and imaging services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130), the Hospital Services Program rules (OAR chapter 410, division 125), and Dental Services Program rules (OAR chapter 410, division 123);

(ii) Rural health clinic services, as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);

(jj) School-based health services, as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);

(kk) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Program rules (OAR chapter 410, division 129) and Hospital Services Program rules (OAR chapter 410, division 125);

(ll) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation Program rules (OAR chapter 410, division 136);

(mm) Vision services as described in the Visual Services Program rules (OAR chapter 410, division 140).

(3) Other Authority or Department Divisions, units or Offices, including Vocational Rehabilitation, AMH, and SPD may offer services to Medicaid eligible clients, which are not reimbursed by or available through the Division of Medical Assistance Programs.

Stat. Auth.: ORS 413.042 Stats. Implemented: ORS, 414.025, 414.065 & 414.705

410-120-1200 - Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of (1) Certain services or items are not covered under any program or for any group of eligible clients. If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

(2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

(a) Not expected to significantly improve the basic health status of the client as determined by Division staff, or its contracted entities, for example, the Division's Medical Director, medical consultants, dental consultants or Quality Improvement Organizations (QIO);

(b) Not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury;

(c) Determined not medically or dentally appropriate by Division staff or authorized representatives, including Acumentra or any contracted utilization review organization;

(d) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his or her scope of practice or licensure;

(e) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the client. Examples include exams for employment or insurance purposes;

(f) Provided by friends or relatives of eligible clients or members of his or her household, except when the friend, relative or household member:

(A) Is a health professional, acting in a professional capacity; or

(B) Is directly employed by the client under the Department of Human Services (Department) Seniors and People with Disabilities Division (SPD) Home and Community Based Waiver or the SPD administrative rules, OAR 411-034-000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) Is directly employed by the client under the Children, Adults and Families Division (CAF) administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor client (under the age of 18) must not be legally responsible for the client in order to be a provider of personal care services;

(g) For services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Division's administrative rules;

(h) Needed for purchase, repair or replacement of materials or equipment caused by adverse actions of clients to personally owned goods or equipment or to items or equipment that the Division rented or purchased;

(i) Related to a non-covered service; some exceptions are identified in the individual provider rules. If the Division determines the provision of a service related to a non-covered service is cost-effective, the related medical service may, at the discretion of the Division and with Division prior authorization (PA), be covered;

(j) Considered experimental or investigational, including clinical trials and demonstration projects, or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(k) Identified in the appropriate program rules including the Division's Hospital Services Program administrative rules, Revenue Codes Section, as non- covered services.

(l) Requested by or for a client whom the Division has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(m) For copying or preparing records or documents that except those Administrative Medical Reports requested by the branch offices or the Division for casework planning or eligibility determinations;

(n) Whose primary intent is to improve appearances;

(o) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

(p) For the purpose of establishing or reestablishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence,

(q) Items or services which are for the convenience of the client and are not medically or dentally appropriate;

(r) The collection, processing and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled;

(s) Educational or training classes that are not medically appropriate (Lamaze classes, for example);

(t) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;

(u) Plasma infusions for treatment of Multiple Sclerosis;

(v) Post-mortem exams or burial costs, or other services subsequent to the death of a client;

(w) Radial keratotomies;

(x) Recreational therapy;

(y) Telephone calls, except for:

(A) Tobacco cessation counseling, as described in OAR 410-130- 0190;

(B) Maternity case management as described in OAR 410-130-0595;

(C) Telemedicine as described in OAR 410-130-0610; and

(D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and ~~chemical dependency~~ substance use disorder procedure code and reimbursement rates published by the Addiction and Mental Health Division;

(z) Transsexual surgery or any related services or items;

(aa) Weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs. Food supplements will not be authorized for use in weight loss;

(bb) Whole blood (whole blood is available at no cost from the Red Cross); the processing, storage and costs of administering whole blood are covered;

(cc) Immunizations prescribed for foreign travel;

(dd) Services that are requested or ordered but not provided (i.e., an appointment which the client fails to keep or an item of equipment which has not been provided to the client);

(ee) Transportation to meet a client's personal choice of a provider;

(ff) Pain center evaluation and treatment for unfunded condition/treatment pairs on the Oregon Health Services Commission's Prioritized List of Health Services;

(gg) Alcoholics Anonymous (AA) and other self help programs;

(hh) Medicare Part D covered prescription drugs or classes of drugs, and any cost sharing for those drugs, for Medicare-Medicaid Fully Dual Eligible clients, even if the Fully Dual Eligible client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for benefit package.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025

410-120-1210 - Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based upon the benefit package for which they are eligible.. 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 each of the 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 Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

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

(iii) ~~Chemical dependency~~ Substance use disorder treatment and recovery services provided through local ~~alcohol and drug~~ substance use disorder treatment and recovery providers;

(iv) Mental health services based on the HSC Prioritized List of Health Services, 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;

(B) 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 Standard:

(A) Benefit Package identifier code: KIT;

(B) Eligiblity criteria: Adults and childless couples who are eligible through the 1115 Medicaid expansion waiver and meet Authority-adopted income and other eligibility criteria; the Department identifies these clients through the program acronym, OHP-OPU;

(C) Coverage includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

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

(iii) Outpatient ~~chemical dependency~~ substance use disorder treatment and recovery services provided through local ~~alcohol and drug~~ substance use disorder treatment and recovery providers;

(iv) Outpatient mental health services based on the HSC Prioritized List of Health Services, 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.

(B) Limitations: The following services have limited coverage (Refer to the cited OAR chapters and divisions for details):

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

(ii) Selected durable medical equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Other limitations as identified in individual Division program administrative rules.

(C) Exclusions: The following services are not covered. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for ~~chemical dependency~~ substance use disorder treatment and recovery services(OAR chapter 410, division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home health services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency medical transportation (OAR chapter 410, division 136);

(vi) Occupational therapy services (OAR chapter 410, division 131);

(vii) Physical therapy services (OAR chapter 410, division 131);

(viii) Private duty nursing services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and language therapy services (OAR chapter 410, division 129);

(x) 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);

(xi) Other limitations as identified in individual Division program administrative rules, chapter 410.

(c) 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:

(i) Services covered by Medicare and OHP Plus as described in section (4) of these rules;

(D) Limitations:

(i)The same as OHP Plus, as described in section (4) of these rules;

(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;

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

(A) Benefit Package identifier code MED:

(B) Eligibility criteria: Eligibleclients 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.

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

(A) Benefit Package identifier CWM:

(B) Eligibility criteria: Eligible clientsare 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.

(f) CAWEM Plus-CHIP Prenatal coverage for CAWEM (benefit code CWX) - refer to OAR 410-120-0030 for coverage.

(4) 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, ~~chemical dependency~~ 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 Fee-for-Service Hospital Services Program rule (OAR 410 Division 125).

(d) Primary Care Managers (PCM):

(A) These clients are enrolled with a PCM for their medical care;

(B) Most non-emergency services provided to clients enrolled with a PCM require referral from the PCM.

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

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.706, 414.707, 414.708, 414.710

410-120-1855 - Client's Rights and Responsibilities

(1) Division of Medical Assistance Programs (Division) clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, ~~chemical dependency~~ substance use disorder or family planning services without getting a referral from a Primary Care Practitioner (PCP) or other provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the Division client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive Division covered services that meet generally accepted standards of practice and are medically appropriate;

(l) To obtain covered preventive services;

(m) To receive a referral to specialty providers for medically appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, ~~chemical dependency~~ substance use disorder or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 -- Patient Self-Determination Act;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with the Division and receive a response as defined in OAR 410-120-1860 and 410120-1865;

(t) To request an Administrative Hearing with the Oregon Health Authority (Authority);

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of Authority privacy practices.

(2) Division clients shall have the following responsibilities:

(a) To treat the providers and clinic's staff with respect;

(b) To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use emergency services appropriately;

(g) To give accurate information for inclusion in the clinical record;

(h) To help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the provider that his or her health care is covered with the Division before services are received and, if requested, to show the provider the OMAP Medical Care Identification form;

(n) To tell the Department worker of a change of address or phone number;

(o) To tell the Department worker if the Division client becomes pregnant and to notify the Department worker of the birth of the Division client's child;

(p) To tell the Department worker if any family members move in or out of the household;

(q) To tell the Department worker and provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(r) To pay for non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist the Division in pursuing any TPR available and to pay the Division the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the Division; and

(v) To sign an authorization for release of medical information so that the Authority can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 414.025 & 414.065

2-1-10

7-1-10 (Hk -Stats)

9-1-10 (Hk)