

Secretary of State
NOTICE OF PROPOSED RULEMAKING
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (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
Annual Updates; Relative Value Unit (RVU) Weight; Clinical Lab, ASC
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

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

ADOPT:

AMEND: OAR 410-120-1340

REPEAL: OAR 410-120-1340(T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742 & 414.743

RULE SUMMARY

The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible clients. The Division temporarily amends OAR 410-120-1340 to implement the annual updates by the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services, Clinical Lab and Ambulatory Surgical Centers.

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.

February 19, 2016 by 5 p.m.

Send comments to: dmap.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)



Signature

Rhonda Busek

Printed name

12/22/15

Date

Note: Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin*. A Rulemaking Hearing may be requested in writing by 10 or more people, or by an association with 10 or more members, within 21 days following notice publication or 28 days from the date notice was sent to people on the agency's interested party mailing list, whichever is later. In such cases a Hearing Notice must be published in the *Oregon Bulletin* at least 14 days before the hearing.

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)
Agency and Division

410

Administrative Rules Chapter Number

Annual Updates; Relative Value Unit (RVU) Weight; Clinical Lab, ASC

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

In the Matter of: The amendment of OAR 410-120-1340 and the repeal of OAR 410-120-1340(T)

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742 & 414.743

Need for the Rule(s): The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible clients. The Division temporarily amends OAR 410-120-1340 to implement the annual updates by the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services, Clinical Lab and Ambulatory Surgical Centers.

Documents Relied Upon, and where they are available: Federal register, Vol. 80, No.220 published November 16, 2015
<https://www.federalregister.gov/regulations/0938-AS40/cy-2016-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions-to-medica>.

Fiscal and Economic Impact: Amending these rules will be budget neutral to the Authority and no impact to other state agencies, local government, and clients. Small businesses impact will vary depending upon the rate of utilization and how the RVU weight changes for that particular procedure code; some will go up and some will go down.

Statement of Cost of Compliance:

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

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 percent of the total OHP population. The Division does not have available information to estimate the percentage of these medical practices that are small businesses. The impact to these smaller provider groups will vary depending upon the rate of utilization and how the RVU weight changes for that particular specialty. The RVU update is a standard reimbursement methodology for all payers, and CMS calculates the costs associated with the visit and adjusts the RVU weight to account for variations in office costs and other factors, as they do for the clinical lab and ambulatory surgical centers.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None

c. Equipment, supplies, labor and increased administration required for compliance: None

How were small businesses involved in the development of this rule? Because these proposed rules implement the annual RVU, ASC and Clinical Lab update by the Centers for Medicare and Medicaid, small business providers did not participate in the development of these rules.

Administrative Rule Advisory Committee consulted?: No. If not, why?: Because the proposed rules implement the annual update to the RVUs, ASC and Clinical Lab by Centers for Medicare and Medicaid, a formal rule advisory committee was not consulted.

Signature

Printed name

Date

410-120-1340

Payment

(1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.

(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:

(a) The amount billed;

(b) The Division maximum allowable amount or;

(c) Reimbursement specified in the individual program provider rules.

(5) Amount billed may not exceed the provider's "usual charge" (see definitions).

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2015-2016 Total RVU weights published in the Federal Register, Vol. 7980, November 1316, 2014 2015 to be effective for dates of services on or after January 1, 20152016:

(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;

(B) For professional services typically performed in a facility, the Facility Total RVU weight;

(C) The Division applies the following conversion factors:

(i) \$40.79 for labor and delivery codes (59400-59622);

(ii) \$36.0666 for Federally Qualified primary care codes billed by providers meeting the criteria in OAR 410-130-0005 for dates of service between January 1, 2013 and December 31, 2014;

(iii) \$27.82 for Oregon primary care providers and services not specified in sub-paragraph (ii). A current list of primary care CPT, HCPCS, and provider specialty codes is available at <http://www.oregon.gov/oha/healthplan/Pages/providers.aspx>

http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(iv) \$25.48 for all remaining RVU weight based CPT/HCPCS codes.

(D) Rate calculation: Effective January 1, 20152016, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) $(\text{Work RVU}) \times (\text{Work GPCI of } 1) + (\text{Practice Expense RVU}) \times (\text{Practice GPCI of } 0.974) + (\text{Malpractice RVU}) \times (\text{Malpractice GPCI of } 0.708)$;

(ii) Sum in paragraph (D)(i) multiplied by the applicable conversion factor in paragraph (C) .

(b) Non RVU based rates:

(A) \$20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

(B) Clinical lab codes are priced at 70 percent of the ~~2015-2016~~ Medicare clinical lab fee schedule;

(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80 percent of the ~~2014 2016~~ Medicare fee schedule;

(D) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed, the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25 percent. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling;

(F) Individual provider rules may specify reimbursement rates for particular services or items.

(7) The rates in section (6) are updated periodically and posted on the Authority web site at

<http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx>

http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(8) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.

(9) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(10) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.

(11) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities and psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by APD for out-of-state nursing facilities.

(12) The Division may not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent, or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(13) The Division may not make a separate payment or copayment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);

(c) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).

(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(15) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;

(b) The Division pays the allowable rate for covered services that are not covered by Medicare.

(16) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.

(17) The Division payments, including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(18) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

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