

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*
 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
Cheryl Peters	500 Summer St NE, Salem, OR 97301
Rules Coordinator	Address
DMAP.Rules@dhsosha.state.or.us	503-945-6527
Telephone	Telephone

RULE CAPTION

Align claim filing with CCO rules, clarify language for billing clients, technical corrections for forms
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

10/15/13	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Cheryl Peters
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: 410-120-1280, 410-120-1300, 410-120-1400, 410-120-1860

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth. : ORS 413.042, 414.065, 183.341

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065, 414.085, 414.019, 414.055, 183.411 - 183.470

RULE SUMMARY

The General Rules program administrative rules govern Division payments for services to clients.
 OAR 410-120-1280- Billing: Rewriting rule for readability and clarification when clients can be billed for non-covered services and adding a form used as the financial responsibility waiver.
 OAR 410-120-1300- Timely Filing: Revise language to align with claim submission timelines with those used for CCOs.
 OAR 410-120-1400- Provider Sanctions: Strengthens relationship between OAR 410-120-1280, Billing, and discretionary sanctions.
 OAR 410-120-1860- Contested Case Hearing Procedures: Adds language about the form number, corrects rule reference, aligns "good cause" language with OAR 137-003-050.

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.

10/17/13 by 5:00 p.m.

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

	Rhonda Busel	9-12-13
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

Align claim filing with CCO rules, clarify language for billing clients, technical corrections for forms	
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 410-120-1280, 410-120-1300, 410-120-1400, 410-120-1860

Statutory Authority: ORS 413.042, 414.065, 183.341

Other Authority:

Stats. Implemented: ORS 414.025, 414.065, 414.085, 414.019, 414.055, 183.411 - 183.470

Need for the Rule(s): The General Rules program administrative rules govern Division payments for services to clients.

OAR 410-120-1280- Billing: Rewriting rule for readability and clarification when clients can be billed for non-covered services and adding a form used as the financial responsibility waiver.

OAR 410-120-1300- Timely Filing: Revise language to align with claim submission timelines with those used for CCOs.

OAR 410-120-1400- Provider Sanctions: Strengthens relationship between OAR 410-120-1280, Billing, and discretionary sanctions.

OAR 410-120-1860- Contested Case Hearing Procedures: Adds language about the form number, corrects rule reference, aligns "good cause" language with OAR 137-003-050.

Documents Relied Upon, and where they are available:

Fiscal and Economic Impact: See Below

Statement of Cost of Compliance:

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

Amending rule 410-120-1280, 410-1201400 and 410-120-1860 will have no fiscal impact on the Authority other state agencies, local government, clients, the public, or businesses, including small businesses.

Amending rule 410-120-1300 may have a fiscal impact to small provider groups who do not bill their health care claims in a timely manner. 90% of the population are enrolled in CCOs who have been under this time frame for claims for several years, so the impact would be to those few providers who see less than 10% of the population and submit bills older than 4 month from date of service.

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. OAR 410-120-1280 provides a form that providers would fill out in order to bill a client for non covered services. The form includes information required from a provider under the previous rule but without the ease of a preprinted form.

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

Amending this rule 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?

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 n meetings referenced above. Those invited are made up of large and small providers groups and associations.

Administrative Rule Advisory Committee consulted?: Yes, a RAC was held on August 26, 2013, details are as outlined in the question above.

If not, why?:

Rhonda Busek

Signature

Rhonda Busek 9-12-13

Printed name

Date

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

410-120-1280

Billing

(1) (a) A provider enrolled with the Authority or providing services to a client in a CCO or PHP under the Oregon Health Plan (OHP) must not seek payment, from the client for any services covered by Medicaid fee-for-service or through contracted health care plans.:

(a) A client cannot be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client cannot be billed for services or treatment that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(2) For Medicaid covered services the provider must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division Program rules.

(23) Providers shall only bill a client or a financially responsible relative or representative of that client in the following situations:

, except any coinsurance, co-payments, and deductibles expressly authorized by Oregon Administrative Rules chapter 410 division 120 or 141:

(1) A provider enrolled with the Division of Medical Assistance Programs (Division) must bill using the Authority assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available, pursuant to 410-120-1260.

(2) For Medicaid covered services the provider must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division Program rules:

(a) A provider enrolled with the Authority or providing services to a client in a CCO or PHP under the Oregon Health Plan (OHP) must not seek payment for any services covered by Medicaid fee-for-service or through contracted health care plans, except any coinsurance, co-payments, and deductibles expressly authorized by Oregon Administrative Rules chapter 410 division 120 or 141:

(A) A Division client for covered benefits; or

~~(B) A financially responsible relative or representative of that individual.~~

~~_(b) Exceptions under which an enrolled provider may seek payment from an eligible client or client representative are described below:~~

~~(aA) The Forprovider may seek~~ any applicable coinsurance, copayments and deductibles expressly authorized ~~by Division rules~~ in OAR chapter 410, division 120, OAR chapter 410, division 141, or any other individual Division Program rules;

~~(bB) The client did not inform the provider of their OHP coverage, enrollment in a prepaid health plan (PHP) or coordinated care organization (CCO) eligibility, of OHP managed health plan enrollment, or of other third party insurance coverage at the time of or after a service was provided. Therefore, the provider could not bill the appropriate payer, for reasons including, but not limited to, the lack of prior authorization, or the time limit to submit the claim for payment has past. , either at the time the service was provided or subsequent to the provision of the service or item, and as a result the provider could not bill the Division, the managed health care plan, or third party payer for any reason, including timeliness of claims, lack of prior authorization, etc. The provider must verify eligibility, pursuant to OAR 410-120-1140, and document attempts to obtain coverage information prior to billing the client on eligibility or enrollment;~~

~~(cC) The client became eligible for Division benefits retroactively but did not meet all of the other established criteria required to receive the service described in the General Rules Program rules and the appropriate Division Program rules (i.e., priorretroactive authorization);~~

~~(dD) A third party payerresource made payments directly to the client for services provided;~~

~~(eE) The client has a limited benefit package:~~

~~(A) Citizen Alien Waived Emergency Medical Program (CWM), may be billed for services that are not benefits of those programs, refer to OAR 410-120-1210 for coverage. The provider must document that the client was informed in advance that the service or item would not part of their benefit coverage by the Division. A DMAP 3165 is not required for these services.~~

~~_did not have full Division benefits. Clients receiving a limited Medicaid coverage, such as the Citizen Alien Waived Emergency Medical Program, may be billed for services that are not benefits of those programs. The provider must document pursuant to section (3) of this rule that the client was informed that the service or item would not be covered by the Division[TA1];~~

~~(fF) The client has requested a continuation of benefits during the contestedadministrative case hearing process and the final decision was not in favor of the client. The client iswill be responsible for any charges incurred for the denied~~

service, on or after the effective date on the Notice of Action or Notice of Appeal Resolution, since the effective date of the initial notice of denial denial. The provider must complete the DMAP 3165 pursuant to section (1)(e) of this rule before providing these services;

~~(G) A client cannot be billed for services or treatment that has been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.);~~

~~(gH) The charge is for a copayment when a client is required to make a copayment as outlined in the OAR 410-120-1230 Division's General Rules Program rule (410-120-1230) and individual Division Program rules;~~

~~(gh) In exceptional circumstances, a client may decide to privately pay for request continuation of a covered service. In this situation, the provider may bill the client if the provider informs the client while asserting the right to privately pay for that service. Under this exceptional circumstance, a client can be billed for a covered service if the client is informed in advance of receiving the specific service of all of the following:~~

~~(Ai) That the requested service is a covered service, and that the appropriate payer (the Division or, PHP, CCO or third party payer) would pay the provider would be paid in full for the covered service if the claim is submitted to the Division or the client's managed care plan, if the client is a member of a managed care plan; and~~

~~(Bii) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer Division, or the client's managed care plan is would required to pay for the service, and that the provider client cannot bill the client be billed for an amount greater than the amount the appropriate payer would pay maximum Division reimbursable rate or managed care plan rate, if the client is a member of a managed care plan; and~~

~~(iii) That the provider cannot require the client to enter into a voluntary payment agreement for any amount for the covered service; and~~

~~(Civ) That the client knowingly and voluntarily agrees to pay for the covered service; ;~~

~~, the provider must not submit a claim for payment to the Division or the client's managed care plan; and~~

~~(Dv) The provider must be able to documents in writing, signed by the client or the client's representative, that the provider gave the client was provided the information described in (43)(hg)(A-C) above; that the client had was provided an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative; and the client agreed to privately pay for the service be responsible for payment by signing an agreement incorporating all of the information described above. The client must be given a copy of the signed agreement; ;~~

(E) A provider ~~shall~~must not submit a claim for payment for covered services to the Division or to the client's ~~managed care plan~~PHP, CCO or third party payer that is subject to such agreement.

~~(43) Non-covered Medicaid services:~~

~~(ah) A provider may bill a client for services that are not covered by the Division, PHP, or CCO non-covered services (see definition of non-covered services) that are not covered by the Division or the managed care plan. Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (DMAP 3165), or a facsimile containing all of the information and elements of the DMAP 3165, as shown in Table 3165 of this rule. However, the client must be informed in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the client or client's representative is financially responsible for payment for the specific service. The completed DMAP 3165, or facsimile, is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. Providers must be make a copy of the completed DMAP 3165, or facsimile, available to the Division or applicable PHP or CCO upon request. A facsimile of the DMAP 3165 may be used. The facsimile must contain all of the information and elements of the DMAP 3165 able to document in writing signed by the client or client's representative, that the client was provided this information and the client knowingly and voluntarily agreed to be responsible for payment;~~

~~(b) Services which are considered non-covered are listed in the following rules (in rule precedence order):~~

~~(A) OAR 410-141-0480, Benefit Package of Covered Services; and~~

~~(B) OAR 410-141-0520, Prioritized List of Health Services; and~~

~~(C) OAR 410-120-1200, Medical Assistance Benefits: Excluded services and limitations; and~~

~~(D) Applicable Division Program rules;~~

~~(cb) A client cannot be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division.;~~

~~(dc) A client cannot be billed for services or treatment that has have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.);~~

~~(4) Code Set requirements:~~

(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions and payments. Code Set has the meaning established in 45 CFR 162.103 and it includes the codes and the descriptors of the codes. -Federal Code Set requirements are mandatory and the Division lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;

(b) The Division will adhere to the Code Set requirements in 45 CFR 162.1000 — 162.1011;

(c) Periodically, the Division will update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division will apply the national code in effect on the date of request or date of service;

(d) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone should not be construed as coverage, or a covered service by the Division;

(ee) The Division adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS)-. This code adoption should not be construed coverage, or a covered service by the Division.

(5) Claims:

(a) Upon submission of a claim to the Division for payment, the provider agrees that it has complied with all Division Program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;

(b)- A provider enrolled with the Division must bill using the Authority assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available, pursuant to 410-120-1260.

(c) The provider must not bill the Division more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Division Program rules;

(d) All claimsM-must be submittedbilled on the appropriate form as described in the individual Division Program rules or submitted electronically in a manner authorized in OAR chapter 943, division 120by the Authority's Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. Seq.:-

(e) Must be for services provided within the provider's licensure or certification;

(f) Must be submitted after (unless specified otherwise in the Division's individual Program rules):

(A) Delivery of service; or

(B) Dispensing, shipment or mailing of the item.

(g) It is the responsibility of the provider to submit true and accurate information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;

(h) A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements.

(i) A provider or its contracted agency (including billing providers) shall not submit or cause to be submitted:

(A) Any false claim for payment;

(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;

(C) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;

(D) Any claim for furnishing specific care, item(s), or service(s) that have not been provided.

(j) The provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the provider identifies an overpayment made by the Division;

(k) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued such improper billing practices and has had an opportunity for a contested case hearing, shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of such violation. ;

~~(5) Upon submission of a claim to the Division for payment, the provider agrees that it has complied with all Division Program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement.~~

~~(6) All billings must be for services provided within the provider's licensure or certification.~~

~~(7) It is the responsibility of the provider to submit true and accurate information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information.~~

~~(8) A claim must not be submitted prior to delivery of service. A claim must not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in the Division's individual Program rules.~~

~~(9) A claim is considered a valid claim only if all required data is entered on or attached to the claim form. See the appropriate provider rules and supplemental information for specific instructions and requirements. Also, see valid claim in the Definitions section of these rules.~~

~~(10) The HIPAA Codes rules, 45 CFR 162, apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions and payments. Code Set has the meaning established in 45 CFR 162.100, and it includes the codes and the descriptors of the codes. These federal Code Set requirements are mandatory and the Division lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services.~~

~~(a) The Division will adhere to the national Code Set requirements in 45 CFR 162.1000 — 162.1011, regardless of whether a request is made verbally, or a claim is submitted on paper or electronically;~~

~~(b) Periodically, the Division will update its provider rules and tables to conform to national codes. In the event of an alleged variation between a Division-listed code and a national code, the Division will apply the national code in effect on the date of request or date of service and the provider, and the Division-listed code may be used for the limited purpose of describing the Division's intent in identifying the applicable national code;~~

~~(c) Only codes with limitations or requiring prior authorization are noted in rules. National Code Set issuance alone should not be construed as Division coverage, or a covered service.~~

~~(d) The Division adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS) to be effective January 1, 2007. This code adoption should not be construed as Authority coverage, or a covered service.~~

~~(641)~~ Diagnosis code requirement:

(a) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis Code Set, unless specifically excluded in individual Division Program rules;

~~(b) When billing using ICD-9-CM codes, all diagnosis codes are required to the highest degree of specificity;~~

(c) Hospitals are always required to bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups.

~~(742)~~ Procedure code requirement:

(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division Program rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided.

(b) For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Division Program rules. Hospitals must follow national coding guidelines:

(ca) When there is no appropriate descriptive procedure code to bill the Division, the provider must use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;

(db) Where there is one CPT, CDT or HCPCS code that according to CPT, CDT and HCPCS coding guidelines or standards, describes an array of services the provider must bill the Division using that code rather than itemizing the services under multiple codes. Providers must not "unbundle" services in order to increase the Division payment.

~~(13) No provider or its contracted agency (including billing providers) shall submit or cause to be submitted to the Division:~~

~~(a) Any false claim for payment;~~

~~(b) Any claim altered in such a way as to result in a payment for a service that has already been paid;~~

~~(c) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;~~

~~(d) Any claim for furnishing specific care, item(s), or service(s) that have not been provided.~~

~~(14) The provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the provider identifies an overpayment made by the Division.~~

~~(15) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued such improper billing practices and has had an opportunity for a contested case hearing, shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of such violation.~~

~~(846) Third party Liabilityresources (TPLR):~~

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort;

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include determining the existence of insurance or other resources, ~~but are not limited to~~ on each date of service by:

~~(A) Determining the existence of insurance or other resource by asking the recipient;~~

~~(AB) Using an insurance database such as Electronic Verification System (EVS) available to the provider;~~

~~(BC) UsingVerifying the client's insurance coverage through the Automated Voice Response (AVR) or sSecure provider web portal on each date of service and at the time of billing.~~

(c) Except as noted in ~~(846) (d) (A through E)~~ below, when third party coverage is known to the provider, ~~as indicated through AVR, Secure provider web portal or any other means available~~, prior to billing the Division the provider must:

(A) Bill the TPLR; and

(B) Except for pharmacy claims billed through the Division's point-of-sale system the provider must have waited 30 days from submission date of a clean claim and have not received payment from the third party; and

(C) Comply with the insurer's billing and authorization requirements; and

(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.

(d) In accordance with federal regulations the provider must bill the TPLR prior to billing the Division, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility ~~Services~~ for the ~~Mentally Retarded (ICF/MR);~~ Individuals with Intellectual Disabilities (ICF/ID)

(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;

(C) The covered health services are prenatal and preventive pediatric services;

(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the provider may bill the insurer or liable party or place a lien against a settlement or the provider may bill the Division. The provider may not both place a lien against a settlement and bill the Division. The provider may withdraw the lien and bill Division within 12 months of the date of service. If the provider bills Division the provider must accept payment made by the Division as payment in full.

~~(F)~~(e) The provider must not return the payment made by the Division in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement:

(A)~~i~~ In the circumstances outlined in ~~(816)~~(816)(d)(A through E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division will process the claim and, if applicable, will pay the Division allowable rate for these services and seek reimbursement from the liable third party insurance plan;

~~(B)~~(B) In making the decision to bill the Division the provider should be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than the Division, and that, once the Division makes payment no additional billing to the third party is permitted by the provider.

~~(e)~~(f) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-

covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first;

~~(f)~~(g) Providers are required to submit an Individual Adjustment Request showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit the Individual Adjustment Request within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery and/or sanction;

(A) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) ~~Except as described in (15),~~ Any provider who accepts third party payment for furnishing a service or item to a Division client after having billed the Division, shall:

(i) Submit an Individual Adjustment Request indicating the amount of the third party payment, after submitting a claim to the Division, ~~F~~ following instructions in the individual Division Program provider rules and supplemental billing ~~information, indicating the amount of the third party payment;~~ or

(ii) When the provider has already accepted payment from the Division for the specific service or item, the provider shall make direct payment of the amount of the third party payment to the Division. The check to repay the Division shall include ~~When the provider chooses to directly repay the amount of the third party payment to the Division, the provider must indicate~~ the reason the payment is being made and ~~must submit with the check either:~~

(I) An Individual Adjustment Request which identifies the original claim, name and number of the client, date of service and item(s) or service(s) for which the repayment is made; or

(II) A copy of the Remittance Advice showing the original Division payment.

~~(C) Any provider who accepts payment from a client, or client's representative, and is subsequently paid for the service by the Division, shall reimburse the client, or their representative, the full amount of their payment.-~~

~~(h)~~(g) The Division reserves the right to make a claim against any third party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, requesting the provider to bill the third party and to refund the Division in accordance with ~~(15) of~~ this rule;

~~(h)~~(i) For services rendered to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment and the provider must honor that request. Under federal regulation, a provider agrees not to charge a

beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so.

(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued and Medicare denial must be obtained prior to submitting the claim for payment to Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.

(947) Full use of alternate resources:

(a) The Division will generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in subsection (18) of this rule, alternate resources may be available:

(A) Under a federal or state worker's compensation law or plan;

(B) For items or services furnished by reason of membership in a prepayment plan;

(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity, such as:

(i) Armed Forces Retirees and Dependents Act (CHAMPVA);

(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); and

(iii) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or

(E) Through other reasonably available resources.

(180) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR ~~35.64~~136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under ~~a s~~Public Law 93, Section 638 agreement are payers of last resort, and are not considered an alternate resource or TPLR;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPLR.

~~(1911)~~ **Table 120-1280**

(12) Table 120-1365

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.085

410-120-1300

Timely Submission of Claims

(1) All claims for services must be submitted within 412 months of the date of service. The date of service for an inpatient hospital stay is considered the date of discharge.

(2) A claim that was submitted within 412 months of the date of service, but that was denied, may be resubmitted within 618 months of the date of service. These claims must be submitted to the Division of Medical Assistance Programs (Division) at the address listed in the provider contacts document. The provider must present documentation acceptable to the Division verifying the claim was originally submitted within 412 months of the date of service, unless otherwise stated in individual provider rules. Acceptable documentation is:

(a) A remittance advice from the Division that shows the claim was submitted before the claim was ~~fourteen months-year~~ old;

(b) A copy of a billing record or ledger showing dates of submission to the Division.

(3) Exceptions to the 412-month requirement that may be submitted to the Division are as follows:

(a) Pregnancy;

(b) Medicare id the primary payer;

(c) When the Division or the client's branch office has made an error that caused the provider not to be able to bill within 412 months of the date of service. The Division must confirm the error;

(~~d~~) When a court or an Administrative Law Judge has ordered the Division to make payment;

(~~e~~) When the Authority determines a client is retroactively eligible for Division medical coverage and more than 412 months have passed between the date of service and the determination of the client's eligibility.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-120-1400 Provider Sanctions

- (1) The Authority recognizes two classes of provider sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.
- (2) Except as otherwise noted, the Authority will impose Provider Sanctions at the discretion of the Authority Director or the Administrator of the Authority Office whose budget includes payment for the services involved.
- (3) The Division of Medical Assistance Programs (Division) will impose mandatory sanctions and suspend the provider from participation in Oregon's medical assistance programs:
 - (a) When a provider of Medical Services has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws;
 - (b) When a provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services or from the Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services. The Provider will be excluded and suspended from participation with Division for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General;
 - (c) If the provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the Provider submits a Provider enrollment application or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.
- (4) The Division may impose discretionary sanctions when the Division determines that the provider fails to meet one or more of the Division's requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary Sanction include, but are not limited to, when a Provider has:
 - (a) Been convicted of fraud related to any federal, state, or locally financed health care program or committed fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;
 - (b) Been convicted of interfering with the investigation of health care fraud;
 - (c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;
 - (d) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity either:
 - (A) Had his or her health care license suspended or revoked, or has otherwise lost such license; or

- (B) Surrendered his or her license while a formal disciplinary proceeding is pending before such licensing authority.
- (e) Been suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;
- (f) Billed excessive charges (i.e., charges in excess of the usual charge); furnished items or services substantially in excess of the Division client's needs or in excess of those services ordered by a medical provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;
- (g) Failed to furnish medically necessary services as required by law or contract with the Division if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the Division client;
- (h) Failed to disclose required ownership information;
- (i) Failed to supply requested information on subcontractors and suppliers of goods or services;
- (j) Failed to supply requested payment information;
- (k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of the Division or the State of Oregon's Medicaid Fraud Unit conducting their regulatory or statutory functions;
- (l) In the case of a Hospital, failed to take corrective action as required by the Division, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Division;
- (m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The Division:
 - (A) Must have made a reasonable effort to secure payment;
 - (B) Must take into account access of beneficiaries to services; and
 - (C) Will not exclude a community's sole physician or source of essential specialized services.
- (n) Repeatedly submitted a claim with required data missing or incorrect:
 - (A) When the missing or incorrect data has allowed the Provider to:
 - (i) Obtain greater payment than is appropriate;
 - (ii) Circumvent prior authorization requirements;
 - (iii) Charge more than the provider's usual charge to the general public;

(iv) Receive payments for services provided to persons who were not eligible;

(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount or type of health care provided.

(B) Does not comply with the requirements of OAR 410-120-1280.

- (o) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;
- (p) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a Client and payments received from any source;
- (q) Failed to develop, maintain and retain adequate financial or other records that support information submitted on a cost report;
- (r) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;
- (s) Submitted claims or written orders contrary to generally accepted standards of medical practice;
- (t) Submitted claims for services that exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical provider;
- (u) Breached the terms of the Provider contract or agreement. This includes failure to comply with the terms of the provider certifications on the medical claim form;
- (v) Rebated or accepted a fee or portion of a fee or charge for a the Division client referral; or collected a portion of a service fee from the client, and billed the Division for the same service;
- (w) Submitted false or fraudulent information when applying for a the Division assigned provider number, or failed to disclose information requested on the provider enrollment application;
- (x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from the Division;
- (y) Submitted any claim for payment for which payment has already been made by the Division or any other source unless the amount of the payment from the other source is clearly identified;
- (z) Threatened, intimidated or harassed clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the Division;

(aa) Failed to properly account for a Division client's Personal Incidental Funds; including but not limited to using a client's Personal Incidental Funds for payment of services which are included in a medical facility's all-inclusive rates;

(bb) Provided or billed for services provided by ineligible or unsupervised staff;

(cc) Participated in collusion that resulted in an inappropriate money flow between the parties involved, for example, referring clients unnecessarily to another provider;

(dd) Refused or failed to repay, in accordance with an accepted schedule, an overpayment established by the Division;

(ee) Failed to report to Division payments received from any other source after the Division has made payment for the service;

(ff) ~~Collected or made repeated attempts to collect payment from clients for services~~ without following Failure to comply with the requirements listed in OAR 410-120-1280, Billing.

~~covered by the Division, per OAR 410-120-1280, Billing.~~

(5) A provider who has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any billing agent/service, billing provider or other provider, for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension or termination.

(6) Providers must not submit claims for payment to the Division for any services or supplies provided by a person or provider entity that has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension or termination.

(7) When the provisions of subsections (5) or (6) are violated, the Division may suspend or terminate the billing provider or any individual performing provider within said organization who is responsible for the violation(s).

Stat. Auth.: ORS ~~413.042~~ 409.010, 409.040 & 409.050

Stats. Implemented: ORS 414.019, 414.025 & 414.065

410-120-1860

Contested Case Hearing Procedures

(1) These rules apply to all contested case hearings provided by the Division of Medical Assistance Programs (Division) involving a client's health care benefits, except as otherwise provided in OAR 410-141-0263. The hearings are conducted in accordance with the Attorney General's model rules at 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Division for purposes of this rule. Except for 137-003-0528(1)(a), the method described in 137-003-0520(8)-(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of client requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Division contested cases.

(2) Medical provider appeals and administrative reviews involving the Division are governed by OAR 410-120-1560 through 410-120-1600.

(3) Complaints and appeals for clients requesting or receiving medical assistance from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OAR 410-141-~~0360~~-3260 or 0260. This rule describes the procedures applicable when those clients request and are eligible for a Division contested case hearing.

(4) Contested Case Hearing Requests:

(a) A client has the right to a contested case hearing in the following situations upon the timely completion of a request for a hearing:

(A) The Authority acts to deny client services, payment of a claim, or to terminate, discontinue or reduce a course of treatment, or issues related to disenrollment in a CCO or PHP; or

(B) The right of a client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264, when a client of a PHP or 410-141-0364 when a client of a CCO may request a state hearing.

(b) To be timely, a request for a hearing is complete when the Division receives the ~~Authority's Administrative Hearing request form (DMAP 443)~~ Division approved appeal and grievance forms not later than the 45th day following the date of the decision notice;

(c) In the event a request for hearing is not timely, the Division will determine whether the client showed there was good cause, as defined in OAR 137-003-0501(7) for their failure to timely file the hearing request ~~was caused by circumstances beyond the control of the client and enter an order accordingly~~. In determining whether to accept a

late hearing request, the Division requires the request to be supported by a written statement that explains why the request for hearing is late. The Division may conduct such further inquiry as the Division deems appropriate. In determining timeliness of filing a hearing request, the amount of time that the Division determines accounts for circumstances beyond the control of the client is not counted. The Division may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness;

(d) In the event the claimant has no right to a contested case hearing on an issue, the Division may enter an order accordingly. The Division may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has a right to a contested case hearing;

(e) A client who requests a hearing shall be referred to as a claimant. The parties to a contested case hearing are the claimant and, if the claimant has requested a hearing about a decision of a CCO or PHP, the claimant's CCO or PHP;

(f) A client may be represented by any of the persons identified in ORS 183.458. A CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(5) Expedited hearings:

(a) A claimant who feels his or her medical or dental problem cannot wait for the normal review process may be entitled to an expedited hearing;

(b) Expedited hearings are requested using Authority Form 443 or other Division approved appeal and/or hearing forms;

(c) Division staff will request all relevant medical documentation and present the documentation obtained in response to that request to the Division Medical Director or the Medical Director's designee for review. The Division Medical Director or the Medical Director's designee will decide if the claimant is entitled to an expedited hearing within, as nearly as possible, two working days from the date of receiving the documentation applicable to the request;

(d) An expedited hearing will be allowed, if the Division Medical Director or the Medical Director's designee, determines that the claimant has a medical condition which is an immediate, serious threat to claimant's life or health and claimant has been denied a medical service.

(6) Informal conference:

(a) The Division hearing representative and the claimant, and their legal representative if any, may have an informal conference, without the presence of the Administrative law

Judge (ALJ), to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

- (A) Provide an opportunity for the Division and the claimant to settle the matter;
 - (B) Provide an opportunity to make sure the claimant understands the reason for the action that is subject of the hearing request;
 - (C) Give the claimant and the Division an opportunity to review the information that is the basis for that action;
 - (D) Inform the claimant of the rules that serve as the basis for the contested action;
 - (E) Give the claimant and the Division the chance to correct any misunderstanding of the facts;
 - (F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and
 - (G) Give the Division an opportunity to review its action.
- (b) The claimant may, at any time prior to the hearing date, request an additional informal conference with the Authority representative, which may be granted if the Authority representative finds, in his or her sole discretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;
 - (c) The Division may provide to the claimant the relief sought at any time before the Final Order is served;
 - (d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.
- (7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Division or the ALJ, whichever is first. The ALJ will send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth calendar day following the date such an order is effective.
- (8) Contested case hearings are closed to non-participants in the hearing.
- (9) Proposed and Final Orders:
- (a) In a contested case, an ALJ assigned by the Office of Administrative Hearings will serve a proposed order on all parties and the Division, unless, prior to the hearing, the Division notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in

subsection (b) unless the Division notifies the parties and the ALJ that the Division will issue the final order;

(b) If the ALJ issues a proposed order, and a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for the Division's consideration:

(A) The exceptions must be in writing and reach the Division not later than 10 working days after date the proposed order is issued by the ALJ;

(B) After receiving the exceptions, if any, the Division may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority will issue an amended proposed order.

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Division will cancel the dismissal order on request of the party, upon the party being able to show good cause, as defined in OAR 137-003-0501(7), as to why they were -on a showing that the party was unable to attend the hearing and unable to request a postponement ~~for reasons beyond his or her control.~~

(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the claimant's withdrawal of the hearing request is effective the date the claimant withdraws. When claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.

(12) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 183.341 & 413.042

Stats. Implemented: ORS 183.411 - 183.470, 414.025, 414.055 & 414.065