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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/19/2026 6:54 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Transitioning defined term “Client” to “Member”, “CCO Member”, or “Open Card Member” where appropriate.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
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HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026
TIME: 9:00 AM - 9:45 AM
OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1658671365
SPECIAL INSTRUCTIONS:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

In the Oregon Health Authority’s (OHA) external communications, the agency has referred to individuals receiving

services from the Oregon Health Plan (Medicaid) as a “Member” for many years. This rule language change aligns rule language with external communications.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The purpose of this rule change is to improve plain language and grammar. These changes are consistently applied to all rules within chapter 410 (Medical Assistance Programs). The Oregon Health Authority does not expect a disproportional impact to racial equity within any specific community as a result of this rulemaking.

FISCAL AND ECONOMIC IMPACT:

The purpose of this rule change is to improve clarity, plain language, and grammar. These changes do not effect policy, operations, or service delivery. The Oregon Health Authority does not expect any fiscal or economic impact to any entity or individual as a result of this rulemaking.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).
There is no expected economic impact.

(2) Effect on Small Businesses:
None.

(a) Estimate the number and type of small businesses subject to the rule(s);
None.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
None.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-120-0000, 410-120-0025, 410-120-0045, 410-120-0250, 410-120-1140, 410-120-1180, 410-120-1210, 410-120-1260, 410-120-1285, 410-120-1295, 410-120-1300, 410-120-1320, 410-120-1340, 410-120-1360, 410-120-1390, 410-120-1395, 410-120-1397, 410-120-1510, 410-120-1560, 410-120-1580, 410-120-1600, 410-120-1860, 410-120-1865, 410-120-1875, 410-120-1940, 410-120-1960, 410-120-1990

AMEND: 410-120-0000

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Update “Healthier Oregon” definition. Add definition for “Health Evidence Review Commission” and update definition for “OHA Prioritized List of Health Services”.

CHANGES TO RULE:

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), chapter 410 administrative rules, applicable to medical assistance programs. This rule does not include an exhaustive list of program acronyms and definitions. For program and services definitions, see the appropriate OAR in the applicable division of chapter 410 administrative rules, and any appropriate governing acronyms and definitions in other Authority chapters such as 309 and 943 or the Oregon Department of Human Services (Department) administrative rules found in chapters 411, 413, or 461, or contact the Authority.¶
(1) "Abuse" means ~~p~~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 ~~m~~Medically ~~n~~Necessary or ~~m~~Medically ~~a~~Appropriate. It also includes ~~recipient~~Member practices that result in unnecessary cost to the Authority.¶
(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled ~~n~~Nursing ~~f~~Facility or ~~n~~Nursing ~~f~~Facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a Coordinated Care Organization (CCO) member, refer to OAR 410-141-3500.¶
(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶
(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶
(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶
(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶
(7) ~~"Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶~~
~~(8)~~ "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
(~~9~~8) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the Oregon Health Plan (OHP) 729 form through the local Department branch office or requested or approved by the Authority to establish ~~client~~Member eligibility for a ~~m~~Medical ~~a~~Assistance ~~p~~Program or for casework planning.¶
(~~10~~9) "Adults and Youths Discharged from an HRSN Eligible Behavioral Health Facility" means Members who have been discharged from one of the settings listed below within the last 365 calendar days. Eligibility for HRSN Services shall expire on the 366th calendar day after discharge.¶
(a) Acute Care Psychiatric Hospitals as defined in OAR 309-015-0005,¶
(b) Institution for Mental Diseases as defined in 42 CFR 435.1010,¶
(c) Integrated Psychiatric Residential Treatment Facilities and Residential Substance Use Disorders Treatment Programs as defined in OAR 309-022-0105,¶
(d) Residential Treatment Facilities (RTF) as defined in OAR 309-035-0105,¶
(e) Residential Treatment Homes (RTH) as defined in OAR 309-035-0105,¶
(f) Secure Residential Treatment Facilities (SRTF), as defined in OAR 309-035-0105,¶
(g) Psychiatric Residential Treatment Facilities (PRTF) as defined in OAR 309-022-0105, and¶
(h) Residential Substance Use Disorders Treatment Programs as defined in OAR 309-018-0105¶

(1~~1~~0) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 365 calendar days, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections or tribal correctional facilities. Eligibility for HRSN Services shall expire on the 366th calendar day after release from a carceral facility.¶
(1~~2~~1) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
(1~~3~~2) "Adverse ~~d~~Determination" means a determination made that the individual does not require the level of services provided by a ~~n~~Nursing ~~f~~Facility or that the individual does or does not require specialized services.¶
(1~~4~~3) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
(1~~5~~4) "Affiliation" means for ~~p~~Provider requesting enrollment or revalidation as an Oregon Medicaid ~~p~~Provider any of the following:¶
(a) Five (5) percent or greater direct or indirect ownership interest that an individual or entity has in another organization;¶
(b) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization;¶
(c) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization, either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization; includes sole proprietorships;¶
(d) An interest in which an individual is acting as an officer or director of a corporation; or¶
(e) Any payment assignment relationship under 42 CFR 447.10(g).¶
(1~~6~~5) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a ~~p~~Provider.¶
(1~~7~~6) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for ~~senior~~older adults and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶
(1~~8~~7) "All-Inclusive Rate" or "Bundled Rate" means the ~~n~~Nursing ~~f~~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.¶
(1~~9~~8) "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 individuals (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), and federally recognized American Indian tribes).¶
(~~20~~19) "Alternative Care Settings" means sites or groups of ~~p~~Practitioners that provide care to ~~m~~Members under contract with a ~~Ma~~Coordinagted Care ~~Entity (MCE~~Organization (CCO), including urgent care centers, ~~h~~Hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶
(2~~1~~0) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
(2~~2~~1) "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).¶
(2~~3~~2) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶
(2~~4~~3) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and 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.¶
(2~~5~~4) "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).¶
(2~~6~~5) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
(2~~7~~6) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
(2~~8~~7) "Appeal" means a request for review of an ~~a~~Adverse ~~d~~Determination, ~~a~~Action or as it relates to a~~n MCE~~ CCO an adverse benefit determination.¶

(2~~9~~8) "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~~older adults and people with disabilities.¶
(~~30~~29) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or ~~t~~Telehealth services may include audio and video, audio without video, ~~client or m~~Member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages.¶
(3~~1~~0) "At Risk of Homelessness" means a Member who:¶
(a) Has an income that is 30 percent or less than the area median income where the individual resides according to the most recent available data from the U.S. Department of Housing and Urban Development; and,¶
(b) Lacks sufficient resources or support networks to prevent their homelessness; and,¶
(c) Meets any HRSN Housing and Nutrition Clinical Risk Factor as further defined in OAR 410-120-2005 in Tables 2-3.¶
(d) At Risk of Homelessness does not include individuals in Category 1 of the HUD Homeless definition (24 CFR 91.5 (1)). Category 1 (also called "literally homeless") includes people residing in Transitional Housing, as defined in 24 CFR 578.3. Recovery Housing is not Transitional Housing, and a Member in Recovery Housing may be eligible for HRSN Housing Supports.¶
(3~~2~~1) "Atypical Provider" means an entity able to enroll as a Billing Provider (BP) or ~~r~~Rendering ~~p~~Provider for ~~m~~Medical ~~a~~Assistance ~~p~~Programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
(3~~3~~2) "Audiologist" means an individual licensed to practice ~~a~~Audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(3~~4~~3) "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.¶
(3~~5~~4) "Audio ~~o~~Only" means the use of audio technology, permitting real-time communication between a health care ~~p~~Provider and a ~~m~~Member for the purpose of diagnosis, consultation or treatment. "Audio ~~o~~Only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.¶
(3~~6~~5) "Automated Voice Response (AVR)" means a computer system that provides information on ~~client~~Members' current eligibility status from the Division by computerized phone response.¶
(3~~7~~6) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(3~~8~~7) "Behavioral Health Assessment" means a qualified mental health professional's determination of a ~~m~~Member's need for mental health services.¶
(3~~9~~8) "Behavioral Health Case Management" means services provided to ~~m~~Members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service ~~p~~Providers.¶
(39) "Behavioral Health Division" means the Division within the Authority that administers mental, emotional, and behavioral health and substance use disorder programs and services.¶
(40) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(41) "Benefit Package" means the package of covered health care services for which the ~~client~~Member is eligible.¶
(42) "Billing Agent" or "Billing Service" means third party or organization that contracts with a ~~p~~Provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the ~~p~~Provider.¶
(43) "Billing Provider (BP)" means an individual, ~~a~~Agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a ~~r~~Rendering ~~p~~Provider and has been delegated the authority to obligate or act on behalf of the ~~r~~Rendering ~~p~~Provider.¶
(44) "Buying-Up" means the practice of obtaining ~~client~~Member payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶
(45) "By Report (BR)" means services designated, as BR requires 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 shall facilitate evaluation.¶
(46) "Care Coordination" means the act and responsibility of care coordination entities to deliberately organize a ~~client~~Member's services, care activities and information sharing among all participants involved with a ~~client~~Member's care according to the physical, developmental, behavioral, dental, and social needs (including

Health Related Social Needs and Social Determinants of Health and Equity) of the ~~client~~Member. Care Coordination requirements are described in OAR 410-120-1215, 410-120-1221, 410-120-1225, and in accordance with CFR 438.208.¶
(47) "Care Plan" means a care plan that is developed for and in collaboration with the member, their family, representatives or guardian; and in consultation with the ~~m~~Member's ~~p~~Providers, community supports and services, where applicable, to ensure continuity and coordination of a ~~m~~Member's care according to their needs.¶
(48) "Care Profile" means the electronic record the Authority or its designee develops and maintains for all ~~m~~Members. The ~~c~~Care ~~p~~Profile is the platform that receives feeds from different data sources used to identify, track and manage a ~~m~~Member's needs and risk level to direct the frequency of the outreach and care coordination activities/opportunities that shall be offered to the ~~m~~Member.¶
(49) "Case Management Services" means services provided to ensure that CCO ~~m~~Members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case ~~m~~Management ~~s~~Services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder 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 ~~m~~CCO Members to community services and supports that may include referrals to Allied Agencies.¶
(50) "CCO Member" means a Member who is enrolled to receive Medical Assistance Program services though a Coordinated Care Organization (CCO).¶
(51) "Center of Excellence (COE)" means a ~~h~~Hospital, medical center, or other health care ~~p~~Provider that meets or exceeds standards set by the agency for specific treatments or specialty care.¶
(5~~1~~2) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
(5~~2~~3) "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.¶
(5~~3~~4) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(5~~4~~5) "Chiropractic Services" means services provided by a licensed ~~c~~Chiropractor within the scope of practice as defined under state law and federal regulation.¶
(5~~5~~6) "Citizenship Waived Medical (CWM) Benefit Package" means the coverage and limitations defined in OAR 410-134-0005(2) for individuals who met the eligibility requirements in OAR 410-200-0240(1). Benefit Package ended on June 30, 2023. As of July 1, 2023, individuals that met eligibility requirements in OAR 410-200-0240(1) receive the Healthier Oregon Benefit Package described in OAR 410-134-0000.¶
(5~~6~~7) "Citizenship Waived Medical Plus (CWX) Benefit Package" means coverage and limitations described in OAR 410-134-0005(2) for CWM individuals who were pregnant or in their post-partum period and meet the eligibility requirements defined in OAR 410-200-0240(2).~~¶~~
~~(57) "Claimant" means an individual who has requested a hearing~~ Benefit Package ended on June 30, 2023. As of July 1, 2023, individuals that met eligibility requirements in OAR 410-200-0240(1), receive the Healthier Oregon Benefit Package described in OAR 410-134-0000.¶
(58) "Cl~~ie~~aimant" means an individual ~~found eligible to receive OHP health services~~who has requested a hearing.¶
(59) "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.¶
(60) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(61) "Clinical Record" means the medical, dental, or mental health records of a ~~client or m~~Member.¶
(62) "Clinically Appropriate" means having at least one HRSN Clinical Risk Factor and at least one HRSN Social Risk Factor, each of which must be applicable to the HRSN Service for which the Member is authorized. For example, to determine whether a Member must be authorized to receive Home Changes for Health-Related Supports, the Member must, in addition to belonging to an HRSN Covered Population, have at least one HRSN Clinical Risk Factor and one HRSN Social Risk Factor. HRSN Services are not Clinically Appropriate if they are solely for the convenience or preference of the Member.¶
(63) "Closed Loop Referral" means the process of exchanging information between and among a~~n MCE~~ CCO, the Oregon Health Authority (which may include ~~its Fee For S~~ fee-for-service (FFS) ~~Program~~), a Member, HRSN Service Providers, and other similar organizations, to make referrals and communicate about the status of referrals and services for a Member.¶
(64) "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.¶
(65) "Community Health Worker" means an individual who:¶
(a) Has expertise or experience in public health;¶
(b) Works in an ~~u~~Urban or ~~r~~Rural community either for pay or as a volunteer in association with a local health care

system;¶
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
(f) Provides health education and information that is culturally appropriate to the individuals being served;¶
(g) Assists community residents in receiving the care they require;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(66) "Community Information Exchange~~" and "CIE" each~~ (CIE)" means a technology system used by a network of collaborative partners to exchange information for the purpose of connecting individuals to the services and supports they need. CIE functionality must include Closed Loop Referrals, a shared resource directory, and documentation of consent to the use of technology by the Member or other individual being connected to services.¶
(67) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶
(68) "Community Partner" means an individual affiliated with an organization contracted, trained, and certified by the Oregon Health Authority's Community Partner Outreach Program to provide free assistance to people applying for health coverage in Oregon that includes but is not limited to:¶
(a) Health coverage application;¶
(b) Help to enroll in health insurance plans;¶
(c) Health coverage renewal assistance;¶
(d) Healthcare System Navigation defined in OAR 410-120-0000; and¶
(e) Outreach and engagement related to subsections (a) through (d) of this section (6).¶
(69) "Co~~-~~morbid Condition" or "Comorbidity" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
(70) "Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as:¶
(a) Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to:¶
(A) Alcohol;¶
(B) Illicit drugs; and¶
(C) Gambling.¶
(b) Physical Health conditions, including but not limited to:¶
(A) Cancer;¶
(B) Diabetes;¶
(C) Bariatric Care.¶
(c) Developmental Disabilities.¶
(71) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired~~ by the Health Evidence Review Commission (HERC)~~, constitute the line items in the OHA Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
(72) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an ~~a~~Adverse ~~d~~Determination, ~~a~~Action, or as it relates to ~~an MCE enrollee~~ CCO Member, an adverse benefit determination:¶
(a) A ~~client or m~~Member or their ~~r~~Representative;¶
(b) A ~~member of an MCE~~CCO Member after resolution of the ~~MCE~~CCO's appeal process;¶
(c) An ~~MCE m~~CCO Member's ~~p~~Provider; or¶
(d) An ~~MCE~~CCO.¶
(73) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
(74) "Contiguous Area Provider" means a ~~p~~Provider practicing in a ~~c~~Contiguous ~~a~~Area.¶
(75) "Continuing Treatment Benefit" means a benefit for ~~client~~Members 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~~Member's ~~b~~Benefit ~~p~~Package changed to one that does not cover the treatment.¶
(76) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).¶
(77) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a ~~client~~Member must pay out of their own pocket to a ~~p~~Provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)¶
(78) "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~~Member.¶
(79) "Cover All Kids (CAK)" meaning defined in OAR 410-200-0015.¶
(80) "Covered Services" means ~~m~~Medically ~~n~~Necessary and ~~a~~Appropriate health services and items described in ORS chapter 414 and applicable administrative rules. Covered services include:¶
(a) Services described in the OHA Prioritized List of Health Services ~~above the funding line set by the legislature~~;¶
(b) Ancillary Services OAR 410-120-0000 (22);¶
(c) Diagnostic Services OAR 410-120-0000 (82);¶
(d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and¶
(e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 division 151.¶
(81) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
(82) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by ~~p~~Physicians and other health care ~~p~~Providers.¶
(83) "Credible Allegation of Fraud" means an allegation for fraud, which has been verified by the Authority or delegate, from any source, including but not limited to: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have the indicia of reliability and the Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.¶
(84) "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.¶
(85) "Date of Service" means the date on which the ~~client~~Member receives medical services or items, unless otherwise specified in the appropriate ~~p~~Provider rules. For items that are mailed or shipped by the ~~p~~Provider, the ~~d~~Date of ~~s~~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.¶
(86) "Deactivation" means an ~~a~~Action prohibiting a ~~p~~Provider's participation where the Authority assigned ~~p~~Provider number is ~~t~~Terminated as the result of inactivity, as evidenced by failure to submit claims for ~~eighteen (~~18~~)~~ months, or relocation, as evidenced by returned/undeliverable mail by the United States Postal Service or any other mail carrier.¶
(87) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶
(88) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶
(89) "Dental Subcontractor" means a prepaid managed care health services organization that enters into a noncomprehensive risk contract with a ~~c~~Coordinated ~~c~~Care ~~o~~Organization (CCO) or the Authority to provide dental services to their CCO Members or, as applicable, ~~Client~~Open Card Members enrolled in OHP. Dental Subcontractors contracting with CCOs must perform all delegated activities in accordance with OAR 410-141-3505.¶
(90) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶
(91) ~~"Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶~~
~~(92) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶~~
~~(93) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶~~
~~(94)~~ "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶
(9~~5~~2) "Dental Hygienist with an Expanded Practice Permit" means an individual 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.¶
(9~~6~~3) "Dentally Appropriate"¶
~~(a)~~ means dental services, items or dental supplies that are:¶
(~~A~~a) Recommended by a licensed health ~~p~~Provider practicing within the scope of their license; and¶
(~~B~~b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶
(~~C~~c) Not solely for the convenience or preference of a~~n OHP client, m~~Member or a ~~p~~Provider of the service, item or dental supply; and¶
(~~D~~d) The most ~~c~~Cost ~~e~~Effective of the alternative levels or types of health services, items or supplies that are ~~c~~Covered ~~s~~Services that can be safely and effectively provided to a ~~client or m~~Member in the Division or CCO or MCE's judgment.¶
(~~b~~e) All ~~c~~Covered ~~s~~Services must be ~~d~~Dentally ~~a~~Appropriate for the ~~m~~Member ~~or client~~ but not all ~~m~~Medically ~~a~~Appropriate services are ~~c~~Covered ~~s~~Services.¶
~~(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410, division 151.¶~~
~~(97) "Oregon Department of Human Services (Department or ODHS)" means the agency established in ORS chapter 409, including such divisions, programs and off~~94) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶
(95) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶
(96) "Denturist Services" means services provided within the scope of practice~~s~~ as ~~may be established therein~~defined under state law by or under the personal supervision of a denturist.¶
(9~~8~~7) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(9~~9~~8) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary ~~d~~Diagnosis ~~c~~Code is shown in all billing claims, unless specifically excluded in individual ~~p~~Provider rules. Where they exist, ~~d~~Diagnosis ~~c~~Codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶
(~~100~~99) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(10~~1~~0) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and ~~p~~Physician or other professional diagnostic or evaluative services.¶
(10~~2~~1) "Dietitian" means an individual licensed by the Board of Licensed Dietitians to provide nutrition services as outlined in the Standards of Practice in the OR Administrative Rules, chapter 834, division 60 (OAR 834-060-0000).¶
(10~~3~~2) "Division" means the Health Systems 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.¶
(10~~4~~3) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means 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.¶
(10~~5~~4) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means the program requiring specific coverage for children and young adults, as described in chapter 410 division 151.¶
(10~~6~~5) "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 OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶
(10~~7~~6) "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.¶
(10~~8~~7) "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.¶
(10~~9~~8) "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.¶

(~~1~~109) "Emergency Health Benefit Funding" means ~~funding for the health benefits defined in OAR 410-134-0004(2)(a-j), included in~~the combined state and matched federal funds (42 CFR 440.255) for the Healthier Oregon health benefits ~~package that is in part funded with state funding and matched with federal funds (42 CFR 440.255~~identified in OAR 410-134-0004(2)).¶
(11~~1~~0) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by ~~a~~Acute symptoms of sufficient severity 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 the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis but is based on presenting symptoms as perceived by a prudent layperson 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.¶
(11~~2~~1) "Emergency Medical Transportation" means transportation necessary for a ~~client~~Member with an ~~e~~Emergency ~~m~~Medical ~~c~~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.¶
(11~~3~~2) "Emergency Services" means health services from a qualified ~~p~~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~~Member's discharge from a facility or transfer to another facility.¶
(11~~4~~3) "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 evaluation 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)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings.¶
(11~~5~~4) "False Claim" means a claim that a ~~p~~Provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result, or has resulted, in an ~~o~~Overpayment.¶
(11~~6~~5) "Family Planning Services" means services for ~~client~~Members of child-~~-~~bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.¶
(11~~7~~6) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:¶
(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;¶
(b) Is qualified to participate in 340B discount purchasing as an HTC;¶
(c) Actively participates in the U.S. Centers for Disease Control ~~(CDC)~~ and Prevention (CDC) surveillance and has an identification number that is listed in the HTC directory on the CDC website;¶
(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and¶
(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.¶
(11~~8~~7) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that 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.¶
(11~~9~~8) "Fee-for-Service Provider" means a health care ~~p~~Provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization ~~or Prepaid Health Plan (PHP~~(CCO)). A medical ~~p~~Provider participating in a ~~PHP or a~~ CCO may be considered a ~~f~~Fee-for-~~s~~Service ~~p~~Provider when treating ~~client~~Open Card Members who are not enrolled in a ~~PHP or a~~ CCO.¶
(1~~2~~019) "For Cause Termination" means a mandatory or discretionary ~~t~~Termination by the Authority as is outlined in OAR 410-120-1400.¶

(12~~1~~0) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to ~~hi~~them or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶
(12~~2~~1) "Fruit and Vegetable Benefit" means a service that allows a HRSN Fruit and Vegetable Authorized Member (as that term is defined in this rule) to obtain or otherwise receive fruits and vegetables, including herbs, from an HRSN Service Vendor or HRSN Service Provider. The Fruit and Vegetable Benefit includes fresh, frozen, pureed, dried or canned (or any combination of fresh, frozen, dried, pureed or canned) fruits and vegetables, as well as herbs. The Fruit and Vegetable Benefit is one of several discrete benefits that comprise the Nutrition-Related Supports, which is an HRSN Service.¶
(12~~3~~2) "Fruit and Vegetable Benefit Card" means a service that allows an HRSN Fruit and Vegetable Authorized Member to purchase the Fruit and Vegetable Benefit from participating food retailers, vendors, or farms, or any combination of them, while utilizing an approved Fruit and Vegetable Benefit retail card obtained from a vendor that is enrolled with OHA as an HRSN Service Provider.¶
(12~~4~~3) "Fruit and Vegetable Box" means one of the Fruit and Vegetable Benefits that consists of pre-selected, pre-packaged fruit and vegetables that an HRSN Fruit and Vegetable Authorized Member obtains from an HRSN Fuit and Vegetable Service Vendor or Service Provider. Depending on which HRSN Fruit and Vegetable Service Vendor or Service Provider a CCO or the Authority works with, the HRSN Fruit and Vegetable Authorized Member may have the Fruit and Vegetable Box delivered to them by the HRSN Fruit and Vegetable Service Vendor or, if available, the Member may be able to pick up the box from the HRSN Fruit and Vegetable Service Vendor or HRSN Service Provider.¶
(12~~5~~4) "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 Authority for full medical assistance coverage.¶
(12~~6~~5) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶
(12~~7~~6) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a ~~p~~Provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶
(12~~8~~7) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶
(12~~9~~8) "Health Care Professionals" means 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.¶
(1~~30~~29) "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, the Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.¶
(13~~1~~0) "Healthcare System Navigation" means the process by which a Community Partner supports individuals who are in need of health care by:¶
(a) Assisting with application for or renewal of Oregon Health Plan (OHP);¶
(b) Assisting with the management of the application process for OHP;¶
(c) Assisting with accessing available benefits;¶
(d) Identifying and removing barriers to care;¶
(e) Providing the information needed to build the knowledge and confidence necessary for utilizing benefits; or¶
(f) Promoting the establishment of healthcare services and continuity of care.¶
(13~~2~~1) "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.¶
(13~~3~~2) "Health Insurance Portability and Accountability Act 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.¶
(13~~4~~3) "Health Maintenance Organization (HMO)" means a public or private health care organization that 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.¶
(13~~5~~4) "Health Plan New/~~n~~Non-~~c~~Categorical ~~client~~Member (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~~Member.¶

(136) "Healthier Oregon" means the ~~medical assistanc~~health care benefit ~~package~~ that is equal to the OHP Plus ~~b~~Benefit ~~p~~Package defined in OAR 410-120-1210. ~~The~~ Healthier Oregon is for individuals;¶
(a) Who do not meet the citizenship and non-citizen status requirements defined in OAR 410-200-0215 and OAR 461-120-0110; and¶
(b) Who do meet the financial and other non-financial eligibility requirements for a Health Systems Division (HSD) Medical Program (see OAR chapter 410 division 200) or an Oregon Supplemental Income Program Medical (OSIPM) Program (see OAR chapter 461).¶
(137) "Health-Related Social Needs~~" and "HRSN" each~~ (HRSN)" means the unmet, housing, nutrition, and outreach and engagement-related social needs, that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.¶
(138) "Health Risk Assessment (HRA)" means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a ~~m~~Member, their ~~r~~Representative or guardian about key areas of the ~~m~~Member's health, including their physical, developmental, behavioral, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity). The HRA is intended to inform the coordination of services and supports that meet the ~~m~~Member's individualized needs.¶
(139) "Hearing Aid Dealer" means an individual 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.¶
(139) "HERC Prioritized List of Health Services" means the listing of condition and treatment pairs, together with diagnosis and treatment codes, guideline notes, ancillary guideline notes, diagnostic guideline notes, excluded services guideline notes, statements of intent, and coding specifications and annotations, developed by the Health Evidence Review Commission for the purpose of advising the Authority on the administration of the Oregon Health Plan and the OHA Prioritized List of Health Services.¶
(140) "Home Changes for Health During Extreme Weather Supports" means health-related devices delivered, and as applicable installed or serviced (or both) by HRSN Service Vendors or HRSN Service Providers in the home of an HRSN-Home Changes for Health Authorized Member (as that term is defined in this rule). "Home Changes for Health" has the same meaning.¶
(a) Clinically Appropriate home changes for health devices include:¶
(A) Air conditioners for individuals at health risk due to significant heat;¶
(B) Heaters for individuals at increased health risk due to significant cold;¶
(C) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;¶
(D) Mini refrigeration units as needed for individuals to store their medications; and¶
(E) Portable power supplies (PPSs) for individuals who utilize and need to have access to medically necessary electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that could prevent or interfere with their ability to use medically necessary devices.¶
(b) Home Changes for Health services include, as may be needed by the Member, the provision and service delivery, and, as needed, installation of all the Home Changes for Health devices (identified in (a)(A)- (E) above in this rule) and device maintenance.¶
(141) "Home Changes for Safety" means home modifications or remediations that are made by an HRSN Services Vendor for the purpose of eliminating known home-based health and safety risks and ensuring the HRSN Home Changes for Safety Authorized Member's living environment meets that Member's functional, health, or safety needs. The term "Home Modifications and Remediations" has the same meaning.¶
(142) "Home Enteral Nutrition" means services provided in the ~~client~~Member'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 ~~p~~Provider rules.¶
(143) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that 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.¶
(144) "Home Health Services" means 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~~Member's home.¶
(145) "Home Intravenous Services" means services provided in the ~~client~~Member'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.¶
(146) "Home Parenteral Nutrition" means services provided in the ~~client~~Member'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.¶
(147) "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 is currently licensed by the Oregon Health Authority, Public Health Division.¶
(148) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall 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 ~~p~~Provider of hospital services with the Medicaid agency within that state.¶
(149) "Hospital-Based Professional Services" means professional services provided by licensed ~~p~~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 (DMAP 42) report for the Division.¶
(150) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific ~~client~~Member need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶
(151) "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.¶
(152) "Housing-Related Supports" means housing services provided to Members authorized to receive one or more of the HRSN Housing-Related Supports service categories to help them maintain healthy and safe housing (as detailed in OAR 410-120-2005). Housing-Related Supports include:¶
(a) Rent and Utility financial assistance (past due and prospective);¶
(b) Hotel/Motel Stays;¶
(c) Utilities Arrears;¶
(d) Utilities Set Up;¶
(e) Storage Fees (past due and prospective);¶
(f) Tenancy Services (paid via 15-minute increments);¶
(g) Tenancy Services (paid per member per month);¶
(h) Home Changes for Safety; or¶
(i) Home Changes for Health.¶
(153) "HRSN Authorized Member" means a Member who has participated in an HRSN Eligibility Screening and has been approved by the ~~MCE~~CCO or, as applicable, the Authority, to receive one or more HRSN Services. Members who have been authorized for a specific HRSN Service may be identified by the specific HRSN service or benefit that they have been authorized to receive such as, without limitation, "HRSN Fruit and Vegetable Authorized Member" or "HRSN Rent and Utility Authorized Member" or "HRSN Tenancy Supports Authorized Member."¶
(154) "HRSN Clinical Risk Factor" is the generic term to describe the clinical risk a Member must have in order to be eligible for an HRSN service. All HRSN Clinical Risk Factors are identified in OAR 410-120-2005 in Tables 1 through 3 and include the following:¶
(a) Table 1: Home Changes for Health Device-Specific and Outreach and Engagement Clinical Risk Factors;¶
(b) Table 2: Home Modifications and Remediations, Tenancy Supports, Nutrition Supports, and Outreach and Engagement Clinical Risk Factors; and¶
(c) Table 3: Rent and Utility Financial Assistance and Outreach and Engagement Clinical Risk Factors.¶
(155) "HRSN Connector" means any person or entity, including HRSN Service Providers and other similar social service organizations, that assists Members in documenting the information necessary to make an HRSN Request to a~~n MCE~~ CCO for an HRSN Eligibility Screening and HRSN Service authorization.¶
(156) "HRSN Covered Populations" means Members, excluding Members receiving the BRG service package defined in OAR 410-115-0030, who belong to one or more of the following populations, which are further defined in this OAR 410-120-0000:¶
(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD)~~:~~, residential mental health and substance use disorder facility, or inpatient psychiatric unit;¶
(b) Adults and Youth Released from Incarceration;¶
(c) Individuals currently or previously involved in Oregon's Child Welfare system;¶
(d) Individuals Transitioning to Dual Medicaid and Medicare Status;¶
(e) Individuals who meet the definition of "HUD Homeless";¶

(f) Individuals who meet the definition of "At Risk of Homelessness"; or¶
(g) Individuals identified as "Young Adults with Special Health Care Needs".¶
(157) "HRSN Eligibility Screening" means the process set out in OAR 410-120-2015, followed by ~~MCE~~CCOs or, as applicable, the Authority to determine whether a Member meets the criteria necessary for authorizing an HRSN Service.¶
(158) "HRSN Eligible" means a Member, except for Members receiving the BRG service package defined in OAR 410-115-0030, who meets all of the following criteria:¶
(a) Belongs to at least one of the HRSN Covered Populations,¶
(b) Has at least one HRSN Clinical Risk Factor applicable to the HRSN Services,¶
(c) Has at least one HRSN Social Risk Factor applicable to the HRSN Services, and¶
(d) Meets any additional eligibility criteria and requirements that may apply to a specific HRSN Service all of which are identified in OAR 410-120-2005.¶
(159) "HRSN Fee Schedule" means the comprehensive list of rates that establishes the maximum allowable reimbursement amount for each HRSN Service. Each service is associated with a unique procedure code and a corresponding procedure code modifier, which are used to correctly identify each service for billing purposes.¶
(160) "HRSN Outreach and Engagement Services (HRSN O&E Services)" means the activities performed by HRSN Service Providers, the Authority, or ~~MCE~~CCOs as described in OAR 410-120-2005. HRSN Service Providers shall be compensated for providing HRSN O&E Services when provided to "Presumed HRSN Eligible" Members as described in OAR 410-120-2005.¶
(161) "HRSN Person-Centered Service Plan" and "HRSN PCSP" each means the HRSN-related component of the care plan that is developed in consultation with the Member upon authorization of HRSN Services as described in OAR 410-120-2025.¶
(162) "HRSN Self-Attestation" and "Self-Attestation" means an oral or written statement made by the Member or Member Representative that the Member satisfies the applicable requirements necessary to establish the Member is HRSN Eligible to receive one or more HRSN Services. Also see OAR 410-120-2015.¶
(163) "HRSN Service Provider" means a private or public social service organization, community organization, or other similar individual or entity that provides HRSN Services and meets the qualifications outlined in OAR 410-120-2030 as applicable.¶
(164) "HRSN Service Request(s)" and "HRSN Request" means a request from an HRSN Connector (an organization or an individual) made to a~~n MCE~~ CCO or, as applicable, the Authority, for the purpose of requesting that the ~~MCE~~CCO, or as applicable, the Authority, perform an HRSN Eligibility Screening. Some HRSN Requests will be considered complete when the HRSN Connector identifies (i) the name and contact information of the individual who wants to be screened for an HRSN Service and (ii) the anticipated HRSN Service need; however, as described in OAR 410-120-2010, other HRSN Requests will need to identify other information in addition to the name, contact information, and HRSN Service need in order to be considered complete. HRSN Requests may also include confirmation of OHP enrollment, including confirmation of ~~MCE~~CCO or FFS enrollment, as well as any other information regarding the individual's potential HRSN Eligibility. The ~~MCE~~CCO or, as applicable, the Authority, shall be required to document its attempts to collect the information needed to determine eligibility.¶
(165) "HRSN Service Vendor" means any individual or entity that is contracted or procured by the Authority, a~~n MCE~~ CCO, or an HRSN Service Provider to deliver or provide HRSN Services directly to an HRSN Eligible Member who has been approved to receive HRSN Services. HRSN Service Vendors do not provide HRSN O&E and Tenancy Services. All HRSN Service Vendors that contract directly with the Authority must be enrolled as a Medicaid HRSN Service Provider in accordance with the applicable provisions OAR 410-120-1260. Examples of HRSN Service Vendors include, without limitation, entities, individuals, or organizations that deliver or install air conditioners, heaters, air filtration devices, Portable Power Supplies (PPSs) or mini refrigeration units, as well as home modification vendors, landlords, hotels/motels, chore service providers, utilities and moving companies, pest eradication companies and storage facilities, organizations that assess Members for, plan, prepare, or deliver Medically Tailored Meals and organizations that coordinate, deliver, provide an array of Fruit and Vegetable produce services, and provide an array of Pantry Stocking services including, but not limited to, prepaid produce cards as applicable, usage of vouchers, associated internet platforms, delivery of produce, and produce box programs.¶
(166) "HRSN Services" means any one of the Home Changes for Health Housing-Related Supports, Nutrition-Related Supports, or HRSN Outreach and Engagement services that address a Member's Health-Related Social Needs. Additional information regarding the different components of HRSN Services are detailed in OAR 410-120-2005 Tables 4-10 The term "HRSN Benefits" has the same meaning.¶
(167) "HRSN Social Risk Factor" means the need(s) of a Member related to a Health-Related Social Needs service. The HRSN Social Risk Factors are specific to each of the HRSN Services, which are Home Changes for Health, Housing-Related Supports, Nutrition-Related Supports, and Outreach and Engagement Services. HRSN Social Risk Factors are the following:¶

(a) HRSN Home Changes for Health Social Risk Factor: A Member who requires a qualifying device to treat, improve, stabilize, or prevent their HRSN Clinical Risk Factor~~.~~:¶
(b) HRSN Housing-Related Social Risk Factor: A Member who (i) meets the HUD homeless definition as defined in OAR 410-120-0000, or (ii) is at risk of homelessness as defined in OAR 410-120-0000, or (iii) requires a home modification or remediation service to treat, improve, stabilize, or prevent their HRSN Clinical Risk Factor~~.~~:¶
(c) HRSN Nutrition-Related Social Risk Factor: A Member who meets the USDA definition of low food security or very low food security as defined in this OAR 410-120-0000~~.~~; or¶
(d) HRSN Outreach and Engagement Social Risk Factor: A Member who requires support to obtain or maintain connection with benefit programs, services, or supports for basic needs.¶
(168) "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR § 91.5.¶
(169) "Imminent Eviction" means a tenant has received a court summons or documentation of a similar nature indicating that the eviction process has been initiated.¶
(170) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶
(171) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶
(172) "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.¶
(173) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service.¶
(174) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with~~-~~out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶
(175) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or ~~o~~Overpayments.¶
(176) "Individuals Involved with Child Welfare" means Members who are currently, or have previously been, involved in Oregon's Child Welfare System including Members who are currently or have previously been:¶
(a) In foster/substitute care;¶
(b) The recipient of adoption or guardianship assistance;¶
(c) Served on an in-home plan; or¶
(d) The subject of an open child welfare case.¶
(177) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to Fully Dual Eligible as defined in this rule. Members who are Individuals Transitioning to Dual Status shall be included in HRSN Covered Population for the ~~ninety (~~90~~)~~ calendar days preceding the date Medicare coverage is to take effect and 270 calendar days after it takes effect.¶
(178) "Inpatient Hospital Services" means 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.)¶
(179) "Institutional Level of Income Standards (ILIS)" means 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 ~~n~~Nursing ~~f~~Facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶
(180) "Institutionalized" means a patient admitted to a ~~n~~Nursing ~~f~~Facility or ~~h~~Hospital for the purpose of receiving nursing or hospital care for a period of ~~thirty (~~30~~)~~ days or more.¶
(181) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)" means a book of diagnosis codes (including volumes 1, 2, and 3, as revised annually)~~" means a book of diagnosis codes~~ used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶
(182) "Joint Fair Hearing Request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.¶
(183) "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 and to provide ~~l~~Laboratory ~~s~~Services (as

defined in this rule) within or apart from a hospital. An entity is considered to be a ~~l~~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).¶
(184) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a ~~p~~Physician or other licensed ~~p~~Practitioner of the ~~h~~Healing ~~a~~Arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a ~~p~~Physician or appropriate licensed ~~p~~Practitioner in an office or similar facility, hospital, or independent laboratory.¶
(185) "Licensed Direct Entry Midwife" means a ~~p~~Practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶
(186) "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.¶
(187) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.¶
(188) "Long-~~t~~Term Care (LTC)" or "Long-~~t~~Term Services and Supports (LTSS)" means Medicaid funded Long-~~t~~Term ~~c~~Care or ~~l~~Long-~~t~~Term ~~s~~Services and ~~s~~Supports ~~services~~ that include:¶
(a) "Long-term Care (LTC)" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;¶
(b) "Long-~~t~~Term Services and Supports (LTSS)" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, ~~D~~division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶
(189) "Low Food Security" means reduced quality, variety, or desirability of diet; little or no indication of reduced food intake, as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture published in May 2024, available here: https://www.ers.usda.gov/media/xxsjnqd1/short2024.pdf¶
(190) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶
(191) "Managed Care Organization (MCO)" means a 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), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(192) "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the ~~p~~Provider, whether the ~~p~~Provider is an individual, institution, organization or agency.¶
(193) "Maternity Case Management" means a program available to pregnant ~~client~~Members. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶
(194) "Meaningful ~~a~~Access" means ~~client or m~~Member-centered access reflecting the following statute and standards:¶
(a) Pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the corresponding Federal Regulation at 45 CFR Part 92 and The Americans with Disabilities Act (ADA), ~~p~~Providers' telemedicine or ~~t~~Telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have Limited English Proficiency (LEP) including providing access to auxiliary aids and services as described in 45 CFR Part 92;¶
(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards; and¶
(c) As applicable to the ~~client or m~~Member, Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx;¶

~~(d) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring.¶~~
(195) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶
(196) "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.¶
(197) "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, ~~or Healthier Oregon,~~ or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).¶
(198) "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).¶
(199) "Medical Services" means care and treatment provided by a licensed medical ~~p~~Provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶
(200) "Medical Transportation" means transportation to or from covered medical services.¶
(201) "Medically Appropriate"~~¶~~
~~(a) M~~means health services, items, or medical supplies that are:¶
(~~A~~a) Recommended by a licensed health ~~p~~Provider practicing within the scope of their license; and¶
(~~B~~b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶
(~~C~~c) Not solely for the convenience or preference of a~~n OHP client, m~~Member, or a ~~p~~Provider of the service item or medical supply; and¶
(~~D~~d) The most ~~c~~Cost ~~e~~Effective of the alternative levels or types of health services, items, or medical supplies that are ~~c~~Covered ~~s~~Services that can be safely and effectively provided to a Division ~~client or m~~Member in the Division or CCO or MCE's judgment.¶
(~~b~~e) All ~~c~~Covered ~~s~~Services must be ~~m~~Medically ~~a~~Appropriate for the ~~m~~Member ~~or client~~, but not all ~~m~~Medically ~~a~~Appropriate services are ~~c~~Covered ~~s~~Services.¶
(~~c~~f) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.¶
(202) "Medically Necessary" means:¶
(a) Health services and items that are required to address one or more of the following:¶
(A) The prevention, diagnosis, or treatment of a ~~client or m~~Member's disease, condition, or disorder that could result in health impairments or a disability; or¶
(B) The ~~client's or m~~Member's ability to achieve age-appropriate growth and development; or¶
(C) The ~~client's or m~~Member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(D) The ~~client's or m~~Member's ability to have access to the benefits of non-institutionalized community living, to achieve person-~~-~~centered care goals, and to live and work in the setting of their choice, when they are receiving Long-~~-~~Term Services or Supports (as defined in these rules);¶
(b) A ~~m~~Medically ~~n~~Necessary service must also be ~~m~~Medically ~~a~~Appropriate. All ~~c~~Covered ~~s~~Services must be ~~m~~Medically ~~n~~Necessary, but not all ~~m~~Medically ~~n~~Necessary services are ~~c~~Covered ~~s~~Services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.¶
(203) "Medically Tailored Meal" means a fully prepared meal comprised of foods that have been identified, in consultation with a registered ~~d~~Dietician nutritionist licensed in the ~~s~~State of Oregon, to meet the specific needs of a Member who has been authorized to receive HRSN Medically Tailed Meals.¶
(204) "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 ~~h~~Hospital or skilled ~~n~~Nursing ~~f~~Facility, home health care, and ~~h~~Hospice care; and¶
(b) Medical Insurance (Part B) for ~~p~~Physicians' services, ~~o~~Outpatient ~~h~~Hospital ~~s~~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 that 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. It 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.¶
(205) "Medical Nutrition Therapy" means~~"~~ an evidence-based application of the Nutrition Care Process provided by licensed ~~d~~Dietitians; focused on prevention, delay or management of diseases and conditions; and involving an

in-depth assessment, periodic reassessment and intervention(s). (OAR 834-020-0000)¶
(206) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
(207) "Member" means an ~~OHP client enrolled with a pre-paid health plan or coordinated care organization.~~individual who is enrolled to receive Medical Assistance Program services. A Member may receive services through a CCO (CCO Member), fee-for-service (Open Card Member), or both. The terms "client" and "recipient" have the same meaning as "Member."¶
(208) "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.¶
(209) "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 shall display less than 11 digits, but the number assumes leading zeroes.¶
(210) "National Provider Identification (NPI)" means federally administered 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 and Medicaid covered entities are required to apply for an NPI.¶
(211) "Naturopathic ~~p~~Physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
(212) "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.¶
(213) "Non-Billing Provider" also referred to as non-payable, means a ~~p~~Provider who is issued a ~~p~~Provider number for purposes of rendering, ordering, referring, prescribing, data collection, encounters, or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶
(214) "Non-~~c~~Covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-~~c~~Covered ~~s~~Services are identified in:¶
(a) OAR 410-120-1200 Excluded Services and Limitations; and¶
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶
(c) OAR 410-141-382~~0 OHP Benefit Package of Covered Services;¶~~
~~(d) OAR 410-141-0520 Prioritized List of Health Service~~5Excluded Services and Limitations; and¶
(~~e~~d) Any other applicable ~~Division~~program administrative rules.¶
(215) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of ~~c~~Covered ~~s~~Service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring ~~e~~Emergency ~~m~~Medical ~~s~~Services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a ~~h~~Hospital, where appropriate emergency medical care is available.¶
(216) "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.¶
(217) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a ~~n~~Nurse ~~p~~Practitioner pursuant to state law.¶
(218) "Nurse Practitioner Services" means services provided within the scope of practice of a ~~n~~Nurse ~~p~~Practitioner as defined under state law and by rules of the Board of Nursing.¶
(219) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶
(220) "Nursing Services" means 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.¶
(221) "Nutrition Care Plan for HRSN Medically Tailored Meals" means a detailed plan created and documented by a dietitian during the Nutrition Care Process that details how Medically Tailored Meals will be used to treat the HRSN Authorized Member's nutrition sensitive health condition. The term "HRSN MTM Nutrition Care Plan" has the same meaning.¶
(222) "Nutrition Care Plan for HRSN Pantry Stocking" means the written description of the service, service duration, and service goals incorporated within the HRSN Pantry Stocking Authorized Member's Person Centered Service Plan, as outlined in OAR 410-120-2025 4(a)-(h). The term "HRSN Pantry Nutrition Care Plan" has the same meaning.¶
(223) "Nutrition Care Process" means a systematic method that ~~d~~Dietetics and nutrition professionals use to provide nutrition care. It is comprised of four steps: nutrition assessment and reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation.¶

(224) "Nutrition-Related Supports" means nutrition services provided to Members who are authorized to receive one or more of the HRSN Nutrition-Related Supports service categories identified in (a) - (d) of this section, for the purpose of improving their access to food and health (as detailed in OAR 410-120-2005 Table 6). Nutrition-Related Supports include the following:¶
(a) Assessment for HRSN Medically Tailored Meals (if not already authorized, performed, and covered by OHP under the Medically Necessary standard);¶
(b) Medically Tailored Meals;¶
(c) Nutrition Education; and¶
(d) Fruit and Vegetable Box and Fruit and Vegetable Benefit Card; and¶
(e) Pantry Stocking Grocery Box and Pantry Stocking Grocery Benefit Card¶
(225) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶
(226) "Nutrition Education" means any combination of educational strategies, accompanied by environmental supports, designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being.¶
(227) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶
(228) "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, the 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.¶
(229) "O~~mbudsman~~HA Prioritized List of Health Services" means ~~advocacy~~the 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.¶~~
~~(230) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued.¶~~
~~(231) "~~identified in the State Medicaid Plan which are listed on the same line with one or more conditions (Condition-Treatment Pairs), together with diagnosis and treatment codes, guideline notes, ancillary guideline notes, diagnostic guideline notes, excluded services guideline notes, statements of intent, coding specifications and annotations, all of which have been identified by the Health Evidence Review Commission for the purpose of supporting the Authority in the administration of the Oregon Health Plan~~(OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that 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.¶~~
(230) "Ombudsman Services" means advocacy services provided by the Authority to Members whenever the Member is reasonably concerned about access to, quality of, or limitations on the health services provided.¶
(231) "Open Card Member" means a Member who is enrolled to receive Medical Assistance Program services from Providers who are paid by the Authority on a fee-for-service basis.¶
(232) "Optometric Services" means services provided within the scope of practice of ~~o~~Optometrists as defined under state law.¶
(233) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶
(234) "Oregon Department of Human Services (Department or ODHS)" means the agency established in ORS chapter 409, including such divisions, programs and offices as may be established therein.¶
(235) "Oregon Health Authority (Authority)" 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 ~~m~~Medical ~~a~~Assistance ~~p~~Program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, ~~Health Systems~~Behavioral Health Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.¶
(23~~5~~6) "Oregon Health ID" means a card the size of a business card that lists the Member's name, client ID (prime number), and the date it was issued.¶
(237) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that 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.¶
(238) "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.¶
(23~~6~~9) "Out-of-State Providers" means any ~~p~~Provider located outside the borders of the State of Oregon:¶

(a) Contiguous ~~a~~Area ~~p~~Providers are those located no more than 75 miles from the border of the State of Oregon;¶
(b) Non-contiguous area ~~p~~Providers are those located more than 75 miles from the borders of the State of Oregon.¶
(2~~37~~40) "Outpatient Hospital Services" means services that are furnished in a ~~h~~Hospital for the care and treatment of an outpatient. For information on outpatient ~~c~~ Covered ~~s~~Services, see the Division's Hospital Services administrative rules chapter 410, division 125.¶
(2~~38~~41) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.¶
(2~~39~~42) "Overpayment" means a payment made by the Authority to a ~~p~~Provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.¶
(240~~3~~) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.¶
(241~~4~~) "Ownership ~~i~~Interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity. A person with an ownership or control interest is a person or corporation that:¶
(a) Has an ownership interest totaling ~~5~~five (5) percent or more in a disclosing entity;¶
(b) Has an indirect ownership interest equal to ~~5~~five (5) percent or more in a disclosing entity;¶
(c) Has a combination of direct and indirect ownership interests equal to ~~5~~five (5) percent or more in a disclosing entity;¶
(d) Owns an interest of ~~5~~five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least ~~5~~five (5) percent of the value of the property or assets of the disclosing entity;¶
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or¶
(f) Is a partner in a disclosing entity that is organized as a partnership.¶
(242~~5~~) "Pantry Stocking Benefit" means a service that allows an HRSN Pantry Stocking Authorized ~~m~~Member to purchase or receive from an HRSN Service Vendor or HRSN Service Provider an assortment of foods aimed at promoting improved nutrition for that ~~m~~Member. Foods available through this service may be fresh, frozen, dried, pureed, or canned and may include herbs.¶
(243~~6~~) "Pantry Stocking Benefit Card" means a service that allows an HRSN Pantry Stocking Authorized ~~m~~Member to purchase the Pantry Stocking Benefit from participating food retailers, vendors, or farms, or any combination of them, while utilizing an approved Pantry Stocking Benefit retail card obtained from a vendor that is enrolled with OHA as an HRSN Service Provider.¶
(244~~7~~) "Pantry Stocking Grocery Box" means one of the Pantry Stocking Benefits that consists of pre-selected, pre-packaged assortment of foods aimed at promoting improved nutrition that the HRSN Pantry Stocking Authorized Member obtains from an HRSN Pantry Stocking Service Vendor or HRSN Service Provider. Depending on which HRSN Pantry Stocking Service Vendor or HRSN Service Provider, a CCO or the Authority works with, the HRSN Pantry Stocking Authorized Member may have the Pantry Stocking Box delivered to them by the HRSN Pantry Stocking Vendor or, if available, the Member may be able to pick up the box from the HRSN Pantry Stocking Service Vendor or HRSN Service Provider.¶
(245~~8~~) "Participating ~~p~~Provider" means a ~~p~~Provider that has a contractual relationship with an MCE. A Participating Provider is not a ~~S~~subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(246~~9~~) "Payable Provider" means a ~~p~~Provider who is issued a ~~p~~Provider number for purposes of submitting ~~m~~Medical ~~a~~Assistance ~~p~~Program claims directly to the Authority for payment.¶
(247~~50~~) "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 the~~se~~ chapter 410, division 120 general rules and the appropriate program rules. See the individual program rules for services requiring authorization.¶
(248~~51~~) "Peer Review Organization (PRO)" means an entity of health care ~~p~~Practitioners of services contracted by the state to review services ordered or furnished by other ~~p~~Practitioners in the same professional field.¶
(249~~52~~) "Peer Support Specialist" means an individual providing services to another individual who shares a similar life experience such as (i) addiction to addiction, (ii) mental health condition to mental health condition, or (iii) family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be a self-identified individual:¶
(a) Currently or formerly receiving addictions or mental health services;¶
(b) In recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;¶
(c) In recovery from problem gambling.¶
(250~~3~~) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in

order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶
(2514) "Person-Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and shall assist the patient in achieving the goals.¶
(2525) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and considering the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(2536) "Pharmaceutical Services" means services provided by a pPharmacist, including medications dispensed in a pharmacy upon an order of a licensed pPractitioner prescribing within the scope of practice.¶
(2547) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(2558) "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 individual.¶
(2569) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice pPhysical tTherapy.¶
(25760) "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 may not include radiology or electrosurgery.¶
(25861) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A pPhysician may be an individual licensed under ORS 677 or ORS 685.¶
(25962) "Physician Associate" means an individual licensed as a physician associate in accordance with ORS 677. Physician aAssociates provide medical services under the direction and supervision of an Oregon licensed pPhysician according to a practice description approved by the Board of Medical Examiners.¶
(2603) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a pPhysician.¶
(2614) "Podiatric Services" means services provided within the scope of practice of pPodiatrists as defined under state law.¶
(2625) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(2636) "Post-Payment Review" means review of billings or other medical information for accuracy, mMedical aAppropriateness, level of service, or for other reasons subsequent to payment of the claim.¶
(2647) "Practitioner" or "Practitioner of the Healing Arts" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the pPractitioner's license or certification.¶
(2658) "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), Mental Health Organization (MHO), or Physician Care Organization (PCO)¶
(2669) "Presumed HRSN Eligible" means an OHP Member who, through Self-Attestation or other information available to the HRSN Service Provider or, as applicable, the Authority or the MCE, is believed to (i) belong to at least one HRSN Covered Population, (ii) have an HRSN Clinical Risk Factor, and (iii) have an HRSN Social Risk Factor. If the Member provides the HRSN Service Provider with Self-Attestation, the Self-Attestation does not need to identify the Member's specific HRSN Covered Population or their specific HRSN Clinical Risk Factors. For purposes of making a presumption of HRSN Eligibility, it is sufficient that the Member attest that they belong to at least one of the HRSN Covered Populations and have at least one qualifying Clinical Risk Factor. However, the Member must attest to the specific HRSN Service need.¶
(2670) "Primary Care Dentist (PCD)" means a dental pPractitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶
(26871) "Primary Care Provider (PCP)" means any enrolled medical assistance pProvider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clientMembers. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of mMedically aAppropriate clientMember care. A Federally qualified PCP means a pPhysician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶
(26972) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A pPhysician referral is not a PA.¶
(270) "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.¶

(2713) "Private Duty Nursing Services" means 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 pPhysician to an individual who is not in a health care facility.¶
(2724) "Provider" means an individual, facility, institution, corporate entity, or other organization enrolled or not enrolled that provides or supplies health services or items, also termed a rendering provider or participating provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term p"Provider" refers to both rRendering pProviders and BP unless otherwise specified.¶
(2735) "Provider Organization" means a group practice, facility, or organization that is:¶
(a) An employer of a pProvider, if the pProvider 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 pProvider 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 pProvider 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) An aAgent if such entity solely submits billings on behalf of pProviders and payments are made to each provider. (See Subparts of Provider Organization.)Provider.¶
(2746) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶
(2757) "Public Health Clinic" means a clinic operated by a county government.¶
(2768) "Public Rates" means the charge for services and items that pProviders, including hHospitals and nNursing fFacilities, made to the general public for the same service on the same date as that provided to Authority clientMembers.¶
(2779) "Public Safety Power Shutoff" and "PSPS" means the temporary shutdown of electricity for the purpose of protecting communities in high fire-risk areas when experiencing extreme weather events, which could cause the electrical system to spark wildfires. The decision to implement a PSPS is usually made by the utility provider of the affected service area.¶
(2780) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶
(27981) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶
(2802) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶
(2813) "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.¶
(2824) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a pPhysician or other licensed pPractitioner of the hHealing aArts within the scope of practice as defined under state law and provided to a patient by or under the direction of a pPhysician or appropriate licensed pPractitioner in an office or similar facility, hHospital, or independent radiological facility.¶
(283) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶
(2845) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶
(2856) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a pProvider's future payments.¶
(2867) "Reduction of Services" means situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested twenty (20) p20 Physical tTherapy visits and the Division denies the individual's coverage of twenty (20) visits, covering instead only ten (10) visits-this is considered a denial of a service and could be appealed.¶
(2878) "Reentry FCAA Services" means the defined set of existing Medicaid and CHIP services that must be provided to Members who are FCAA-Covered Youth, as defined in OAR 410-155-0000 and 410-155-0010. Reentry FCAA Services include:¶
(a) Screening and diagnostic services in the thirty (30) days prior to release, or no later than one week, or as soon as practicable, after release; and¶

(b) Targeted Case Management in the ~~thirty (~~30~~)~~ days prior to release and for at least ~~thirty (~~30~~)~~ days post-release (as defined in OAR 410-138-0000).¶
(28~~8~~9) "Referral" means the transfer of total or specified care of a ~~client~~Member from one ~~p~~Provider to another. As used by the Authority, the term ~~r~~"Referral" also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of ~~client~~Members 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.¶
(2~~8~~90) "Remittance Advice (RA)" means the automated notice a ~~p~~Provider receives explaining payments or other claim actions. It is the only notice sent to ~~p~~Providers regarding claim actions.¶
(29~~0~~1) "Rendering ~~p~~Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a ~~p~~Provider, or bills, obligates, and receives reimbursement on behalf of a ~~p~~Provider of services, also termed a ~~b~~Billing ~~p~~Provider (BP). The term ~~r~~Rendering ~~p~~Provider refers to both ~~p~~Providers and BP unless otherwise specified.¶
(29~~1~~2) "Request for Hearing" means a clear expression in writing by an individual or ~~r~~Representative that the individual wishes to ~~a~~Appeal a Department or Authority decision or ~~a~~Action and wishes to have the decision considered by a higher authority.¶
(29~~2~~3) "Representative" means an individual who can make OHP-related decisions for a ~~client~~Member who is not able to make such decisions themselves.¶
(29~~3~~4) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a ~~client~~Member retroactive to a date prior to the ~~client~~Member's application for medical assistance.¶
(29~~4~~5) "Ride" means ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT) services for a ~~client~~Member either to or from a location where ~~c~~Covered ~~s~~Services are ~~p~~Provided. "Ride" does not include ~~client~~Member-reimbursed medical transportation or emergency medical transportation in an ~~a~~Ambulance.¶
(29~~5~~6) "Rural" means a geographic area that is ~~ten~~10 or more map miles from a population center of 30,000 people or less.¶
(29~~6~~7) "Sanction" means an ~~a~~Action against ~~p~~Providers taken by the Authority in cases of misuse or abuse of Oregon Health Authority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.¶
(29~~7~~8) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a ~~p~~Physician or other licensed ~~p~~Practitioner.¶
(29~~8~~9) "Self-Sufficiency (SSP)" means the division in the Oregon Department of Human Services that administers programs for adults and families.~~(299~~¶
(300) "Service Agreement" means an agreement between the Authority and a specified ~~p~~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~~Member. Service agreements do not preclude the requirement for a provider to enroll as a ~~p~~Provider.¶
(~~299~~301) "Service Authorization Request" means a ~~m~~Member's initial or continuing request for the provision of a service including ~~m~~Member requests made by their ~~p~~Provider or the ~~m~~Member's authorized ~~r~~Representative.¶
(30~~0~~2) "Service ~~l~~Location" means the location of a ~~p~~Provider when services are rendered.¶
(30~~1~~3) "Sliding Fee Schedule" means a fee schedule with varying rates established by a ~~p~~Provider of health care to make services available to indigent and low-income individuals. The ~~s~~Sliding ~~f~~Fee ~~s~~Schedule is based on ability to pay.¶
(30~~2~~4) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(30~~3~~5) "Special Health Care Needs (SHCN)" means individuals of any age who experience or exhibit signs of developing;¶
(a) Physical, functional, intellectual or developmental disabilities; or¶
(b) Long-standing or chronic medical condition(s); or¶
(c) Complex behavioral health conditions, including "Substance Use Disorders" or "Serious and Persistent Mental Illness;" or¶
(d) Live with other health or social conditions placing them at risk, that without intervention will likely cause negative impact to an individual's health or wellbeing.¶
(30~~4~~6) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(30~~5~~7) "Speech-Language Pathology Services" means 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.¶
(30~~6~~8) "State Facility" means a ~~h~~Hospital or training center operated by the State of Oregon that provides long-

term medical or psychiatric care.¶
(3079) "Supplemental Health Benefit State Funding" means funding for the health benefits included in the Healthier Oregon bBenefits pPackage described in OAR 410-134-0004(3)(a-m).¶
(3108) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization may 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 and could be components of an organization or separate physical locations of an organization.¶
(30911) "Subrogation" means the right of the state to stand in place of the clientMember in the collection of Third-Party Resources (TPR).¶
(3102) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶
(3113) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled personolder adults and people with disabilities that is administered by the Social Security Administration through the Social Security office.¶
(3124) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(3135) "Suspension" means a temporary sanction prohibiting a pProvider's participation in the mMedical aAssistance pPrograms by suspending the pProvider's Authority-assigned pProvider number for a specified period of time for one or more of the reasons in OAR 410-120-1400. No payments, Title XIX, or State Funds shall be made for services provided while the provider is suspendedProvider is suspended.¶
(316) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring.¶
(3147) "Targeted Case Management (TCM)" means activities that assist the clientMember 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 aAllied aAgency pProviders.¶
(3158) "Telecommunication tTechnologies" means the use of devices and services for tTelemedicine or tTelehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.¶
(3169) "Telehealth" includes tTelemedicine and includes the use of electronic information and tTelecommunications tTechnologies to support remote clinical healthcare, client or mMember and professional health-related education, public health, and health administration.¶
(31720) "Telemedicine" means the mode of delivering remote clinical health services using information and tTelecommunication tTechnologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or mMember's health care.¶
(3218) "Termination" means a sSanction prohibiting a pProvider's participation in the Authority's programs by canceling the pProvider's Authority-assigned pProvider number and pProvider agreement for one or more of the reasons in OAR 410-120-1400 and the pProvider has exhausted all applicable aAppeal rights or the timeline for aAppeal has expired. No payments, Title XIX, or state funds shall be made for services provided after the date of tTermination. Termination is permanent unless:¶
(a) The exceptions to mandatory exclusion are met; or¶
(b) Otherwise stated by the Authority at the time of tTermination.¶
(31922) "Third--Party Liability (TPL), Third--Party Resource (TPR), or Third-p-Party pPayer (TPP)" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client Member.¶
(3203) "Traditional Health Worker" means a cCommunity hHealth wWorker, pPeer wWellness sSpecialist, pPersonal hHealth nNavigator, pPeer sSupport sSpecialist, birth doula, or other similar health workers not regulated or certified by the State of Oregon.¶
(3214) "Transportation" means medical transportation.¶
(3225) "Trauma iInformed aApproach" means an approach undertaken by pProviders and health care or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. TheA Trauma Informed

Approach also means that ~~p~~Providers and health care or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.¶
(32~~3~~6) "Trauma Informed Services" means those services provided using a ~~t~~Trauma ~~i~~Informed ~~a~~Approach.¶
(32~~4~~7) "Type A Hospital" means a ~~h~~Hospital identified by the Office of Rural Health as a Type A ~~h~~Hospital.¶
(32~~5~~8) "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~~older adults and people with disabilities.¶
(32~~6~~9) "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.¶
(3~~27~~30) "Type B Hospital" means a ~~h~~Hospital identified by the Office of Rural Health as a Type B ~~h~~Hospital.¶
(3~~28~~31) "Urban" means a geographic area that is less than ~~ten~~10 map miles from a population center of 30,000 people or more.¶
(3~~3~~29) "Urgent Care Services" means health services that are ~~m~~Medically ~~a~~Appropriate and immediately required to prevent serious deterioration of a ~~client~~Member's health that are a result of unforeseen illness or injury.¶
(33~~0~~3) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:¶
(a) The ~~p~~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 ~~p~~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 ~~p~~Provider has established a written ~~s~~Sliding ~~f~~Fee ~~s~~Scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the ~~u~~Usual ~~c~~Charge. Any amounts charged to Third-Party Resources (TPR) are to be considered.¶
(33~~1~~4) "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.¶
(33~~2~~5) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of ~~c~~Covered ~~health care s~~Services rendered to an eligible ~~client~~Member that:¶
(a) Can be processed without obtaining additional information from the ~~p~~Provider of the goods or services or from a TPR; and¶
(b) Has been received within the time limitations prescribed in ~~these General Rules (~~OARs chapter 410 division 120).¶
(33~~3~~6) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a ~~m~~Member who may be eligible for the service at the time of the service, and the document contains:¶
(a) A beginning and ending date not exceeding ~~twelve~~12 months, except for cases of PHP or CCO enrollment where four (4) months may apply; and¶
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶
(33~~4~~7) "Very Low Food Security" means reports of multiple indications of disrupted eating patterns and reduced food intake, as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture published in May 2024, available here: https://www.ers.usda.gov/sites/default/files/_laserfiche/DataFiles/50764/short2024.pdf¶
(33~~5~~8) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(33~~6~~9) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.¶
(3~~37~~40) "Young Adults with Special Health Care Needs (YSHCN)" means a program that provides young adults who meet pre-determined social and clinical criteria with supplementary benefits, in addition to OHP Plus or Healthier Oregon coverage. The supplementary benefits include EPSDT services, HRSN services, and extended vision and dental services. The YSHCN program is more fully described in OAR 410-200-0455.
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.231
Statutes/Other Implemented: ORS 414.025, ORS 414.065

AMEND: 410-120-0025

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping changes.

CHANGES TO RULE:

410-120-0025
Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence ¶

(1) The Oregon Health Authority (Authority) and its Division of Medical Assistance Programs (Division) may adopt reasonable and lawful policies, procedures, rules, and interpretations to promote the orderly and efficient administration of ~~m~~Medical ~~a~~Assistance ~~p~~Programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.591 (Coordinated Care Organizations), and 414.115 to 414.145 (services contracts), subject to the rulemaking requirements of the Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.¶
(2) In applying its policies, procedures, rules, and interpretations, the Division shall construe them as much as possible to be complementary. In the event that Division policies, procedures, rules and interpretations may not be complementary, the Division shall apply the following order of precedence to guide its interpretation:¶
(a) For purposes of the provision of covered medical assistance to Division ~~client~~Members, including but not limited to authorization and delivery of service or denials of authorization or services, the Division, ~~client~~Members, enrolled ~~p~~Providers, and Coordinated Care Organizations~~, and the Prepaid Health Plans~~ shall apply the following order of precedence:¶
(A) Oregon Revised Statutes governing ~~m~~Medical ~~a~~Assistance ~~p~~Programs;¶
(B) Consistent with ORS 413.071, those federal laws and regulations governing the operation of the ~~m~~Medical ~~a~~Assistance ~~p~~Program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services to operate ~~m~~Medical ~~a~~Assistance ~~p~~Programs including the Oregon Health Plan;¶
(C) Generally, for Coordinated Care Organizations, the requirements applicable to ~~the~~ providing covered medical assistance to ~~Division client~~CCO Members are found in OAR 410-141-3500 through 410-141-5380; and where applicable, 410-120-0000 through 410-120-1990; and the ~~p~~Provider rules applicable to the category of medical service;¶
(D) Generally, for Prepaid Health Plans, the requirements applicable to providing covered medical assistance to Division ~~client~~Members are found in OAR 410-141-3500 through 410-141-5380; and where applicable, 410-120-0000 through 410-120-1990; and the ~~p~~Provider rules applicable to the category of medical service;¶
(E) Generally, for enrolled ~~f~~Fee-for-~~s~~Service ~~p~~Providers or other contractors, the requirements applicable to providing covered medical assistance to ~~Division client~~Open Card Members are found in OAR 410-120-0000 through 410-120-1990, the OHA Prioritized List and program coverage set forth in 410-141-3820 to 410-141-3830, and the ~~p~~Provider rules applicable to the category of medical service;¶
(F) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Authority or Oregon Department of Human Services (Department) necessary to administer ~~the State of~~ Oregon's ~~m~~Medical ~~a~~Assistance ~~p~~Programs, such as electronic data transaction rules in OAR 943-120-0100 to 943-120-0200; and¶
(G) The basic framework for ~~p~~Provider enrollment in OAR 943-120-0300 through 943-120-0380 that generally apply to ~~p~~Providers enrolled with the Authority or Department, subject to more specific requirements applicable to the administration of the Oregon Health Plan and ~~m~~Medical ~~a~~Assistance ~~p~~Programs administered by the Authority. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the ~~p~~Provider type and ~~c~~Covered ~~s~~Services described in paragraphs (A)-(F) of this section of this rule.¶
(b) For purposes of contract administration solely as between the Authority and ~~its~~ Coordinated Care Organizations ~~or Prepaid Health Plans~~, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule apply to the provision of covered medical assistance to Division ~~client~~Members:¶
(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supersede any rules of construction of such contracts that may be provided for in such contracts;¶
(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any individual or entity unless the individual or entity is identified as a named party to the contract.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-120-0045

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-0045
Applications for Medical Assistance at Provider Locations ¶

(1) The Oregon Health Authority (Authority) allows Division enrolled ~~p~~Providers the opportunity to assist ~~applicant~~individuals applying for public and private health coverage offered through the Authority and the Oregon Health Insurance Exchange (OHIX, as defined in ORS 741.300(6)). To apply for this opportunity, ~~p~~Providers fill out and submit form OHA 3128, Application Assistance by Provider Staff or "addendum"; this is an addendum to the ~~p~~Provider's agreement to provide Medicaid reimbursed services. Once the ~~p~~Provider is determined certified by the Oregon Health Authority to provide application assistance, ~~p~~Providers shall receive an approval letter, requirements for assister certification, training requirements, and other information.¶
(2) For purposes of this rule, the ~~p~~Provider's practice shall be referred to as a site. Sites can be, but are not limited to, the following:¶
(a) Hospitals;¶
(b) Federally ~~q~~Qualified ~~h~~Health ~~c~~Centers/~~r~~Rural ~~h~~Health ~~c~~Clinics (FQHC/RHCs);¶
(c) County health departments;¶
(d) 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 Oregon Health Authority.¶
(3) The site may sign the "Application Assistance by Provider Staff Form" (OHA 3128) or "the addendum" indicating the site's willingness to provide application assistance. The addendum outlines site and application assister standards as well as conflict of interest protections. The site shall require employees that are assisting to participate in mandatory training sessions for application assistance certification. Employees and volunteers shall complete the certification process before initiating application assistance. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Oregon Health Authority. For purposes of this rule, certified staff shall be referred to as "application assisters."¶
(4) Application assisters shall utilize authorized methods to provide application assistance. Application assisters shall maintain copies of all eligibility verification documents and all records related to application assistance, including the required, current OHA-provided 6610 Form for six (6) years, whether in paper, electronic, or other forms in a secure and locked location. Application assisters support patients potentially eligible for public and private health coverage offered through the Authority and OHIX.~~-~~¶
(5) The application assister shall encourage ~~a~~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 may not attempt to pre-determine ~~a~~Applicant eligibility or make any assurances to an ~~a~~Applicant regarding the eligibility for public or private health coverage offered through the Oregon Health Authority and OHIX.¶
(6) The application assister shall provide information to ~~a~~Applicants about public medical programs and plans through OHIX so each ~~a~~Applicant can make an informed choice when enrolling into a health insurance product. The application assister must offer language interpreters or interpreter services or referrals before beginning an application and must provide a language interpreter or interpretive services or referral to all patients who accept. This must also include linguistically and culturally appropriate written materials:¶
(a) The information given to the ~~a~~Applicant shall, at a minimum:~~-~~¶
(A) Include a review of public medical programs and qualified health plans through OHIX;¶
(B) Provide unbiased health coverage choices and information provided by the Oregon Health Authority or OHIX during the enrollment process;¶
(C) ~~a~~Answer questions; and¶
(D) ~~and a~~Assist in filling out online or paper application forms.~~-~~¶
(b) The application assister shall make copies of the original eligibility verification documentation required to accompany the application, but not uploaded to ONE applicant portal.¶
(7) Providers, staff, contracted employees, and volunteers are subject to all applicable provisions under General Rules OAR Chapter 410, Division 120, and Application Assistance by Provider Staff addendum (OHP 3128):¶
(a) The application assister shall treat all information they obtain for public medical programs and OHIX as

confidential and privileged communications. The application assister may not disclose such information without the written consent of the individual, their delegated authority, attorney, or responsible parent of a minor child or child's guardian.¶
(b) The Oregon Health Authority, Oregon Department of Human Services and sites shall share information as necessary to effectively serve public medical programs and OHIX eligible or potentially eligible individuals;¶
(c) Personally identifiable health information about ~~a~~Applicants and ~~recipient~~Members shall 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 shall 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.¶
(8) The Oregon Health Authority shall be responsible for the following:¶
(a) The Oregon Health Authority shall provide training to application assisters on public medical programs and OHIX, eligibility and enrollment, application procedures, and documentation requirements. The Authority shall set dates and times for these additional training classes as needed, following changes in policy or procedure;¶
(b) The Authority shall make available public medical programs application forms online and in hard copy (in English, translated languages, and alternative formats), and health insurance coverage options ;¶
(c) The Oregon Authority and Oregon Department of Human Services shall process all applications in accordance with Authority and OHIX standards;¶
(d) The Authority shall process completed applications within the time requirements in the Authority and OHIX policy. In the event of a change in policy, the time for completion of processing shall be changed to the new time requirements.¶
(9) The Oregon Health Authority shall 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, because there is compensation for Out ~~s~~Stationed Outreach Worker (OSOW) activities outlined in OAR 410-147-0400 for FQHCs and RHCs and OAR 410-146-0460 for Indian Health Care Providers (IHCPs). The Authority does not guarantee a particular volume of business under these rules.¶
(10) The ~~p~~Provider may terminate enrollment at any time as outlined in OAR 410-120-1260(15).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.041

AMEND: 410-120-0250

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-0250
Managed Care Entity ¶

(1) The Authority provides ~~client~~Members with health services through contracts with a Managed Care Entity (MCE).¶
(2) The MCE is responsible for providing, arranging, and making reimbursement arrangements for ~~c~~Covered ~~s~~Services as governed by state and federal law, or MCE's contract with the Authority, and the OHP administrative rules governing MCEs (OAR chapter 410, division 141).¶
(3) All MCEs are required to provide benefit coverage pursuant to OAR 410-120-1210 and 410-141-0480 through 410-141-0520; however, authorization criteria may vary between MCEs. It is the ~~p~~Providers' responsibility to comply with the MCE's Prior Authorization requirements or other policies necessary for reimbursement from the MCE before providing services to any ~~OHP client~~CCO Member enrolled in an MCE.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.631, 414.651

AMEND: 410-120-1140

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1140
Verification of Eligibility and Coverage ¶

(1) To ensure Division reimbursement of services, ~~p~~Providers are responsible to verify the following before rendering services:¶
(a) ~~Client~~Member eligibility: ~~T~~that the ~~person~~individual is an eligible ~~Oregon Health Plan (OHP) client~~Member on the date(s) services are rendered; and¶
(b) Benefit coverage: ~~T~~that the ~~person~~individual is enrolled in an OHP benefit package that covers the services they plan to render. See OAR 410-120-1210 for services covered under each Division ~~b~~Benefit ~~p~~Package.¶
(2) Providers who do not verify eligibility and benefit coverage with the Division before serving a person shall assume full financial responsibility in serving that person.¶
(3) The following types of ~~client~~Member identification (ID) only list the ~~client~~Member's name, Oregon Medicaid ID number (prime number), and the date the ID was issued. They do not guarantee ~~client~~Member eligibility or benefit coverage:¶
(a) The standard ID (called the Oregon Health ID, formerly the DHS Medical Care ID) printed on perforated paper the size of a business card;¶
(b) Replacement IDs (printed on regular printer paper in case of misplaced originals).¶
(4) When a person presents a standard or replacement ID, providers must verify ~~client~~Member eligibility and benefit coverage through one of the following (~~F~~for instructions see the Division General Rules Supplemental Information available on the web at http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-General-Rules.aspx):¶
(a) The Division's Medicaid Management Information System (MMIS) Provider Web portal;¶
(b) The Automated Voice Response (AVR) telephone system;¶
(c) Batch or real-time ~~e~~Electronic ~~d~~Data ~~i~~Interchange (EDI) eligibility inquiry (270) and response (271) transactions;¶
(5) The ~~client~~Member may also present the Temporary Oregon Health ID: OHP 3263A: Approval Notice for Hospital Presumptive Eligibility for Medical Coverage: This ID is issued for those who are "presumed" eligible based on certain information and authorizes benefit coverage only on a temporary basis. The OHP 3263A informs the ~~client~~Member of the exact date by which the Division must receive their full Medicaid application so that they may be evaluated for ongoing eligibility.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.025, 411.400

AMEND: 410-120-1180

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1180
Medical Assistance Benefits: Out-of-State Services ¶

(1) A ~~p~~Provider located in a state other than Oregon whose services are rendered in that state shall be licensed and otherwise certified by the proper agencies in the state of residence as qualified to render the services. Certain cities within 75 miles of the Oregon border may be closer for Oregon residents than major cities in Oregon, and therefore, these areas are considered ~~c~~Contiguous ~~a~~Areas, and ~~p~~Providers are treated as providing in-state services.¶
(2) Out-of-~~s~~State ~~p~~Providers must enroll with the Authority as described in OARs 943-120-0320 and 410-120-1260, Provider Enrollment. Out-of-~~s~~State ~~p~~Providers must provide services and bill in compliance with these rules and the OARs for the appropriate type of services provided.¶
(3) Payment rates for ~~o~~Out-of-~~s~~State ~~p~~Providers are established in the individual provider rules through contracts or ~~s~~Service ~~a~~Agreements and in accordance with OAR chapter 943, division 120 and OAR 410-120-1340, Payment.¶
(4) For enrolled non-contiguous, ~~o~~Out-of-~~s~~State ~~p~~Providers, the Division reimburses for ~~c~~Covered ~~s~~Services under any of the following conditions:¶
(a) For ~~clients enrolled in an MCE~~CCO Members:¶
(A) The service is authorized by an MCE, and payment to the ~~o~~Out-of-~~s~~State provider is the responsibility of the MCE;¶
(B) If a ~~client~~Member has coverage through an MCE, the request for non-emergency services must be referred to the MCE. Payment for these services is the responsibility of the MCE;¶
(C) The service or item is not available in the ~~S~~state of Oregon or provision of the service or item by an ~~o~~Out-of-~~s~~State ~~p~~Provider is ~~c~~Cost ~~e~~Effective, as determined by the MCE.¶
(D) MCE must provide all CCO Members with the option to utilize mail order pharmacy services. MCE may use an out-of-state mail order provider when necessary to meet the needs of the CCO Member, as long as the pharmacy has signed a ~~p~~Participating ~~p~~Provider agreement or subcontract with the MCE, is licensed to operate in state they reside, and adheres to out-of-state services and other applicable Division rules.¶
(b) For ~~clients not enrolled in an MCE~~Open Card Members:¶
(A) The service to a ~~Division client~~n Open Card Member is emergent as defined in 410-120-0000;¶
(B) A delay in the provision of services until the ~~client~~Open Card Member is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;¶
(C) The Division authorized payment for the service in advance of the provision of services or is otherwise authorized in accordance with ~~p~~Payment ~~a~~Authorization requirements in the individual provider rules or in the ~~G~~general ~~R~~rules (OARs chapter 410, division 120);¶
(D) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage;¶
(E) The ~~client~~Open Card Member is traveling and unable to use an in-state pharmacy;¶
(F) The pharmacy is out-of-state and mail order; the primary insurance TPL policy requires the use of the pharmacy;¶
(G) The pharmacy is out-of-state and mail order and provides one or more pharmaceutical products that are only available through a limited distribution network.¶
(5) The Authority may give ~~p~~Prior ~~a~~Authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled ~~p~~Provider under the following conditions:¶
(a) The service is billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage; or¶
(b) The Division covers the service or item under the specific ~~client~~Member's ~~b~~Benefit ~~p~~Package; and¶
(c) The service or item is not available in the ~~S~~state of Oregon, or provision of the service or item by an ~~o~~Out-of-~~s~~State ~~p~~Provider is ~~c~~Cost ~~e~~Effective, as determined by the Division; and¶
(d) The service or item is deemed ~~m~~Medically ~~a~~Appropriate and is recommended by a referring Oregon ~~p~~Physician.¶
(6) Laboratory analysis of specimens sent to out-of-state independent or hospital-based laboratories is a ~~c~~Covered ~~s~~Service and does not require PA. The laboratory must meet the same certification requirements as Oregon laboratories and must bill in accordance with Division rules.¶

(7) Reimbursement and services outside the territorial limits of the United ~~s~~States:¶
(a) For purposes of this provision, the United States includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa;¶
(b) The ~~d~~Division may not provide any payments for items or services to any financial institution or entity located outside of the United States pursuant to 1902(a)(80) of the Social Security Act.¶
(A) This provision also prohibits payments to ~~t~~Telemedicine ~~p~~Providers and pharmacies located outside of the United States;~~-~~¶
(B) This does not preclude ~~p~~Providers from providing covered items and/or services to Medicaid beneficiaries provided that reimbursement is made to a financial institution or entities located within the United States.¶
(8) The Division shall reimburse within limits described in these ~~G~~general ~~R~~rules and in individual pro~~vider~~gram rules all services provided by enrolled ~~p~~Providers to children:¶
(a) Who the Division has placed in foster care;¶
(b) Who the Department has placed in a subsidized adoption outside the ~~S~~state of Oregon; or¶
(c) Who are in the custody of the Department and traveling with the consent of the Department.¶
(9) The Division does not require authorization of non-emergency services for the children covered by section (8) except as specified in the individual pro~~vider~~gram rules.¶
(10) Payment rates for ~~o~~Out-of-~~s~~State ~~p~~Providers are established in the individual pro~~vider~~gram rules, through contracts or service agreements, and in accordance with OAR 943-120-0350 and 410-120-1340~~, Payment~~.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.025

AMEND: 410-120-1210

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping changes.

CHANGES TO RULE:

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

(1) The services ~~client~~Members are eligible to receive are based on their ~~b~~Benefit ~~p~~Package. Not all packages receive the same benefits.¶
(2) The ~~Health Systems Division (Division), Medical Assistance Programs b~~Division Benefit ~~p~~Package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in th~~ese~~is rule~~s~~.¶
(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.¶
(4) Benefit ~~p~~Package descriptions:¶
(a) Oregon Health Plan (OHP) Plus:¶
(A) Benefit ~~p~~Package identifier: BMH;¶
(B) Eligibility criteria~~: A~~ is defined in federal regulations and in the 1115 OHP waiver demonstration~~, a client~~. A Member is categorically eligible for medical assistance if they are eligible under ~~a~~:¶
(i) A federally defined mandatory, selected, optional Medicaid program; or ~~t~~¶
(ii)The Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;¶
(C) Coverage includes:¶
(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage for individuals under age 21 and individuals who qualify for the Young Adults with Special Health Care Needs (YSHCN) program, as detailed in Chapter 410 Division 151.~~-~~¶
(ii) Services consistent with the ~~Health Evidence Review Commission (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List), (OAR 410-141-3820 through 410-141-3830);¶
(iii) Ancillary ~~s~~Services, (OAR 410-141-3820);¶
(iv) Substance ~~u~~Use ~~d~~Disorder ~~treatment and recovery s~~Services provided through local substance use disorder treatment and recovery ~~p~~Providers;¶
(v) Mental health services based on the OHA Prioritized List to be provided by ~~B~~board licensed, certified, or credentialed ~~p~~Providers or through Community Mental Health Programs certified and credentialed providers;¶
(vi) Hospice;¶
(vii) Post-hospital extended care benefit up to a ~~one hundred (~~100~~)~~ day stay in a ~~n~~Nursing ~~f~~Facility for non-Medicare ~~Division client~~ Members who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires ~~p~~Prior ~~a~~Authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for ~~clients enrolled in a CCO~~CCO Members; and¶
(viii) HRSN Services (OAR 410-120-2005).¶
(D) Limitations:~~-~~Except for individuals who qualify for the Young Adults with Special Health Care Needs program (see OAR 410-200-0455), the following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):¶
(i) Selected dental (OAR chapter 410, division 123 and 200);¶
(ii) Vision ~~s~~Services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).¶
(b) OHP with Limited Drugs:¶
(A) Benefit package identifier: ~~BMM;~~¶
(i)BMM; or¶
(ii) BMD~~;~~.¶
(B) Eligibility criteria: ~~E~~eligible ~~client~~Members are eligible for Medicare and Medicaid benefits;¶
(C) Coverage includes: services covered by Medicare and OHP Plus as described in this rule;¶
(D) Limitations:¶
(i) The same as OHP Plus as described in this rule;¶
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:¶

(I) Over-the-counter (OTC) drugs;¶
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D shall 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 related to Medicare Part D is not covered since drugs covered by Part D are excluded from the ~~b~~Benefit ~~p~~Package.¶
(c) Qualified Medicare Beneficiary (QMB)-Only:¶
(A) Benefit Package identifier~~ code;~~ MED;¶
(B) Eligibility criteria: ~~E~~eligible ~~client~~Members 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~~: I~~ 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 ~~client~~Members for the deductible and coinsurance amounts due for services that are covered by Medicare;¶
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.¶
(d) Citizenship Waived Medical (CWM) Benefit Package defined in OAR 410-120-0000. Refer to OARs 410-134-0005~~(2)~~ and 410-134-0005~~(3)~~ for coverage and billing guidance.¶
(e) Compact of Free Association (COFA) Dental Program:¶
(A) Benefit Package identifier~~ code;~~ DEN;¶
(B) Eligib~~ility criteria: Eligible client~~le Members are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of ~~D~~dental services that the Authority determines shall be provided to ~~medical assistance recipient~~Members in accordance with OAR chapter 410 division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible ~~client~~Members.¶
(f) Veteran Dental Program:¶
(A) Benefit Package identifier~~ code DEN and~~;¶
(i) DEN; or¶
(ii) DNT~~;~~.¶
(B) Eligib~~ility criteria: Eligible client~~le Members are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of dental services that the Authority determines shall be provided to ~~medical assistance recipient~~Members in accordance with OAR chapter 410 division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible ~~client~~Members.¶
(g) Young Adults with Special Health Care Needs (YSHCN) Program:~~-~~¶
(A) Benefit ~~p~~Package identifier~~ codes BMH,~~;¶
(i) BMH;¶
(ii) BMM~~;~~; or¶
(iii) BMD~~;~~.¶
(B) Eligib~~ility criteria: Eligible client~~le Members are specified in OAR 410-200-0455;¶
(C) Coverage: ~~E~~eligible ~~individual~~Members receive OHP Plus coverage with the following supplemental benefits:~~-~~¶
(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage as described in chapter 410 ~~D~~division 151;~~-~~¶
(ii) All dental and ~~v~~Vision ~~s~~Services available to EPSDT beneficiaries, as detailed in chapter 410 ~~D~~division 123 and chapter 410 ~~D~~division 140; and~~-~~¶
(iii) Health-Related Social Needs ~~or "~~(HRSN~~" s~~) Services (as defined in OAR 140-120-0000 and detailed in OAR 410-120-2000) are available to those receiving YSHCN as an ~~"~~HRSN Covered Population~~"~~.¶
(D) Limitations:~~-~~Individuals receiving OHP Plus benefits under the YSHCN program are not eligible for ~~l~~Long-term ~~care s~~Services and ~~s~~Supports (LTSS) under Oregon's 1915(c) waiver, and HRSN ~~s~~Services must be annually reassessed for eligibility for HRSN ~~s~~Services as set out in OAR 410-120-2015.¶
(5) ~~Division client~~Members are enrolled for covered health services and HRSN Services to be delivered through one or a combination of the following means:¶
(a) Coordinated Care Organization (CCO):¶

(A) These ~~client~~Members are enrolled in a CCO that provides integrated and coordinated health care;¶
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services, dental care, or HRSN Services.¶
(b) Fee-for-~~s~~Service (FFS):¶
(A) These ~~clients are~~Members may or may not be enrolled in a CCO;¶
(B) Subject to limitations and restrictions in the Division's individual program rules, the ~~client~~Open Card Member may receive health care from any ~~Division~~ enrolled ~~p~~Provider that accepts ~~FFS client~~Open Card Members. The ~~p~~Provider shall bill the Division directly for any ~~c~~Covered ~~s~~Service and shall receive a fee for the service provided.¶
(C) Delivery of HRSN Services for ~~members enrolled in FFS~~Open Card Members shall be provided as set forth in OAR 410-120-2000.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690, 414.572, 414.605, 414.665, 414.719, SB 269-b (2025)

AMEND: 410-120-1260

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1260
Provider Enrollment ¶

(1) This rule applies to ~~p~~Providers requesting enrollment, currently enrolled, and previously enrolled with the Oregon Health Authority (Authority)~~, Health Systems Division (Division)~~.¶
(2) Providers signing the ~~P~~provider ~~E~~enrollment ~~A~~agreement constitute agreement to comply with all applicable Authority ~~provider~~ rules, Oregon Department of Human Services (ODHS~~) provider~~ or Department) rules, and federal and state laws and regulations applicable to Medicaid payments.¶
(3) Authority review of a ~~p~~Provider application for enrollment, material change in a ~~p~~Provider's enrollment information, and any documentation received in response to an Authority re-validation request is based on a categorical risk level of limited, moderate, or high. If a ~~p~~Provider falls within more than one risk level described in 42 CFR 455.450, the highest level of review is conducted by Authority. Authority will assign a risk level which meets or exceeds federal requirement and reserves the right to adjust ~~p~~Provider risk level at any time when:¶
(a) Authority imposes a payment ~~s~~Suspension, in accordance with OAR 410-120-1400, on a ~~p~~Provider based on credible allegation of fraud, waste or abuse;¶
(b) The ~~p~~Provider has an existing Medicaid ~~o~~Overpayment which, including all outstanding de~~p~~bts and interest, is $1,500 or greater and all of the following:¶
(A) Is more than 30 calendar days old;¶
(B) Has not been repaid at the time the application for enrollment is filed;¶
(C) Is not currently being appealed; and¶
(D) Is not part of an Authority approved extended repayment schedule for the entire outstanding ~~o~~Overpayment.¶
(c) The ~~p~~Provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid program within the previous 10 years; or¶
(d) Authority or CMS in the previous six (6) months lifted a temporary moratorium for the particular ~~p~~Provider type, in compliance with 42 CFR 455.470 and 42 CFR 424.570, and a ~~p~~Provider that was prevented from enrolling based on the moratorium applies for enrollment as a ~~p~~Provider at any time within six (6) months from the date the moratorium was lifted.¶
(4) Authority, CMS, its ~~agent~~delegates, or its designated contractors may, in accordance with 42 CFR 455.432, conduct pre- and post-enrollment on-site visits and unannounced inspections of any and all ~~p~~Provider locations at any time, for all ~~p~~Provider types.¶
(5) Providers enrolled by the Authority include:¶
(a) A ~~n~~Non-~~b~~Billing ~~p~~Provider, meaning a ~~p~~Provider who is issued a ~~p~~Provider number for purposes of screening, data collection or non-claims-use such as, but not limited to:¶
(A) Ordering or referring ~~p~~Providers, required by 42 CFR 455.410,~~-~~whose only relationship with the Authority is to order, refer, or prescribe services for ~~Authority m~~Members;¶
(B) A ~~b~~Billing ~~a~~Agent or ~~b~~Billing ~~s~~Service submitting claims or providing other business services on behalf of a ~~p~~Provider but not receiving payment in the name of or on behalf of the ~~p~~Provider;¶
(C) An encounter only ~~p~~Provider contracted with and credentialed by a MCE, as required by OAR 410-141-3510.¶
(b) A ~~p~~Payable ~~p~~Provider, meaning a ~~p~~Provider who is issued a ~~p~~Provider number for submitting health care claims for reimbursement from the Authority. A ~~p~~Payable ~~p~~Provider may be:¶
(A) The ~~r~~Rendering ~~p~~Provider;¶
(B) An individual, ~~a~~Agent, business, corporation, clinic, group, institution, or other entity that in connection with the submission of claims or encounters receives or directs the payment on behalf of a ~~r~~Rendering ~~p~~Provider.¶
(6) When a ~~p~~Payable ~~p~~Provider is receiving or directing payment on behalf of the ~~r~~Rendering ~~p~~Provider, the ~~p~~Payable ~~p~~Provider must:¶
(a) Meet one of the following standards:¶
(A) Have a relationship with the ~~r~~Rendering ~~p~~Provider described in 42 CFR 447.10(g) and have the authority to submit the ~~r~~Rendering ~~p~~Provider enrollment application and supporting documentation on behalf of the ~~r~~Rendering ~~p~~Provider; and¶
(B) Is a contracted ~~b~~Billing ~~a~~Agent or ~~b~~Billing ~~s~~Service enrolled with the Oregon Health Authority to provide services with the submission of claims and to receive or direct payment in the name of the ~~r~~Rendering ~~p~~Provider pursuant to 42 CFR 447.10(f).¶

(b) Maintain and provide to the Authority upon request records indicating the ~~b~~Billing ~~p~~Provider's relationship with the ~~r~~Rendering ~~p~~Provider. This includes:¶
(A) Identifying all ~~r~~Rendering ~~p~~Providers for whom they bill, or receive, or direct payments at the time of enrollment;¶
(B) Notifying the Authority within 30 days using Authority forms of a change to the ~~r~~Rendering ~~p~~Provider's enrollment record such as name, date of birth, address, Authority assigned ~~p~~Provider numbers, National Provider Identification Numbers (NPI), Social Security Number (SSN), or the Employer Identification Number (EIN); and¶
(C) The authorization to direct payment, signed by the ~~r~~Rendering ~~p~~Provider.¶
(c) Prior to submission of any claims or receipt or direction of any payment from the Authority~~.~~, obtain signed confirmation from the ~~r~~Rendering ~~p~~Provider that the ~~b~~Billing ~~entity or p~~Provider is authorized by the ~~r~~Rendering ~~p~~Provider to submit claims or receive or direct payment on behalf of the ~~r~~Rendering ~~p~~Provider. This authorization, and any limitations or termination of such authorization, must be signed by the ~~r~~Rendering ~~p~~Provider and maintained in the ~~p~~Provider's files for at least seven (7) years following the submission of claims or receipt or direction of funds from the Authority.¶
(7) To facilitate timely claims and encounter processing and payment consistent with applicable privacy and security requirements for ~~p~~Providers:¶
(a) The Authority requires all ~~n~~Non-~~b~~Billing and ~~p~~Payable ~~p~~Providers to be enrolled consistent with the ~~p~~Provider enrollment process described in this rule;¶
(b) If the ~~p~~Provider uses electronic media to conduct transactions with the Authority or authorizes a ~~n~~Non-~~b~~Billing ~~p~~Provider, e.g. ~~b~~Billing ~~s~~Service or ~~b~~Billing ~~a~~Agent, to conduct such electronic transactions, the ~~r~~Rendering ~~p~~Provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. Enrollment as a ~~p~~Payable or ~~n~~Non-~~b~~Billing ~~p~~Provider is a necessary requirement for submitting electronic claims, but the ~~p~~Provider must also register as an EDI trading partner and identify the EDI ~~s~~Submitter in order to submit electronic claims; and¶
(c) The claims and encounters submitted to the Authority must include an NPI for each ~~p~~Provider subject to the NPI requirements in 45 CFR Part 162 Subpart D. Rendering and referring ~~p~~Providers may not have the same NPI listed on the claim or encounter. Billing and ~~r~~Rendering ~~p~~Providers may not have the same NPI listed on the claim or encounter.¶
(8) To be enrolled and able to bill and receive payment as a ~~p~~Provider, an individual or organization must:¶
(a) Meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules. The ~~p~~Provider's license must be active. Authority may deny enrollment, re-enrollment or revalidation when a ~~p~~Provider's licensing body has placed limitations on the ~~p~~Provider's license or an action that created a limitation on the ~~p~~Provider's license impacts the quality or safety of services provided to ~~OHP m~~Members. The Authority may request additional documentation from the ~~p~~Provider or the licensing body or require additional screening.¶
(b) Comply with all Oregon statutes and regulations for provision of Medicaid and CHIP services. This includes meeting all applicable national and state licensure and certification requirements for all employees, subcontractors, vendors or other third parties providing services to Me~~dicaid me~~mbers for which the enrolled ~~p~~Provider is receiving reimbursement from Authority;¶
(c) If providing services within Oregon, have a valid Oregon business license if such a license is a requirement of the state, federal, county, or city government to operate a business or to provide services; and¶
(d) Comply with all requests from Oregon Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) for records and information when MFCU determines it is necessary to carry out its responsibilities. The records and information must be provided without charge and in the form requested by MFCU. A ~~p~~Provider must comply with a request from MFCU for access to any records and information kept by ~~p~~Providers to which OHA, ODHS, MCEs and MFCUs are authorized access by 42 CFR s431.107, including, but not limited to, any records necessary to disclose the extent of services provided to beneficiaries and any information regarding payments claimed by the ~~p~~Provider for furnishing said services. The records and information must be provided without charge and in the form requested by MFCU. When a MFCU request for access is made in~~-~~person such access must be granted immediately. A ~~p~~Provider must make available to MFCU, copies of all procedural and policy statements, directives, and proposed or adopted regulations concerning the Medicaid program, and any other information relevant to the work of MFCU. Providers shall disclose protected health care information to the MFCU for oversight activities as authorized by 45 CFR s164.512(d).¶
(9) An Indian Health Service facility meeting enrollment requirements shall be enrolled on the same basis as any other qualified ~~p~~Provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.¶
(10) A ~~p~~Provider that is currently subject to ~~s~~Sanction by the Authority or the ~~p~~Provider, a person with ownership or control of the ~~p~~Provider, or a ~~p~~Provider's managing employee is excluded, sanctioned or suspended by the federal government or another state from Medicare or Medicaid participation the ~~p~~Provider is not eligible for enrollment, consistent with OAR 410-120-1400, except when the Agency determines good cause exists, in

accordance with 42 CFR 455.23;¶
(11) All ~~þ~~Providers listed in section (5) of this rule must provide the following information before the Authority may enroll and issue or revalidate an Authority assigned ~~þ~~Provider number. Information disclosed by the ~~þ~~Provider is subject to verification by Authority and all ~~þ~~Providers must provide documentation at any time upon written request by the Authority:¶
(a) The ~~þ~~Provider must disclose to the Authority the name, federal Tax Identification Number (TIN), date of birth, primary business address, every business location and P.O Box address of the ~~þ~~Provider and, as applicable, for the following:¶
(A) Each person who has a direct or indirect ownership or control interest in the ~~þ~~Provider, is an ~~a~~Agent or is a managing employee of the ~~þ~~Provider, regardless of whether that person is an individual or corporate entity;¶
(B) Each person who has a direct or indirect ownership or control interest in the ~~þ~~Provider, is an ~~a~~Agent or is a managing employee of the ~~þ~~Provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the CHIP program in the last ~~ten~~10 years;¶
(C) Any subcontractor in which the ~~þ~~Provider has a direct or indirect ~~o~~Ownership ~~i~~Interest of five (5) percent or more.¶
(D) For the purpose of this rule, a person with direct or indirect ownership or control interest is defined in 42 CFR 455.101 and Authority calculates ownership and control percentage as required by 42 CFR 455.102.~~-~~¶
(E) When disclosing ~~t~~Tax ~~i~~Identification ~~n~~Numbers:¶
(i) For corporations, use the federal TIN;¶
(ii) For individuals use the Social Security Number (SSN);¶
(iii) All other ~~þ~~Providers use the EIN;¶
(iv) The SSN or EIN of the ~~r~~Rendering ~~þ~~Provider may not be the same as the Tax Identification Number of the ~~b~~Billing ~~þ~~Provider;¶
(v) Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041, SSN and EIN provided are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the ~~þ~~Provider for payment and collection activities.¶
(F) Whether any of the persons so named with an ownership or control interest in the ~~þ~~Provider requesting enrollment:¶
(i) Is related to another person with ownership or controlling interest in the ~~þ~~Provider requesting enrollment as a spouse, parent, child, sibling, or other ~~family members~~relative by marriage or otherwise; and¶
(ii) The name of any other current or former Medicaid ~~þ~~Providers in which an owner of the ~~þ~~Provider requesting enrollment has an ownership or control interest.¶
(G) A ~~þ~~Provider shall submit, within 35 calendar days of the date of a request by the Authority full and complete information about:¶
(i) the ownership of any subcontractor with whom the ~~þ~~Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and¶
(ii) any significant business transactions between the ~~þ~~Provider and any wholly owned supplier, or between the ~~þ~~Provider and any subcontractor, during the five-year period ending on the date of the request.¶
(H) Failure to disclose or submit required information: Authority may not reimburse a ~~þ~~Provider for services furnished in the period beginning the day following the date the information was due to the Authority and ending on the day before the date on which the information was supplied. Authority will ~~s~~Suspend or ~~t~~Terminate the ~~þ~~Provider's enrollment and Authority assigned ~~þ~~Provider number, in accordance with 42 CFR 455.104.¶
(b) The ~~þ~~Provider must submit required information to the Authority:¶
(A) Provider enrollment application based on the type of ~~þ~~Provider, ~~P~~provider ~~E~~enrollment ~~A~~agreement, ~~P~~provider ~~D~~disclosure ~~S~~statement, and all ~~A~~attachments. The Authority only accepts current versions of enrollment forms. All required forms are available at all times on OHA's Provider ~~E~~enrollment website;¶
(B) Application fee if required under 42 CFR 455.460;¶
(C) Consent to criminal background check to complete Authority established screening process and comply with 42 CFR § 455.410 and § 455.450 requirements for ~~þ~~Provider categories which pose increased financial risk of fraud, waste or abuse to the Medicaid program, 42 CFR § 455.434 when required;¶
(D) The Authority may use Medicare ~~þ~~Provider enrollment data to satisfy the requirement of (11)(b)(C), in this rule; and¶
(E) Copy of ~~þ~~Provider's license,~~-~~certification, or both.¶
(12) The Authority may screen ~~þ~~Providers and validate information disclosed by ~~þ~~Providers as required under 42 CFR 455.436. Authority reserves the right to conduct and review ~~þ~~Providers requesting enrollment or revalidation in a more stringent manner than Medicare or other state Medicaid programs, conduct additional screening, or impose additional requirements on ~~þ~~Providers, or all three, for a ~~þ~~Provider or a group of ~~þ~~Providers identified by the Authority as at increased risk for fraud, waste or abuse.¶

(13) Authority may at its sole discretion require ~~p~~Providers to enroll as a Medicare ~~p~~Provider prior to enrolling in Oregon's Medicaid program.¶
(14) Authority may implement 180-day moratoriums on the enrollment of ~~p~~Providers in a specific service category, on a statewide basis, or within a specific Oregon geographic area, when the Authority determines the action is necessary to safeguard public funds or to maintain the fiscal integrity of the Oregon Medicaid program.¶
(15) Provider enrollment and the signed Provider ~~E~~enrollment ~~A~~agreement expires five (5) years from the date of enrollment. Authority will revalidate all enrolled ~~p~~Providers at least every five (5) years, compliant with 42 CFR §455.414. Authority reserves the right to revalidate more frequently, at its discretion. Failure of a ~~p~~Provider to respond to Authority notice or failure to return requested information for revalidation will result in ~~t~~Termination of the ~~p~~Provider enrollment agreement and Authority assigned ~~p~~Provider number.¶
(16) Enrolled ~~p~~Providers shall notify the Authority in writing using Authority forms within 35 calendar days of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including, but not limited to, those listed in this subsection:¶
(a) Changes in federal TIN, SSN or EIN. Failure to notify the Authority of a change of Federal TIN for entities or a SSN, or EIN for individual ~~p~~Providers may result in the imposition of a $50 fine per incident:¶
(b) Changes in business service location, affiliation, ownership, NPI, ownership and control information, or criminal convictions. The ~~p~~Provider must notify the Authority using Agency provided forms;¶
(c) Providers who have more than one (1) NPI or receive a new NPI after enrolling with the Authority must complete a separate enrollment with the Authority for each NPI prior rendering services or listing the NPI on claims or encounters submitted to Authority.¶
(d) Bankruptcy proceedings, the ~~p~~Provider shall immediately notify the Authority's Provider Enrollment Unit in writing;¶
(e) Claims submitted by or payments made to ~~p~~Providers who have not furnished the notification required by this rule or to a ~~p~~Provider that fails to submit a new application as required by the Division under this rule may be denied or recovered.¶
(17) If Authority notifies the ~~p~~Provider of an error in the federal TIN, the provider must supply the appropriate valid federal TIN within 35 calendar days of the date of Authority's notice. Failure to comply with this requirement may result in Authority imposing a fine of $50 for each such notice. Federal TIN requirements described in this rule refer to any such requirements established by the Internal Revenue Service.¶
(18) Providers upon request may be enrolled by Authority up to 12 months prior to the date application for enrollment is received by the Authority only if:¶
(a) The ~~p~~Provider is appropriately licensed, certified, and otherwise meets all federal and Authority requirements for ~~p~~Providers at the time services are provided;¶
(b) The MCE submits to the Authority all required documentation to enroll the ~~p~~Provider as an encounter only ~~p~~Provider and that ~~p~~Provider has an executed contract with and has successfully completed a credentialing process with the MCE;¶
(c) Upon request, the ~~p~~Provider or MCE must submit to Authority a clear written statement as to why retro-enrollment is necessary to increase access to care and advance the triple aim.¶
(19) The Authority requires two types of ~~p~~Provider numbers:¶
(a) The Authority issued Oregon Medicaid ~~p~~Provider number which establishes an individual or organization's enrollment as an Oregon Medicaid ~~p~~Provider:¶
(A) The Provider ~~E~~enrollment ~~A~~agreement and the ~~p~~Provider's enrollment as an Oregon Medicaid ~~p~~Provider is specific to the ~~p~~Provider type and specialty type listed on the application for enrollment and constitutes a contractual relationship with the Authority. This Authority assigned number designates the specific categories of services covered by the Authority Provider ~~E~~enrollment ~~A~~agreement. For example, a pharmacy ~~p~~Provider number applies to pharmacy services and cannot be used by the ~~p~~Provider to provide or bill for ~~d~~Durable ~~m~~Medical ~~e~~Equipment (DME).¶
(B) A ~~p~~Provider seeking to render services or bill as more than one ~~p~~Provider type shall complete a separate ~~p~~Provider application and establish a separate Oregon Medicaid ~~p~~Provider number;¶
(C) For ~~p~~Providers not subject to NPI requirements, this Authority issued number is the provider identifier for billing the Authority.¶
(b) The Authority requires a National Provider Identification (NPI) in compliance with 45 CFR Part 162 Subpart D, for ~~p~~Providers subject to NPI and Taxonomy requirements, as enumerated by the National Plan and Provider Enumeration System (NPPES). A ~~p~~Provider must obtain an NPI and Taxonomy code prior to requesting enrollment and include these numbers in the application to request enrollment. The NPPES NPI information and ~~p~~Provider applications are available at all times online: https://nppes.cms.hhs.gov/#/. For ~~p~~Providers subject to NPI requirements:¶
(A) The NPI is the ~~p~~Provider identifier for billing the Authority. The Provider ~~E~~enrollment ~~A~~agreement and the ~~p~~Provider's enrollment as an Oregon Medicaid ~~p~~Provider is specific to the NPI listed on the application for

enrollment and constitutes a contractual relationship with the Authority;¶
(B) Providers currently enrolled that obtain a new or additional NPI shall complete a new application for ~~þ~~Provider enrollment with the Division's Provider Enrollment Unit and the application must be approved by the Authority prior to the ~~þ~~Provider rendering or billing for services associated with that NPI;¶
(20) Enrolled ~~þ~~Providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A,655 before prescribing a schedule II-controlled substance pursuant to 42 U.S.C 1396w-3a.¶
(a) The PDMP check does not apply to ~~client~~Members in exempt populations:¶
(A) Individuals receiving ~~h~~Hospice;¶
(B) Individuals receiving palliative care;¶
(C) Individuals receiving cancer treatment;¶
(D) Individuals with sickle cell disease; and¶
(E) Residents of a ~~l~~Long-term ~~c~~Care (LTC) facility, of a facility described in 42 U.S.C. 1396d, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w-3a(h)(2)(B); and¶
(F) Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.¶
(b) PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.¶
(21) Providers of services outside of Oregon shall be enrolled as a ~~þ~~Provider if they comply with the requirements in OAR 410-120-1260 and under the following conditions:¶
(a) The ~~þ~~Provider is appropriately licensed or certified in the state in which the ~~þ~~Provider is located and meets standards for participation in the Medicaid program. Disenrollment or sanction from other states' Medicaid programs or exclusion from any other federal or state health care program is a basis for disenrollment, ~~t~~Termination, or ~~s~~Suspension from participation as a ~~þ~~Provider in Oregon's medical assistance programs;¶
(b) The ~~þ~~Provider bills only for services provided within the ~~þ~~Provider's scope of licensure or certification;¶
(c) For noncontiguous ~~o~~Out-of-~~s~~State ~~þ~~Providers, the services provided must be authorized in the manner required under OAR Ch 410 and Ch 309 rules specific to the service, OAR 410-120-1180 and these rules for out-of-state services:¶
(A) The services provided are for a specific Oregon Medicaid ~~m~~Member who is temporarily outside Oregon or the contiguous area of Oregon;¶
(B) Services provided are for foster care or subsidized adoption children placed out of state; or¶
(C) The ~~þ~~Provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) ~~m~~Members; or¶
(D) The services for which the ~~þ~~Provider bills are covered services under the Oregon Health Plan (OHP) and follow Authority requirements for ~~þ~~Prior ~~a~~Authorization, when applicable.¶
(d) Facilities including but not restricted to ~~h~~Hospitals, rehabilitative facilities, institutions for care of individuals with ~~mental retardation~~intellectual or developmental disabilities, psychiatric hospitals, and residential care facilities shall be enrolled as ~~þ~~Providers only if the facility is enrolled as a Medicaid ~~þ~~Provider in the state in which the facility is located or is licensed as a facility ~~þ~~Provider of services by Oregon;¶
(e) Out-of-~~s~~State ~~þ~~Providers may provide contracted services per OAR 410-120-1880; and¶
(f) Out-of-state entities seeking to enroll, or enrolled, as a ~~b~~Billing ~~þ~~Provider shall register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to ORS 63.701 and OAR 410-120-1260.¶
(g) The Authority shall enroll an out-of-state noncontiguous pharmacy as a ~~þ~~Provider only when enrollment is necessary to meet a need that cannot be met by an in-state pharmacy. The pharmacy is required to be licensed in the state where the ~~m~~Member filled the prescription (i.e. state where medication is dispensed) and must be enrolled with the Authority as a Medicaid ~~þ~~Provider in order to submit claims or encounters to Authority. Identified needs include but are not limited to the following:¶
(A) Enrollment is necessary to reimburse an out-of-state pharmacy for services rendered to a ~~m~~Member that travels out of Oregon and is unable to use a pharmacy licensed in Oregon. The out-of-state pharmacy must be licensed in the state where the services are rendered;¶
(B) Enrollment is necessary to ensure the Authority is the payer of last resort, OAR 410-120-1280, such as when a member's TPL payer requires use of an out-of-state mail order pharmacy;¶
(C) Enrollment is necessary to ensure access to covered pharmacy services that are not otherwise generally available either through the Authority's contracted mail order pharmacy or through enrolled in-state pharmacies; or¶
(D) Enrollment is necessary to ensure access to covered pharmacy services provided to ~~m~~Members residing in a licensed in-state facility, such as a ~~l~~Long-~~t~~Term ~~c~~Care facility. The out-of-state pharmacy and the enrollment is limited to services provided to residents of the in-state facility.¶
(22) Termination of ~~þ~~Provider enrollment and the Authority assigned ~~þ~~Provider number:¶

(a) The ~~þ~~Provider may ~~ŧ~~Terminate enrollment at any time. The request shall be in writing and signed by the ~~þ~~Provider. The notice shall specify the Authority assigned ~~þ~~Provider number to be ~~ŧ~~Terminated and the effective date of ~~ŧ~~Termination. Termination or deactivation of the ~~þ~~Provider enrollment does not terminate any obligations of the ~~þ~~Provider for dates of services during which the enrollment was in effect;¶
(b) The Authority may deny enrollment, revalidation, or re-enrollment, or sanction and ~~ś~~Suspend or ~~ŧ~~Terminate a ~~þ~~Provider at any time including but not limited to any of the reasons listed in OAR410-120-1400; and¶
(c) Authority will send written notice to the ~~þ~~Provider when a ~~þ~~Provider's application for enrollment, revalidation or re-enrollment is denied, enrollment is ~~ŧ~~Terminated or ~~ś~~Suspended, or a ~~ś~~Sanction is imposed by Authority under OAR 410-120-1400, regardless of whether the ~~þ~~Provider is continuously enrolled, or the ~~þ~~Provider number is active at the time notice is issued. Authority notice will state the effective date of the Action.¶
(23) A ~~þ~~Provider may ~~ą~~Appeal a ~~ŧ~~Termination, ~~ś~~Suspension or other ~~ś~~Sanction. If a ~~þ~~Provider's enrollment, revalidation, or re-enrollment is denied, enrollment is ~~ś~~Suspended, ~~ŧ~~Terminated or any ~~ś~~Sanction is imposed by the Authority under this rule, the ~~þ~~Provider may request a ~~ć~~Contested ~~ć~~Case ~~ħ~~Hearing pursuant to OAR 410-120-1400, 410-120-1460, 410-120-1600 and 410-120-1860.¶
(24) If a ~~þ~~Provider's enrollment is ~~ś~~Suspended or ~~ŧ~~Terminated, the Authority may notify board of registration or licensure, federal or other state Medicaid agencies, MCEs and the National Practitioner Data Base of the finding(s) and the ~~ś~~Sanction(s) imposed.¶
(25) If a ~~þ~~Provider's enrollment has been deactivated, ~~ŧ~~Terminated or ~~ś~~Suspended for any reason the ~~þ~~Provider must complete a new application for enrollment, including all required documentation, and submit it to the Authority. To re-enroll the ~~þ~~Provider, Authority review is contingent upon the risk-based screening in section (3) of this rule. A re-enrollment by Authority has the same requirements and process as a new enrollment.¶
(26) Authority may deny enrollment, revalidation or re-enrollment request (for encounter purposes) to an encounter only ~~þ~~Provider, or ~~ś~~Sanction and ~~ś~~Suspend or ~~ŧ~~Terminate an enrolled encounter only ~~þ~~Provider, for any of the reasons in OAR 410-120-1400:¶
(a) Authority will notify the encounter only ~~þ~~Provider and the MCE. Authority notice will state the effective date of the Action;¶
(b) Authority may recoup any ~~ǿ~~Overpayments in accordance with OAR Ch 410, Div. 120, CH 410 Div. 141, and the contract between the MCE and the Authority; and¶
(c) The MCE must adjust encounter claims in accordance with OAR 410-141-3570 and recoup ~~ǿ~~Overpayments from the ~~þ~~Provider in accordance with OAR 410-141-3510.¶
(27) The provision of health care services or items to Authority ~~ṁ~~Members is a voluntary action on the part of the ~~þ~~Provider. Providers are not required to serve all Authority ~~ṁ~~Members seeking service.¶
(28) Providers seeking to enroll in the Authority must be a ~~þ~~Provider type established in the State Plan as approved for Medicaid reimbursement.¶
[NOTE: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-120-1285

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1285
Recoupment and Data Sharing with Third-Party Insurers
(1) The Oregon Health Authority (Authority) delegates to the Oregon Department of Human Services (Department), Office of Payment Accuracy and Recovery (OPAR) (for OPAR see Administrative Rules chapter 407 division 120, or chapter 943 division 120) authority to administer Third-Party Liability programs required by federal law to reduce medical expenditures. This includes the following programs:¶
(a) The Data Match Unit;¶
(b) The Health Insurance Group;¶
(c) The Medical Payment Recovery Unit; and¶
(d) The Personal Injury Liens Unit.¶
(2) For this rule, an "insurer" means an employee benefit plan, self-insured plan, ~~m~~Managed ~~c~~Care ~~o~~Organization or group health plan, a ~~t~~Third-~~p~~Party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service.¶
(3) "OPAR" means the Office of Payment Accuracy and Recovery, Department of Human Services, and subunits. (For OPAR see Administrative Rules chapter 407 division 120, or see chapter 943 division 120).¶
(4) For this rule "subscriber" means an individual who is eligible for coverage on their behalf and not because of dependent status.¶
(5) An insurer shall provide to OPAR, a CCO, or a Managed Care Organization, upon request, within 30 calendar days, the following information:¶
(a) The period during which a recipient, a spouse, partner or dependents are covered by the insurer;¶
(b) The nature of coverage that is provided by the insurer; for example, medical, prescription drug, dental, vision, motor vehicle personal injury protection, or workers compensation;¶
(c) The name, claim submission address, and identifying numbers of the plan; for example, group and policy numbers;¶
(d) The name of the subscriber, if any, and the date of birth and social security number;¶
(e) The amount of any copay, coinsurance, or deductible required by the insurer.¶
(6) An insurer may not deny a claim submitted by OPAR, a ~~m~~Managed ~~c~~Care ~~o~~Organization, or a CCO, based on the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim if:¶
(a) The claim is submitted within the three-year period beginning on the date on which the health care item or service was furnished; and¶
(b) Any action to enforce the claim is commenced within six (6) years of submission of the claim.¶
(7) If an insurer denies a claim or does not pay the claim in full, the insurer shall provide a detailed explanation for its action, including citation to applicable contractual or statutory authority for the action. If the insurer cites a contractual provision, the insurer shall provide a copy of the applicable contractual provision on request.¶
(8) An insurer, when requested by OPAR, shall provide OPAR an electronic file of all insured or subscribed individuals residing in Oregon to assist OPAR to do a data match with ~~recipient~~Member records to determine if any M~~edicaid recipient~~mber has coverage through the insurer. The electronic file shall be delivered to OPAR every 30 days, unless otherwise agreed. The Authority may enter into a trading partner agreement with the insurer to permit the exchange of information via "ASC X 12N 270/271 Health Benefit Inquiry and Response" transactions or other HIPAA compliant secure transaction methods in the event 270/271 transactions are not available. The insurer shall include the following information in the electronic file:¶
(a) The period during which a subscriber or insured, the spouse, partner or dependents are covered by the plan;¶
(b) The nature of coverage that is provided by the plan; for example, medical, prescription, dental, vision, or automotive personal injury protection, and workers compensation;¶
(c) The name, claim submission address, and identifying numbers of the plan; for example, group and policy numbers;¶
(d) The name of the subscriber, if any, and date of birth and social security number;¶
(e) The amount of any copay, coinsurance, or deductible required by the insurer.¶
(9) An insurer may not charge a fee for sharing data with the Authority, OPAR, a ~~m~~Managed ~~c~~Care ~~o~~Organization, or CCO or for processing claims submitted by OPAR, a ~~m~~Managed ~~c~~Care ~~o~~Organization, or a CCO.¶

(10) In the event a claim submitted to an insurer by OPAR, a ~~m~~Managed ~~c~~Care ~~o~~Organization, or a CCO is paid all or in part to a ~~t~~Third-~~p~~-Party, the insurer shall within 14 calendar days, give the name and address of the payee, the check number, date and amount of the check or electronic payment, and a copy of the check or electronic payment to the claimant on request.
Statutory/Other Authority: ORS 413.042, 413.085, 414.685, 42 USC § 1396a(a)(25) & (45), 42 USC § 1396k, 42 CFR §§ 433.135 to 433.139, 42 CFR §§ 433.145 to 433.146, Oregon Medicaid State Plan Attachment 4.22-A(3) & (7)
Statutes/Other Implemented: ORS 414.685, 659.830, 743B.470

AMEND: 410-120-1295

RULE SUMMARY: Technical correction to numbering sequence; replacing “client” and “recipient” with “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1295
Non-Participating Provider ¶

(1) For purposes of this rule, a ~~p~~Provider enrolled with the ~~Health Systems Division (Division)~~Division that does not have a contract with a Division-contracted Managed Care Entity (MCE) is referred to as a non-participating provider.~~-~~¶
(2) For services covered by the CCO or PHP, a non-participating provider, other than a hospital governed by (3) and (4) of this rule, must accept from the Division-contracted MCE, as payment in full, the amount that the ~~p~~Provider would be paid from the Division if the ~~cl~~patient was ~~fee-for-service (FFS).~~ an Open Card Member.¶
(3) For ~~c~~Covered ~~s~~Services provided on and after October 1, 2011, the Division-contracted MCE that does not have a contract with a hospital, is required to reimburse, and hospitals are required to accept as payment in full, the following reimbursement:~~-~~¶
(a) Non-participating Type A and Type B hospital: The MCE shall reimburse a non-participating Type A and Type B hospital fully for the cost of ~~c~~Covered ~~s~~Services based on the cost-to-charge ratio used for each hospital in setting the global payments to the MCE for the contract period;~~-~~¶
(b) Hospitals (not designated as a rural access or Type A and Type B hospital) including Child/Adolescent Psychiatric units in a hospital: As specified in ORS 414.743, the MCE shall reimburse inpatient and outpatient services using a Medicare payment methodology at a specified percentage point less than the percentage of Medicare costs used by the Oregon Health Authority (Authority) when calculating the base hospital capitation payment to the MCE excluding any supplemental payments;~~-~~¶
~~(c) Effective for services on or after January 1, 2025, inpatient psychiatric adult and pediatric services shall be reimbursed using the DRG and outlier methodology outlined in OAR 410-125-0141 (10) and (11).~~¶
(A) Effective for services on or after October 1, 2011, for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 64 percent;~~-~~¶
(B) Effective for services on or after October 1, 2011, for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 66 percent.~~-~~¶
(C) Effective for services on or after January 1, 2020 for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 76 percent.~~-~~¶
(D) Effective for services on or after January 1, 2020 for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 78 percent.~~-~~¶
(E) Effective for services on or after January 1, 2023 but before January 1, 2024.~~-~~¶
(i) For a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 81 percent; and~~-~~¶
(ii) For a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 83 percent.~~-~~¶
(c) Effective for services on or after January 1, 2025, inpatient psychiatric adult and pediatric services shall be reimbursed using the DRG and outlier methodology outlined in OAR 410-125-0141 (10) and (11).¶
(d) For Maternity Services effective on or after January 1, 2026 but before January 1, 2027;~~-~~¶
(A) For hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 100 percent; and~~-~~¶
(B) For a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 102 percent.~~-~~¶
(4) A non-participating hospital must notify the MCE within two (2) business days of an MCE patient admission when the MCE is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The CCO or FCHP is required to review the hospital claim for:~~-~~¶
(a) Medical appropriateness;~~-~~¶
(b) Compliance with emergency admission or prior authorization policies;~~-~~¶
(c) Member's ~~b~~Benefit ~~p~~Package;~~-~~¶

(d) The MCE contract and the Division's administrative rules.-¶
(5) After notification from the non-participating hospital, the MCE may:-¶
(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the MCE has secured another facility to accept the patient;-¶
(b) Perform concurrent review; and/or-¶
(c) Perform case management activities.-¶
(6) In the event of a disagreement between the MCE and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.025, 414.743

AMEND: 410-120-1300

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1300
Timely Submission of Claims ¶

(1) In order to be reimbursed for services rendered, ~~p~~Providers must comply with the following:¶
(a) Medicaid fee-for-service only claims must be filed within 12 months of the ~~d~~Date of ~~s~~Service. The ~~d~~Date of ~~s~~Service for ~~an i~~Inpatient ~~h~~Hospital ~~stay~~Services is considered the date of discharge;¶
(b) Claims for ~~recipient~~Members that have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the ~~d~~Date of ~~s~~Service to meet the Division's timely filing rule;¶
(c) Claims that fail to cross over electronically from Medicare must be submitted hard copy to the Division within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided they are filed with Medicare within one year from the ~~d~~Date of ~~s~~Service;¶
(d) ~~-~~Claims for CCO ~~enrolled m~~Members must comply with Oregon Administrative Rule 410-141-3565.~~-~~¶
(2) A claim submitted within 12 months of the ~~d~~Date of ~~s~~Service but is denied may be resubmitted within 18 months of the ~~d~~Date of ~~s~~Service. These claims must be submitted to the ~~Health Systems Division (Division)~~Authority at the address listed in the ~~p~~Provider contacts document. The ~~p~~Provider must present documentation acceptable to the ~~Division~~Authority verifying the claim was originally submitted within 12 months of the ~~d~~Date of ~~s~~Service, unless otherwise stated in individual pro~~vider~~gram rules. Acceptable documentation is:¶
(a) A remittance advice from the ~~Division~~Authority that shows the claim was submitted before the claim was one year old;¶
(b) A copy of a billing record or ledger showing dates of submission to the ~~Division.~~ Authority.¶
(3) Exceptions to the 12-month requirement that may be submitted to the ~~Division~~Authority are as follows:~~-~~¶
(a) When the Department, Division, or the ~~client~~Member's branch office makes an error that causes the ~~p~~Provider not to be able to bill within 12 months of the ~~d~~Date of ~~s~~Service, the claim may be filed up to six months after the error is discovered. The Division must confirm the error;~~-~~¶
(b) When a court or an Administrative Law Judge orders the ~~Division~~Authority to make payment;~~-~~¶
(c) When the ~~Division~~Authority determines a ~~client~~Member is retroactively eligible for ~~Division~~ medical coverage and more than 12 months passes between the ~~d~~Date of ~~s~~Service and the determination of the ~~client~~Member's eligibility.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1320

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1320
Authorization of Payment ¶

(1) Some services or items covered by the Oregon Health Authority require authorization before the service can be provided. See the appropriate Oregon Health Authority rules for information on services requiring authorization and the process to be followed to obtain authorization, such as "OAR 410-120-1360 Requirements for Financial, Clinical and Other Records."¶
(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in the appropriate Oregon Health Authority rules.¶
(3) The Oregon Health Authority shall authorize for the level of care or type of service that meets the ~~client~~Member's medical need. Only services which are ~~m~~Medically ~~a~~Appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the ~~p~~Provider to determine medical appropriateness or appropriateness of the service.¶
(4) The Oregon Health Authority may not consider quality of life in general measures (e.g., Quality Adjusted Life Years or QALYs), either directly or by considering a source that relies on a quality of life in general measure, in establishing utilization controls (e.g., prior authorization) or otherwise making benefit determinations.~~-~~"Quality of life in general measure" means an assessment of the value, effectiveness or cost-effectiveness of a treatment that gives greater value to a year of life lived in perfect health than the value given to a year of life lived in less than perfect health. "Quality of life in general measure" does not mean an assessment of the value, effectiveness or cost-effectiveness of a treatment during a clinical trial in which a study participant is asked to rate the participant's physical function, pain, general health, vitality, social functions or other similar domains (e.g., the Short Form Health Survey or SF-36).¶
(5) The Oregon Health Authority may not make payment for authorized services under the following circumstances:¶
(a) The ~~client~~Member was not eligible at the time services were provided. The ~~p~~Provider is responsible for checking the ~~client~~Member's eligibility each time services are provided;¶
(b) The ~~p~~Provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency;¶
(c) The service has not been adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). The documentation in the ~~p~~Provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the ~~p~~Provider's files;¶
(d) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be ~~m~~Medically ~~a~~Appropriate;¶
(e) The services billed are not consistent with those provided;¶
(f) The services were not provided within the timeframe specified on the authorization of payment document;¶
(g) The services were not authorized or provided in compliance with the rules in these ~~General R~~chapter 410, division 120 rules and ~~in the~~ the appropriate pro~~vider~~gram rules.¶
(6) Retroactive authorizations:¶
(a) Authorization for payment may be given for a past date of service if:¶
(A) The ~~client~~Member was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the ~~d~~Date of ~~s~~Service; and¶
(B) The services provided meet all other criteria and Oregon Administrative Rules, and;¶
(C) The request for authorization is received within ninety (90) days of the ~~d~~Date of ~~s~~Service;¶
(b) Any requests for authorization after ninety (90) days from ~~d~~Date of ~~s~~Service require documentation from the Provider that authorization could not have been obtained within ninety (90) days of the ~~d~~Date of ~~s~~Service.¶
(7) Payment ~~a~~Authorization is valid for the time period specified on the authorization notice, but not to exceed twelve (12) months, unless the ~~Client~~Member's ~~b~~Benefit ~~p~~Package no longer covers the service, in which case the authorization will terminate on the date coverage ends.¶
(8) When ~~client~~Members have other health care coverage (~~t~~Third-~~p~~Party ~~r~~Resources, or TPR), the Oregon Health Authority only requires ~~p~~Payment ~~a~~Authorization for the services that TPR does not cover. Examples include:¶
(a) When Medicare is the primary payer for a service, no ~~p~~Payment ~~a~~Authorization from the Oregon Health

Authority is required, unless specified in the appropriate Oregon Health Authority program rules;¶
(b) When other TPR is primary, such as Blue Cross, CHAMPUS, etc., the Oregon Health Authority requires ~~p~~Payment ~~a~~Authorization when the other insurer or resource does not cover the service or reimburses less than the Oregon Health Authority rate.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-120-1340

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1340
Payment ¶

(1) The Division shall make payment only to the enrolled ~~p~~Provider (see OAR 410-120-1260) who actually performs the service or to the ~~p~~Provider's enrolled ~~b~~Billing ~~p~~Provider for ~~c~~Covered ~~s~~Services rendered to eligible ~~client~~Members.¶
(2) Division reimbursement for services may be subject to review prior to reimbursement.¶
(3) The Division sets fee-for-service (FFS) payment rates for the billed services or items. The FFS payment rates are the Division's maximum allowable rates for billed services or items.¶
(4) The Division reimburses ~~p~~Providers for billed services or items at the lesser of:¶
(a) The amount billed;¶
(b) The Division's FFS payment rate in effect on the ~~d~~Date of ~~s~~Service; or¶
(c) The rate specified in the individual program ~~provider~~ rules.¶
(5) The amount billed may not exceed the ~~p~~Provider's ~~"u~~Usual ~~c~~Charge~~" (see definitions OAR 410-120-0000).~~ .¶
(6) The Division's maximum allowable rate setting process uses the following methodology for:¶
(a) Relative Value Unit (RVU) weight-based rates. The Division updates all CPT/HCPCS codes assigned an RVU weight effective January 1 of each year, based on the annual RVU updates published in the Federal Register:¶
(A) The Division applies RVU weights as follows:¶
(i) The Non-Facility Total RVU weight, to professional services not typically performed in a facility;¶
(ii) The Facility Total RVU weight, to professional services typically performed in a facility.¶
(B) The Division applies the following conversion factors:¶
(i) $40.79 for labor and delivery codes (59400-59622);¶
(ii) $38.76 for neonatal intensive care and pediatric intensive care professional service codes (99464-99465, 99468-99480);¶
(iii) $28.50 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and ~~p~~Provider types and specialties ("Oregon Primary Care Providers and Procedure Codes") is available at http://www.oregon.gov/OHA/HSD/OHP/Pages/Providers.aspx;¶
(iv) $27.11 for all remaining RVU weight-based CPT/HCPCS codes.¶
(C) The Division calculates rates using statewide Geographic Practice Cost Indices (GPCIs) as follows:¶
(i) (Work RVU) X (Work GPCI) + (Practice Expense RVU) X (Practice GPCI) + (Malpractice RVU) X (Malpractice GPCI). The formula used to create the statewide GPCI is (3*(Portland GPCI) + 33* (Rest of State GPCI))/36 = GPCI.¶
(ii) The sum in subparagraph (C)(i) is multiplied by the applicable conversion factor in ~~section~~paragraph (B) to calculate the rate;¶
(b) Non-RVU-weight-based rates:¶
(A) $21.12 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;¶
(B) Clinical lab codes are 80 percent of the Medicare clinical lab fee schedule effective on the ~~d~~Date of ~~s~~Service;¶
(C) All approved Ambulatory Surgical Center procedures are 80 percent of the Medicare fee schedule provided by the Center for Medicare and Medicaid Services (CMS) effective on the ~~d~~Date of ~~s~~Service;¶
(D) Physician-administered drugs billed under a HCPCS code are 100 percent of the Medicare rate;¶
(i) When no Medicare rate is available, the rate is based upon the Wholesale Acquisition Cost (WAC) provided by First Data Bank;¶
(ii) If no WAC is available, then the rate is the Acquisition Cost. These rates may change periodically based on drug costs;¶
(c) All procedures used for vision materials and supplies are contracted rates that include acquisition cost plus shipping and handling;¶
(d) Individual pro~~vider~~gram rules may specify rates for particular services or items.¶
(7) The Division reimburses ~~i~~Inpatient ~~h~~Hospital ~~s~~Services 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.¶
(8) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services program rules (chapter 410, division 125) unless the ~~h~~Hospital has a contract or ~~s~~Service

~~a~~Agreement with the Division to provide highly specialized services.~~-~~¶
(9) Payment rates for in-home services provided through Oregon 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.~~-~~¶
(10) For services provided by out-of-state institutions and facilities such as skilled nursing care facilities, psychiatric facilities and rehabilitative care facilities, the Division sets rates that are:~~-~~¶
(a) Consistent with the rate for similar services provided in Oregon; and~~-~~¶
(b) The lesser of the rate paid to the most similar licensed Oregon facility or the rate paid by the other state's Medicaid program; or~~-~~¶
(c) Consistent with the rate established by APD for out-of-state nursing facilities.~~-~~¶
(11) The Division may not make payment on the following claims:~~-~~¶
(a) Assigned, sold or otherwise transferred claims; or~~-~~¶
(b) Claims where the ~~b~~Billing ~~p~~Provider, ~~b~~Billing ~~a~~Agent, or ~~b~~Billing ~~s~~Service receives a percentage of the amount billed, amount collected or payment authorized. This includes, but is not limited to, claims transferred to a collection agency or individual who advances money to a ~~p~~Provider for accounts receivable.~~-~~¶
(12) Nursing facility payments:~~-~~¶
(a) The Division may not make a separate payment to a nursing facility or other ~~p~~Provider for services included in the nursing facility's all-inclusive rate (OAR 411-070-0085).~~-~~¶
(b) The following services are not in the all-inclusive rate and may be reimbursed separately:~~-~~¶
(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 ~~p~~Physician or other ~~p~~Provider of ~~m~~Medical ~~s~~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).~~-~~¶
(13) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSAs). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.~~-~~¶
(14) For payment for Division ~~client~~Members 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 ~~c~~Covered ~~s~~Services that are not covered by Medicare.~~-~~¶
(15) For ~~client~~Members with ~~t~~Third-~~p~~Party ~~r~~Resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.~~-~~¶
(16) The Division payments including contracted Managed Care Entity (MCE) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down. For the Division, payment in full includes:~~-~~¶
(a) Zero payments for claims when a ~~t~~Third-~~p~~-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 ~~p~~Payment ~~a~~Authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual pro~~vider~~gram rules.~~-~~¶
(17) 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.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742, 414.743

AMEND: 410-120-1360

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1360
Requirements for Financial, Clinical and Other Records ¶

(1) The Authority shall analyze, monitor, audit, and verify the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, quality of care, and access to care of the Medical Assistance Programs and the Children's Health Insurance Program.¶
(2) The ~~p~~Provider or the ~~p~~Provider's designated ~~b~~Billing ~~s~~Service or other entity responsible for the maintenance of financial, clinical, and other records shall develop and maintain adequate financial and clinical records and other documentation that supports the specific care, items, or services for which payment has been requested. Payment shall be made only for services that are adequately documented. Documentation shall be completed before the service is billed to the Division and meet the following requirements:¶
(a) All records shall document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service is provided, and the individual providing the service. Patient account and financial records shall also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the ~~p~~Provider shall maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records shall be accurate and in sufficient detail to substantiate the data reported;¶
(b) Clinical records, including records of all therapeutic services, shall document the ~~client~~Member's diagnosis and the medical need for the service. The ~~client~~Member's record shall be annotated each time a service is provided and signed or initialed by the individual who provided the service or shall clearly indicate the individual who provided the service. For purposes of medical review, the Authority adopts Medicare's electronic signature policy as outlined in the CMS Medicare Program Integrity Manual. Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the ~~p~~Provider or ~~p~~Practitioner and any additional standards for documentation found in this rule, the individual pro~~vider~~gram rules, and any relevant contracts. When a ~~p~~Provider maintains records electronically, within an EHR, EMR or other electronic clinical trial management or billing system, the ~~p~~Provider must be able to provide:¶
(A) hard copy versions, upon request; and¶
(B) ~~a~~An auditable means of demonstrating the date the record was created, the identity of the creator of a record, the date the record was modified, what was modified in the record, and the identity and credentials of any individual who has modified the record.¶
(C) If the ~~p~~Provider maintains records electronically or permits the use of electronic signatures, the provider must document any aspect of the provision of services. The provider must maintain appropriate safeguards to assure the authenticity of the electronic records and signatures.¶
(c) Electronic Data Transmissions shall comply with the Uniform Electronic Transactions Act cited in ORS chapter 84 and OAR 943-120-0100;¶
(d) Policies and procedures shall ensure the maintenance of the confidentiality of medical record information. These procedures ensure the ~~p~~Provider may release information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, and 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50.¶
(e) Retain clinical records for seven years and financial and other records described in ~~paragraphs~~ subsections (2)(a) and (2)(b) of this rule for at least five years from the date(s) of service.¶
(f) Record requirements applicable only to ~~p~~Providers who are providing routine services for clinical trials:¶
(A) Information must be retained and provided if requested for medical review, audit or investigation by Authority, DOJ MFCU or other state or federal regulators and shall include:¶
(i) The trial name, sponsor, and sponsor-assigned protocol number (This is the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov)~~.~~; and¶
(ii) A copy of the ~~m~~Member's signed consent form.¶
(B) Record for clinical trials must be maintained and accessible for 10 years;¶
(C) The records must be stored and protected compliant with HIPAA and other applicable standards.¶
(3) Upon written request from the Authority, the Medicaid Fraud Control Unit Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives furnish requested documentation immediately or within the time-frame specified in the request. Copies of the documents may be

furnished unless the originals are requested. At their discretion, official representatives of the Authority, Medicaid Control Unit, or DHHS may review and copy the original documentation in the ~~p~~Provider's place of business. Upon the written request of the ~~p~~Provider, the program or the unit may, at their sole discretion, modify or extend the time for providing records if, in the opinion of the program or unit good cause for an extension is shown. Factors used in determining whether good cause exists include:¶
(a) Whether the written request was made in advance of the deadline for production;¶
(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;¶
(c) The efforts already made to comply with the request;¶
(d) The reason(s) for not meeting the deadline;¶
(e) The degree of control that the ~~p~~Provider had over its ability to produce the records prior to the deadline;¶
(f) Other extenuating factors.¶
(4) Access to records, inclusive of medical charts and financial records does not require authorization or release from the ~~client~~Member if the purpose is:¶
(a) To perform billing review activities;¶
(b) To perform utilization review activities;¶
(c) To review quality, quantity, and medical appropriateness of care, items, and services provided;¶
(d) To facilitate ~~p~~Payment ~~a~~Authorization and related services;¶
(e) To investigate a ~~client~~Member's ~~c~~Contested ~~c~~Case ~~h~~Hearing request;¶
(f) To facilitate investigation by the Medicaid Fraud Control Unit or DHHS; or¶
(g) Where review of records is necessary to the operation of the program.¶
(5) Failure to comply with requests for documents within the specified time-frames means that the records subject to the request may be deemed by the Authority not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or ~~o~~Overpayment determination may subject the ~~p~~Provider to possible denial or recovery of payments made by the Division or to ~~s~~Sanctions.¶
[Publications: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135, 414.145

AMEND: 410-120-1390

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1390
Premium Sponsorships ¶

(1) Premium donations made for the benefit of one or more specified ~~the Division of Medical Assistance Programs (Division) client~~Authority Members will be referred to as a Premium Sponsorship and the donor shall be referred to as a sponsor.¶
(2) The Authority may accept ~~P~~premium ~~S~~sponsorships consistent with the requirements of this rule. The Authority may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to carry out its functions under this rule. The Authority may identify one or more designees to perform one or more of the functions of the Authority under this rule.¶
(3) This rule does not create or establish any ~~P~~premium ~~S~~sponsorship program. The Authority does not operate or administer a ~~P~~premium ~~S~~sponsorship program. The Authority does not find sponsors for ~~client~~Members or take requests or applications from ~~client~~Members to be sponsored.¶
(4) This rule does not create a right for any ~~Division client~~Member to be sponsored. Premium ~~S~~sponsorship is based solely on the decisions of sponsors. The Authority only applies the ~~P~~premium ~~S~~sponsorship funds that are accepted by the Authority as instructed by the sponsor. The Authority does not determine who may be sponsored. Any operations of a ~~P~~premium ~~S~~sponsorship program are solely the responsibility of the sponsoring entity.¶
(5) A ~~P~~premium ~~S~~sponsorship amount that is not actually received by the ~~Division client~~Member will not be deemed to be cash or other resource attributed to the ~~Division client~~ Member, except to the extent otherwise required by federal law. A ~~Division client~~Member's own payment of ~~his or he~~their obligation, or payment made by an authorized ~~r~~Representative of the ~~Division client~~Member, is not a sponsorship except to the extent that the authorized ~~r~~Representative is otherwise subject to ~~sub~~section (8) of this rule.¶
(6) Nothing in this rule alters the ~~Division client~~Member's personal responsibility for assuring that ~~his or t~~their own payments (including current or past due premium payments) are made on time as required under any Authority rule.¶
(7) If the Authority accepts a ~~P~~premium ~~S~~sponsorship payment for the benefit of a specified ~~client~~Member, the Authority or its designee will credit the amount of the sponsorship payment toward any outstanding amount owed by the specified ~~client~~Member. The Authority or its designee is not responsible for notifying the ~~client~~Member that a ~~P~~premium ~~S~~sponsorship payment is made or that a sponsorship payment has stopped being made.¶
(8) If a sponsor is a health care Provider, or an entity related to a health care Provider, or an organization making a donation on behalf of such Provider or entity, the following requirements apply:¶
(a) The Authority will decline to accept ~~P~~premium ~~S~~sponsorships that are not "bona fide donations" within the meaning of 42 CFR 433.54. A ~~P~~premium ~~S~~sponsorship is a "bona fide donation" if the sponsorship has no direct or indirect relationship to Medicaid payments made to a health care Provider, a related entity providing health care items or services, or other Providers furnishing the same class of items or services as the Provider or entity;¶
(b) For purposes of this rule, terms "health care Provider," "entity related to a health care Provider" and "Provider-related donation" will have the same meaning as those terms are defined in 42 CFR 433.52. A health care Provider includes but is not limited to any Provider enrolled with ~~Division~~the Authority or contracting with a Prepaid Health Plan for services to Oregon Health Plan ~~client~~Members.¶
(c) Premium ~~S~~sponsorships made to the Authority by a health care Provider or an entity related to a health care Provider do not qualify as a "bona fide donation" within the meaning of subsection (a) of this section, and the Authority will decline to accept such sponsorships;¶
(d) If a health care Provider or an entity related to a health care Provider donates money to an organization, which in turn donates money in the form of a ~~P~~premium ~~S~~sponsorship to the Authority, the organization will be referred to as an organizational sponsor. The Authority may accept ~~P~~premium ~~S~~sponsorship from an organizational sponsor if the organizational sponsor has completed the initial Authority certification process and complies with this rule. An organizational sponsor may not itself be a health care ~~P~~provider, Provider-related entity, or a unit of local government;¶
(e) All organizational sponsors that make ~~P~~premium ~~S~~sponsorships to the Authority may be required to complete at least annual certifications, but no more frequently than quarterly. Reports submitted to the Authority will include information about the percentage of its revenues that are from donations by Providers and Provider-related entities. The organization's chief executive officer or chief financial officer must certify the report. In its

certification, the organizational sponsor must agree that its records may be reviewed to confirm the accuracy, completeness and full disclosure of the donations, donation amounts and sources of donations. The Authority will decline to accept donations or gifts from an organization that refuses or fails to execute necessary certifications or to provide access to documentation upon request;¶
(f) The Authority will decline to accept ~~P~~premium ~~S~~sponsorships from an organizational sponsor if the organization receives more than 25 percent of its revenue from donations from Providers or Provider-related entities during the State's fiscal year;¶
(g) Any health care Provider or entity related to a health care Provider making a donation to an organizational sponsor, or causing another to make a ~~P~~premium ~~S~~sponsorship on its behalf, and any organizational sponsor, is solely responsible for compliance with laws and regulations applicable to any donation, including but not limited to 42 CFR 1001.951 and 1001.952.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1395

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1395
Program Integrity ¶

(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity. These rules describe program integrity actions related to ~~p~~Provider payments. ~~Our~~The Authority's program integrity goal is to pay the correct amount to a properly enrolled ~~p~~Provider for ~~c~~Covered, ~~m~~Medically ~~a~~Appropriate ~~s~~Services provided to an eligible ~~client~~Member according to the ~~client~~Member's ~~b~~Benefit ~~p~~Package of health care services in effect on the ~~d~~Date of ~~s~~Service. Types of program integrity activities include but are not limited to the following activities:¶
(a) Medical review and ~~p~~Prior ~~a~~Authorization processes, including all actions taken to determine the medical appropriateness of services or items;¶
(b) Provider obligations to submit correct claims;¶
(c) Onsite visits to verify compliance with standards;¶
(d) Implementation of Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;¶
(e) Provider credentialing activities;¶
(f) Accessing federal Department of Health and Human Services database (exclusions);¶
(g) Quality improvement activities;¶
(h) Cost report settlement processes;¶
(i) Audits;¶
(j) Investigation of fraud or prohibited kickback relationships;¶
(k) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities.¶
(2) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360, Requirements for Financial, Clinical and Other Records, in the ~~G~~general ~~R~~rules ~~Program~~, the Oregon Health Plan administrative rules, and the rules applicable to the service or item.¶
(3) The following people may review a request for services or items, or audit a claim for care, services or items, before or after payment, for assurance that the specific care, item or service was provided in accordance with the Division of Medical Assistance Program's (Division) rules and the generally accepted standards of a ~~p~~Provider's field of practice or specialty:¶
(a) Authority, Department staff or designee; or¶
(b) Medical utilization and review contractor; or¶
(c) Dental utilization and review contractor; or¶
(d) Federal or state oversight authority.¶
(4) Payment may be denied or subject to recovery if the review or audit determines the care, service or item was not provided in accordance with Division rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment. Related ~~p~~Provider and Hospital billings will also be denied or subject to recovery.¶
(5) When the Authority determines that an ~~o~~Overpayment has been made to a ~~p~~Provider, the amount of ~~o~~Overpayment is subject to recovery.¶
(6) The Authority may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.¶
(7) The Authority must notify HHS-OIG within 20 working days of any disclosures from the date it receives the information, or takes any adverse action to limit the ability of an individual or entity to participate in its program as provided in 42 CFR 1002.3(b). This includes, but is not limited to, suspension, denials, terminations, settlement agreements and situations where an individual or entity voluntarily with-draws from the program to avoid a formal sanction.¶
(8) When the Authority initiates an exclusion under § 1002.210, it must notify the individual or entity subject to the exclusion and other state agencies, the state medical licensing board, the public, beneficiaries, and others as provided in § 1001.2005 and § 1001.2006.
Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1397

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1397
Recovery of Overpayments to Providers - Recoupments and Refunds ¶

(1) The Authority requires Providers to submit true, accurate, and complete claims or encounters. The Authority treats the submission of a claim or encounter, whether on paper or electronically, as certification by the Provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws."¶
(2) Authority staff or a designee may review or audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with the Authority rules and policies, the terms applicable to the agreement or contract and the generally accepted standards of a Provider's field of practice or specialty:¶
(a) "Designee" for the purposes of th~~ese~~is rule~~s~~ includes, but is not limited to, a medical, behavioral, drug or dental utilization and review or a post-payment review contractor;¶
(b) "Claim" for the purposes of th~~ese~~is rule~~s~~ includes requests for payment under a Provider enrollment agreement or contract, whether submitted as a claim or invoice or other method for requesting ~~p~~Payment ~~a~~Authorized by administrative rule, and may include encounter data.¶
(3) The Authority may deny payment or may deem payments subject to recovery as an Overpayment if a review or audit determines the care, item, drug or service was not provided in accordance with Authority policy and rules applicable agreement, intergovernmental agreement or contract, including but not limited to the reasons identified in section (5) of this rule. Related Provider and Hospital billings will also be denied or subject to recovery.¶
(4) If a Provider determines that a submitted claim or encounter is incorrect, the Provider is obligated to submit an Individual Adjustment Request and refund the amount of the Overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the Provider determines that an Overpayment has been made, the Provider must notify and reimburse the Authority immediately, following one of the reimbursement procedures described below:¶
(a) Submitting a Medicaid adjustment form (OHA 1036-Individual Adjustment Request) will result in an offset of future payments. It is not necessary to refund with a check if an offset of future payments is adequate to repay the amount of the Overpayment; or¶
(b) Providers preferring to make a refund by check must attach a copy of the remittance statement page indicating the Overpayment information, except as provided by subsection (c) of this section. If the Overpayment involves an insurance payment or another Third-_-Party Resource, Providers will attach a copy of the remittance statement from the insurance payer:¶
(A) Refund checks not involving Third-_-Party Resource payments will be made payable to Division Receipting - Checks in Salem;¶
(B) Refunds involving Third-_-Party Resource payments will be made payable and submitted to the Division Receipting - MPR Checks in Salem;¶
(c) Providers making a refund by check based on audit or post-payment review will follow the reimbursement procedures described in the Overpayment notice or order in the audit or on post-payment review, if specified.¶
(5) The Authority may determine, as a result of review or other information, that a payment should be denied or that an Overpayment has been made to a Provider, which indicates that a Provider may have submitted claims or encounters, or received payment to which the Provider is not properly entitled. Such payment denial or Overpayment determinations may be based on, but not limited to, the following grounds:¶
(a) The Authority paid the Provider an amount in excess of the amount authorized under the State Plan or Authority rule, agreement or contract;¶
(b) A ~~t~~Third-~~p~~-Party paid the Provider for services (or a portion thereof) previously paid by the Authority;¶
(c) The Authority paid the Provider for care, items, drugs or services that the Provider did not perform or provide;¶
(d) The Authority paid for claims submitted by a data processing agent for whom a written Provider or Billing Agent/Billing Service agreement or other applicable contract or agreement was not on file at the time of submission;¶
(e) The Authority paid for care, items, drugs or services and later determined they were not part of the ~~client~~Member's ~~b~~Benefit ~~p~~Package;¶
(f) Coding, processing submission or data entry errors;¶

(g) The care, items, drugs or service was not provided in accordance with Authority rules or does not meet the criteria for quality of care, item, drug or service, or medical appropriateness of the care, item, drug, service or payment;¶
(h) The Authority paid the Provider for care, items, drugs or services, when the Provider did not comply with Authority rules and requirements for reimbursement.¶
(6) Prior to identifying an Overpayment, the Authority or designee may contact the Provider for the purpose of providing preliminary information and requesting additional documentation. Provider must provide the requested documentation within the time frames requested.¶
(7) When an Overpayment is identified, The Authority will notify the Provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the Overpayment, and any further action that the Authority may take in the matter:¶
(a) The Authority notice may require the Provider to submit applicable documentation for review prior to requesting an appeal from the Authority, and may impose reasonable time limits for when such documentation must be provided in order to be considered by the Authority.¶
(b) The Provider may appeal a Authority notice of Overpayment in the manner provided in OAR 410-120-1560.¶
(8) The Authority may recover Overpayments made to a Provider by direct reimbursement, offset, civil action, or other actions authorized by law:¶
(a) The Provider must make a direct reimbursement to the Authority within thirty (30) calendar days from the date of the notice of the Overpayment, unless other regulations apply;¶
(b) The Authority may grant the Provider an additional period of time to reimburse the Authority upon written request made within thirty (30) calendar days from the date of the notice of Overpayment if the Provider provides a statement of facts and reasons sufficient to show that repayment of the Overpayment amount should be delayed pending appeal because:¶
(A) The Provider will suffer irreparable injury if the Overpayment repayment is not delayed;¶
(B) There is a plausible reason to believe that the ~~o~~Overpayment is not correct or is less than the amount in the notice, and the Provider has timely filed an appeal of the Overpayment, or that Provider accepts the amount of the Overpayment but is requesting to make repayment over a period of time;¶
(C) A proposed method for assuring that the amount of the Overpayment can be repaid when due with interest, including but not limited to a bond, irrevocable letter of credit or other undertaking, or a repayment plan for making payments including interest over a period of time.¶
(D) Granting the delay will not result in substantial public harm;¶
(E) Affidavits containing evidence relied upon in support of the request for stay:¶
(F) The Authority may consider all information in the record of the Overpayment determination, including Provider cooperation with timely provision of documentation, in addition to the information supplied in Provider's request. If Provider requests a repayment plan, the Authority may require conditions acceptable to the Authority before agreeing to a repayment plan. The Authority must issue an order granting or denying a repayment delay request within thirty (30) calendar days after receiving it.¶
(c) Except as otherwise provided in subsection (b) a request for a hearing or administrative review does not change the date the repayment of the Overpayment is due, and if the outcome of the appeal reduces the amount of the Overpayment, that amount previously paid by the Provider in response to the notice of Overpayment will be refunded to the Provider;¶
(d) The Authority may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when Overpayments are not paid as a result of section (7)(a) of this rule;¶
(e) The Authority may file a civil action in the appropriate Court and exercise all other civil remedies available to the Authority in order to recover the amount of an overpayment.¶
(9) In addition to any ~~o~~Overpayment, the Authority may impose a Sanction on the Provider in connection with the actions that resulted in the ~~o~~Overpayment. ~~t~~The Authority may, at its discretion, combine a notice of Sanction with a notice of Overpayment.¶
(10) Voluntary submission of an Individual Adjustment Request or ~~o~~Overpayment amount after notice from the Authority does not prevent the Authority from issuing a notice of Sanction, but the Authority may take such voluntary payment into account in determining the Sanction.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 413.351, 414.805, 416.350

AMEND: 410-120-1510

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1510
Fraud and Abuse ¶

(1) This rule sets forth requirements for reporting, detecting and investigating ~~f~~Fraud and ~~a~~Abuse. The terms fraud and abuse are defined in OAR 410-120-0000. For the purpose of th~~ese~~is rule~~s~~, the following definitions apply:¶
(a) "Credible allegation of fraud" means an allegation of ~~f~~Fraud, that has been verified by the state and has indicia of reliability that comes from any source as defined in 42 CFR 455.2;¶
(b) "Conviction" or "convicted" means that a judgment of conviction has been entered by a federal, state, or local court regardless of whether an appeal from that judgment is pending;¶
(c) "Exclusion" means that the Authority or the Oregon Department of Human Services (Department) shall not reimburse a specific ~~p~~Provider who has defrauded or abused the Authority or Department for items or services which that ~~p~~Provider furnished;¶
(d) "Prohibited kickback relationships" means remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 CFR 1001.951;¶
(e) "Suspension" means the Authority or Department shall not reimburse a specified ~~p~~Provider who has been convicted of a program-related offense in a federal, state, or local court for items or services which that ~~p~~Provider furnished.¶
(2) Cases involving one or more of the following situations shall constitute sufficient grounds for a ~~p~~Provider ~~f~~Fraud referral:¶
(a) Billing for services, supplies, or equipment that are not provided to or used for Medicaid ~~patient~~Members;¶
(b) Billing for supplies or equipment that are clearly unsuitable for the ~~patient~~Member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;¶
(c) Claiming costs for ~~n~~Non-covered or non-chargeable ~~s~~Services, supplies, or equipment disguised as covered items;¶
(d) Materially misrepresenting dates and descriptions of services provided, and the identity of the individual who provided the services or of the recipient of the services;¶
(e) Duplicate billing of the Medicaid program or of the ~~recipient~~Member that appears to be a deliberate attempt to obtain additional reimbursement; and¶
(f) Arrangements by ~~p~~Providers with employees, independent contractors, suppliers, and other various devices such as commissions and fee splitting that appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.¶
(3) The ~~p~~Provider shall promptly refer all suspected ~~f~~Fraud and ~~a~~Abuse, including ~~f~~Fraud or ~~a~~Abuse by its employees or in the Division administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice or to the Department's Provider Audit Unit (PAU). Contact information may be found online at: http://www.oregon.gov/OHA/HSD/OHP//Pages/Policy-General-Rules.aspx.¶
(4) If the ~~p~~Provider is aware of suspected ~~f~~Fraud or ~~a~~Abuse by an Authority or Department ~~client~~Member, the ~~p~~Provider shall report the incident to the Department's Fraud Investigations Unit (FIU). Contact information may be found online at http://www.oregon.gov/OHA/HSD/OHP//Pages/Policy-General-Rules.aspx.¶
(5) The ~~p~~Provider shall permit the MFCU, Authority, Department, or law enforcement entity, together or separately, to inspect, copy, evaluate, or audit books, records, documents, files, accounts, and facilities without charge, as required to investigate an incident of ~~f~~Fraud or ~~a~~Abuse. When a ~~p~~Provider fails to provide immediate access to records, Medicaid payments may be withheld or suspended.¶
(6) Providers and their fiscal ~~a~~Agents shall disclose ownership and control information and disclose information on a ~~p~~Provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, CHIP, or the Title XX services program. Such disclosure and reporting is made a part of the ~~p~~Provider enrollment agreement, and the ~~p~~Provider shall update that information with an amended ~~p~~Provider enrollment agreement if any of the information materially changes. The Authority or Department shall use that information to meet the requirements of 42 CFR 455.100 to 455.106, and this rule shall be construed in a manner that is consistent with the Authority or Department acting in compliance with those federal requirements.¶
(7) The Authority or Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.¶
(8) The Authority or Department may suspend payments in whole or part in a suspected case of ~~f~~Fraud or ~~a~~Abuse;

or where there exists a credible allegation of ~~f~~Fraud or ~~a~~Abuse presented to the Authority, the Department, or law enforcement entity; or where there is a pending investigation or conclusion of legal proceedings related to the ~~p~~Provider's alleged ~~f~~Fraud or ~~a~~Abuse.¶
(9) The Authority or Department may take the actions necessary to investigate and respond to credible allegations of ~~f~~Fraud and ~~a~~Abuse, including but not limited to ~~s~~Suspending or ~~t~~Terminating the ~~p~~Provider from participation in the ~~m~~Medical ~~a~~Assistance ~~p~~Programs, withholding payments or seeking recovery of payments made to the ~~p~~Provider, or imposing other ~~s~~Sanctions provided under state law or regulations. These actions by the Authority or Department may be reported to CMS, or other federal or state entities as appropriate.¶
(10) The Authority or Department shall not pay for ~~c~~Covered ~~s~~Services provided by persons who are currently suspended, debarred, or otherwise excluded from participating in Medicaid, Medicare, CHIP, or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, XXI, or XX of the Social Security Act or related laws.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1560

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping updates.

CHANGES TO RULE:

410-120-1560
Provider Appeals ¶

(1) For purposes of Division ~~þ~~Provider ~~a~~Appeal rules in chapter 410, division 120, the following terms and definitions are used:¶
(a) "Provider" means an individual or entity enrolled with the Division or under contract with the Division that is subject to the Division rules and that has requested an ~~a~~Appeal in relation to health care, items, drugs, or services provided or requested to be provided to a ~~client~~Member on a fee-for-service basis or under contract with the Division where that contract expressly incorporates these rules;¶
(b) "Provider Applicant" means an individual or entity that has submitted an application to become an enrolled ~~þ~~Provider with the Division, but the application has not been approved;¶
(c) "Prepaid Health Plan" has the meaning set forth in OAR 410-141-3500, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to ~~þ~~Provider grievances and ~~a~~Appeals;¶
(d) "Prepaid Health Plan provider" means an individual or entity enrolled with the Division but that provided health care services, supplies or items to a ~~client~~Member enrolled with a PHP, including both participating providers and non-participating providers as those terms are defined in OAR 410-141-0000, except that services provided to a ~~client~~Member enrolled with an MHO shall be governed by the provider grievance and ~~a~~Appeal procedures administered by the Authority's ~~Addictions and Ment~~Behavioral Health Division;¶
(e) The "Provider Appeal Rules" refers to the rules in OAR 410-120-1560 to 410-120-1600, describing the availability of ~~a~~Appeal procedures and the procedures applicable to each;¶
(f) "Non-participating provider" has the meaning set forth in OAR 410-141-3500;¶
(g) "Coordinated Care Organization (CCO)" has the meaning set forth in OAR 410-141-3500.¶
(2) A Division enrolled ~~þ~~Provider may ~~a~~Appeal a Division decision in which the ~~þ~~Provider is directly adversely affected including but not limited to the following:¶
(a) A denial or limitation of payment allowed for services or items provided;¶
(b) A denial related to an NCCI edit;¶
(c) A denial of ~~þ~~Provider's application for new or continued participation in the Medical Assistance Program; or¶
(d) Sanctions imposed, or intended to be imposed, by the Division on a ~~þ~~Provider or ~~þ~~Provider entity; and¶
(e) Division ~~o~~Overpayment determinations made under OAR 410-120-1397.¶
(3) ~~Client a~~Member Appeals of ~~a~~Actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865.¶
(4) A ~~þ~~Provider ~~a~~Appeal is initiated by filing a timely request in writing for review with the Division:¶
(a) A ~~þ~~Provider ~~a~~Appeal request is not required to follow a specific format as long as it provides a clear written expression from a ~~þ~~Provider or ~~þ~~Provider applicant expressing disagreement with a Division decision or from a CCO or PHP ~~þ~~Provider expressing disagreement with a decision by a CCO or PHP.¶
(b) The request must identify the decision made by the Division, a CCO, or PHP that is being ~~a~~Appealed and the reason the ~~þ~~Provider disagrees with that decision.¶
(c) A ~~þ~~Provider ~~a~~Appeal request is timely if it is received by the Division:¶
(A) Within 180 calendar days from the date of the Division's fee-for-service decision;¶
(B) Within 30 calendar days from the date of the CCO or PHP decision after the ~~þ~~Provider completes the CCO or PHP ~~a~~Appeal process.¶
(5) Types and methods for ~~þ~~Provider ~~a~~Appeals are:¶
(a) Claim redeterminations: A Division denial of or limitation of payment allowed, including ~~þ~~Prior ~~a~~Authorization decision, or Division ~~o~~Overpayment determination for services or items provided to a ~~client~~Member must be ~~a~~Appealed as claim re-determinations under OAR 410-120-1570.¶
(b) Contested Case: A notice of ~~s~~Sanctions imposed or intended to be imposed, the effect of the notice of ~~s~~Sanction is, or will be, to deny, suspend, or revoke a ~~þ~~Provider number necessary to participate in the medical assistance on a ~~þ~~Provider, or ~~þ~~Provider applicant is entitled to ~~a~~Appeal under OAR 410-120-1600. A ~~þ~~Provider that may ~~a~~Appeal a notice of sanction as a contested case may choose to request administrative review instead of ~~c~~Contested ~~c~~Case ~~h~~Hearing if the ~~þ~~Provider submits a written request for administrative review and agrees in writing to waive the right to a ~~c~~Contested ~~c~~Case ~~h~~Hearing and the Division agrees to review the ~~a~~Appeal as an administrative review.¶
(c) Administrative review: All ~~þ~~Provider ~~a~~Appeals of Division decisions not described in section (5)(a) or (b) of this

rule are handled as administrative reviews in accordance with OAR 410-120-1580, unless the Division issues an order granting a ~~c~~Contested ~~c~~Case ~~h~~Hearing.¶
(6) Decisions that adversely affect a ~~p~~Provider may be made by different program areas within the Authority:¶
(a) Decisions issued by the Office of Payment Accuracy and Recovery (OPAR) or the Authority information security office shall be ~~a~~Appealed in accordance with the process described in the notice;¶
(b) Other program areas within the Authority that have responsibility for administering medical assistance funding, such as nursing home care or community mental health and developmental disabilities program services, may make decisions that adversely affect a ~~p~~Provider. Those ~~p~~Providers are subject to the ~~p~~Provider grievance or ~~a~~Appeal processes applicable to those payment or program areas;¶
(c) Some decisions that adversely affect a ~~p~~Provider are issued on behalf of the Division by Authority contractors such as the Division pharmacy benefits manager, by entities performing statutory functions related to the ~~m~~Medical ~~a~~Assistance ~~p~~Programs such as the Drug Use Review Board, or by other entities in the conduct of program integrity activities applicable to the administration of the ~~m~~Medical ~~a~~Assistance ~~p~~Programs. For these decisions made on behalf of the ~~d~~Division in which the Division has legal authority to make the final decision in the matter, a ~~p~~Provider may ~~a~~Appeal the decision to the Division as an administrative review, and the Division may accept the review;¶
(d) This rule does not apply to contract administration issues that may arise solely between the Division and a CCO or PHP. Those issues shall be governed by the terms of the applicable contract;¶
(e) The Division provides limited ~~p~~Provider ~~a~~Appeals for CCO or PHP ~~p~~Providers or non-participating ~~p~~Providers concerning a decision by a CCO or PHP. In general, the relationship between a CCO or PHP and their ~~p~~Providers is a contract matter between them. ~~Client a~~Member Appeals are governed by the ~~client a~~Member Appeal rules, not ~~p~~Provider ~~a~~Appeal rules.¶
(A) The CCO or PHP ~~p~~Provider seeking a ~~p~~Provider ~~a~~Appeal must have a current valid ~~p~~Provider enrollment agreement with the Division and, unless the ~~p~~Provider is a non-participating ~~p~~Provider, must also have a contract with the CCO or PHP; and¶
(B) The CCO or PHP ~~p~~Provider or non-participating ~~p~~Provider must have exhausted the applicable ~~a~~Appeal procedure established by the CCO or PHP, and the request for ~~p~~Provider ~~a~~Appeal must include a copy of the CCO or PHP written decision that is being ~~a~~Appealed and a copy of any CCO or PHP policy being applied in the ~~a~~Appeal; and¶
(C) The CCO or PHP ~~p~~Provider ~~a~~Appeal or non-participating ~~p~~Provider ~~a~~Appeal from a CCO or PHP decision is limited to issues related to the scope of coverage and authorization of services under the OHP, including whether services are included as covered on the OHA Prioritized List, guidelines, and in the OHP Benefit ~~p~~Package. The Division ~~p~~Provider ~~a~~Appeal process does not include CCO or PHP payment or claims reimbursement amount issues, except in relation to non-participating ~~p~~Provider matters governed by Division rule;¶
(D) A timely ~~p~~Provider request for ~~a~~Appeal must be made within 30 calendar days from the date of the CCO or PHP's decision and include evidence that the PHP was sent a copy of the ~~p~~Provider ~~a~~Appeal. In every ~~p~~Provider ~~a~~Appeal involving a CCO or PHP decision, the CCO or PHP shall be treated as a participant in the ~~a~~Appeal.¶
(7) If a ~~p~~Provider's request for ~~a~~Appeal is not timely, the Division shall determine whether the failure to file the request was caused by circumstances beyond the control of the ~~p~~Provider, ~~p~~Provider applicant, or CCO or PHP ~~p~~Provider. In determining whether to accept a late request for review, the Division requires the request to be supported by a written statement that explains why the request for review is late. The Division may conduct further inquiry as the Division deems appropriate. In determining timeliness of filing a request for review, the amount of time that the Division determines accounts for circumstances beyond the control of the provider is not counted. The Division may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.¶
(8) The burden of presenting evidence to support a ~~p~~Provider ~~a~~Appeal is on the ~~p~~Provider, ~~p~~Provider applicant, CCO, or PHP ~~p~~Provider:¶
(a) Consistent with OAR 410-120-1360, payment on a claim shall be made only for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to ~~c~~Covered ~~s~~Services for the ~~client~~Member's ~~b~~Benefit ~~p~~Package and establishing the conditions under which services, supplies or items are covered, such as the OHA Prioritized List, medical appropriateness and other applicable standards;¶
(b) Eligibility for enrollment and for continued enrollment is based on compliance with applicable rules, the information submitted or required to be submitted with the application for enrollment and the enrollment agreement, and the documentation required to be produced or maintained in accordance with OAR 410-120-1360.¶
(9) Provider ~~a~~Appeal proceedings, if any, shall be held in Salem, unless otherwise stipulated to by all parties and agreed to by the Division.
Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 413.042

AMEND: 410-120-1580

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1580
Provider Appeals - Administrative Review ¶

(1) An administrative review is a ~~p~~Provider ~~a~~Appeal process that allows an opportunity for the Administrator of the Division of Medical Assistance Programs (Division) or designee to review a Division decision affecting the ~~p~~Provider, ~~p~~Provider applicant, Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) ~~p~~Provider, where administrative review is appropriate and consistent with these ~~p~~Provider ~~a~~Appeal rules OAR 410-120-1560.¶
(2) Administrative review is an ~~a~~Appeal process under OAR 410-120-1560 that addresses primarily legal or policy issues that may arise in the context of a Division decision that adversely affects the Provider and that is not otherwise reviewed as a claim re-determination, a ~~c~~Contested ~~c~~Case, or ~~client a~~Member Appeal.¶
(a) If the Division finds that the ~~a~~Appeal should be handled as a different form of ~~p~~Provider ~~a~~Appeal or as a ~~client a~~Member Appeal, the Administrator or designee will notify the ~~p~~Provider of this determination.¶
(b) Within the time limits established by the Division in the administrative review, the ~~p~~Provider, ~~p~~Provider applicant, CCO or PHP ~~p~~Provider must provide Division (and CCO or PHP, if applicable) with a copy of all relevant records, the Division, CCO or PHP decisions, and other materials relevant to the ~~a~~Appeal.¶
(3) If the Administrator or designee decides that a meeting between the ~~p~~Provider, ~~p~~Provider applicant, CCO or PHP Provider (and CCO or PHP, if applicable) and the Division staff will assist the review, the Administrator or designee will:¶
(a) Notify the ~~p~~Provider requesting the review of the date, time, and place the meeting is scheduled;¶
(b) Notify the CCO or PHP (when ~~client~~Member is enrolled in a CCO or PHP) of the date, time, and place the meeting is scheduled. The CCO or PHP is not required to participate, but is invited to participate in the process.¶
(4) The review meeting will be conducted in the following manner:¶
(a) It will be conducted by the Division Administrator, or designee;¶
(b) No minutes or transcript of the review will be made;¶
(c) The ~~p~~Provider requesting the review does not have to be represented by counsel during an administrative review meeting and will be given ample opportunity to present relevant information;¶
(d) The Division staff will not be available for cross-examination, but the Division staff may attend and participate in the review meeting;¶
(e) Failure to appear without good cause constitutes acceptance of the Division's determination;¶
(f) The Administrator may combine similar administrative review proceedings, including the meeting, if the Administrator determines that joint proceedings may facilitate the review;¶
(g) The Division Administrator or designee may request the ~~p~~Provider, ~~p~~Provider ~~A~~applicant, CCO or PHP Provider making the appeal to submit, in writing, new information that has been presented orally. In such an instance, a specific date for receiving such information will be established.¶
(5) The results of the administrative review will be sent to the participants, involved in the review, and to the CCO or PHP when review involved a CCO or PHP ~~p~~Provider, in writing, within 30 calendar days of the conclusion of the administrative review proceeding, or such time as may be agreed to by the participants and the Division.¶
(6) The Division's final decision on administrative review is the final decision on ~~a~~Appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a ~~c~~Contested ~~c~~Case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Division's final decision on administrative review.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-120-1600

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping updates.

CHANGES TO RULE:

410-120-1600
Provider Appeals - Contested Case Hearings ¶

(1) A ~~c~~Contested ~~c~~Case procedure is a hearing that is conducted by the Office of Administrative Hearings where a ~~c~~Contested ~~c~~Case is appropriate and consistent with the ~~p~~Provider ~~a~~Appeal rules OAR 410-120-1560. If the request for ~~c~~Contested ~~c~~Case ~~h~~Hearing was timely filed but should have been filed as a claim redetermination or administrative review, or ~~client a~~Member Appeal, Division will refer the request to the proper ~~a~~Appeal procedure and notify the Provider, ~~p~~Provider applicant, CCO or PHP ~~p~~Provider.¶
(2) Contested ~~c~~Case ~~h~~Hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 to 137-003-0700.¶
(3) The party to a ~~p~~Provider ~~c~~Contested ~~c~~Case ~~h~~Hearing is the ~~p~~Provider, ~~p~~Provider applicant, CCO or PHP ~~p~~Provider who requested the ~~a~~Appeal. In the event that Division determines that a CCO or PHP ~~p~~Provider is entitled to a Contested Case Hearing under OAR 410-120-1560, the CCO or PHP Provider and the CCO or PHP are parties to the hearing. A ~~p~~Provider, CCO or PHP ~~p~~Provider, CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.¶
(4) Informal conference: Division may notify the ~~p~~Provider(s)~~p.~~ Provider applicant, CCO or PHP ~~p~~Provider (and CCO or PHP, if applicable) of the time and place of an informal conference, without the presence of the Administrative Law Judge (ALJ). The purposes of this informal conference are:¶
(a) To provide an opportunity to settle the matter;¶
(b) To make sure the parties and the Authority understand the specific reason for the action of the hearing request;¶
(c) To give the parties and the Authority an opportunity to review the information which is the basis for action;¶
(d) To give the parties and the Authority the chance to correct any misunderstanding of the facts; and¶
(e) The ~~p~~Provider, ~~p~~Provider applicant, CCO or PHP ~~p~~Provider (or CCO, PHP, if applicable) may, at any time prior to the hearing date, request an additional informal conference with the Division and Authority representative(s), which may be granted if the Division finds at its sole discretion, the additional informal conference will facilitate the Contested Case Hearing process or resolution of disputed issues.¶
(5) Contested Case Hearing: The Administrative Law Judge (ALJ) will conduct the contested case hearing using the Attorney General's Model Rules at OAR 137-003-0501 to 137-003-0700.¶
(a) The burden of presenting evidence to support a ~~p~~Provider ~~a~~Appeal is on the ~~p~~Provider, ~~p~~Provider applicant, CCO or PHP ~~p~~Provider that requested the ~~a~~Appeal. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to ~~c~~Covered ~~s~~Services for the ~~Client~~Member's ~~b~~Benefit ~~p~~Package and establishing the conditions under which services, supplies or items are covered, such as the OHA Prioritized List, medical appropriateness and other applicable standards.¶
(b) Subject to Division approval under OAR 137-003-0525, the ALJ will determine the location of the Contested Case Hearings.¶
(6) Proposed and Final Orders: The ALJ is authorized to 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 by the ALJ.¶
(a) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file written exceptions to the proposed order to be considered by the Division, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by the Division, or the ALJ when the ALJ is authorized to issue the final order, not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of Division.¶
(b) The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (a) of this rule, unless the Division notifies the parties and the ALJ that Division will issue the final order. After receiving the exceptions or argument, 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, Division may issue an amended proposed order.¶
(c) Procedures applicable to default orders for withdrawal of a hearing request, failure to timely request a hearing, failure to appear at a hearing, or other default, are governed by the Attorney General's Model Rules, OAR 137-003-0670 - 137-003-0672.¶

(d) The final order is effective immediately upon being signed or as otherwise provided in the order.¶
(7) All Contested Case Hearing decisions are subject to the procedures established in OAR 137-003-675 to 137-003-0700 and to judicial review under ORS 183.482 in the Court of Appeals.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-120-1860

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1860
Contested Case Hearing Procedures ¶

(1) These rules apply to all ~~c~~Contested ~~c~~Case ~~h~~Hearings provided by the Authority involving a ~~client~~Member's health care benefits, except as otherwise provided in OAR 410-141-3890. The hearings are conducted in accordance with ORS 183.411 through 183.497 and the Attorney General's model rules, OAR 137-003-0501 through 137-003-0700. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Authority for purposes of this rule except for OAR 137-003-0528(1)(a). The method described in OAR 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~~Member requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Authority contested cases.¶
(2) Medical ~~p~~Provider ~~a~~Appeals and administrative reviews involving the Division are governed by OAR 410-120-1560 through 410-120-1600.¶
(3) Grievances, complaints, and ~~a~~Appeals for ~~client~~Members requesting or receiving medical assistance from a~~n MCE~~ CCO shall be governed exclusively by the procedures in OARs 410-141-3875 through 410-141-3915. This rule describes the procedures applicable when ~~MCE client~~CCO members request and are eligible for an Authority contested case hearing.¶
(4) Contested Case Hearing Requests:¶
(a) A ~~client~~Member has the right to a ~~c~~Contested ~~c~~Case ~~h~~Hearing in the following situations upon the timely completion of a request for a hearing:¶
(A) The Authority makes an adverse determination or ~~a~~Action or, as it relates to a~~n MCE~~ CCO, an adverse benefit determination such as denial of ~~client~~Member services, payment of a claim, or to terminate, discontinue, or reduce a course of treatment, or issues related to disenrollment in a~~n MCE~~ CCO; or¶
(B) The right of a ~~client~~Member to request a ~~c~~Contested ~~c~~Case ~~h~~Hearing is otherwise provided by statute or rule, including OAR 410-141-3885 when a ~~client of an MCE~~CCO Member may request a state hearing.¶
(b) To be timely, a request for a hearing is complete when the following requirements are met:¶
(A) The Authority receives the Authority approved ~~a~~Appeal and hearing forms not later than the 60th day following the date of the decision notice;¶
(B) When enrolled in a~~n MCE~~ CCO, the ~~m~~CCO Member files the request for ~~c~~Contested ~~c~~Case ~~h~~Hearing within the time frames specified in OAR 410-141-3900.¶
(c) In the event a request for hearing is not timely, the Authority shall determine whether the ~~client~~Member showed there was good cause, as defined in OAR 137-003-0501(7), for their failure to timely file the hearing request. In determining whether to accept a late hearing request, the Authority requires the request to be supported by a written statement that explains why the request for hearing is late. The Authority may conduct such further inquiry as the Authority deems appropriate. If the Authority finds that the ~~client~~Member has good cause for late filing, the Authority shall refer the case to the Office of Administrative Hearings (OAH) for a ~~c~~Contested ~~c~~Case ~~h~~Hearing. The following factual disputes shall be referred to the OAH for a hearing:¶
(A) Whether the hearing request was received timely;¶
(B) Whether the ~~client~~Member received the notice of adverse benefit determination or ~~a~~Action;¶
(C) The information included in the ~~client~~Member's statement of good cause.¶
(d) In the event the ~~c~~Claimant is not entitled to a ~~c~~Contested ~~c~~Case ~~h~~Hearing on an issue, the Authority may enter an order accordingly. The Authority may refer a hearing request to the OAH for a hearing on the question of whether the ~~c~~Claimant has a right to a ~~c~~Contested ~~c~~Case ~~h~~Hearing;¶
(e) A ~~client~~Member who requests a hearing shall be referred to as a ~~c~~Claimant. The parties to a ~~c~~Contested ~~c~~Case ~~h~~Hearing are the ~~c~~Claimant and, if the ~~c~~Claimant has requested a hearing about a decision of a~~n MCE~~ CCO, the ~~c~~Claimant's ~~MCE~~CCO;¶
(f) A ~~client~~Member may be represented by any of the individuals identified in ORS 183.458. A~~n MCE~~ CCO that is a corporation may be represented by any of the individuals identified in ORS 410.190.¶
(g) For ~~clients enrolled in an MCE~~CCO Members, the following applies:¶
(A) May request a ~~c~~Contested ~~c~~Case ~~h~~Hearing with the state after receiving notice that the adverse benefit determination or ~~MCE~~CCO action is upheld or, in the case of a~~n MCE~~ CCO that fails to adhere to the notice and

timing requirements, the state may deem that the ~~m~~CCO Member has exhausted the ~~MCE~~CCO's ~~a~~Appeals process and may initiate a state ~~c~~Contested ~~c~~Case ~~h~~Hearing pursuant to OAR 410-141-3900;¶
(B) A request for an Authority administrative hearing made prior to a~~n MCE a~~ CCO Appeal by the ~~m~~CCO Member or ~~m~~CCO Member's ~~r~~Representative or ~~p~~Provider shall be forwarded by the Authority to the ~~MCE~~CCO for review, except in the case where the Authority determines the ~~MCE~~CCO failed to act within required timelines.¶
(5) Expedited hearings:¶
(a) A ~~c~~Claimant who feels their health care problem may not wait for the normal review process may be entitled to an expedited hearing;¶
(b) A request for an expedited hearing for a service that has already been provided (post-service) to the ~~c~~Claimant may not be granted;¶
(c) Expedited hearings are requested using Authority Form 443 or other Division approved ~~a~~Appeal and/or hearing request forms;¶
(d) Authority staff shall request all relevant health care documentation and present the documentation obtained in response to that request to the Authority medical director or the medical director's designee for review. The Authority medical director or designee shall decide if the ~~c~~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;¶
(e) An expedited hearing shall be allowed if the Authority medical director or the designee determines that the ~~c~~Claimant has a health care condition that could jeopardize the ~~c~~Claimant's life, health, or ability to maintain or regain maximum function and ~~c~~Claimant has been denied a health care service;¶
(f) Expedited hearing requests shall be completed as expeditiously as the ~~c~~Claimant's health condition requires with the following timelines:¶
(A) For ~~m~~CCO Members ~~enrolled in an MCE's~~ the expedited hearing requests responding to any claim requiring review of a~~n MCE~~ CCO written notice of expedited ~~a~~Appeal resolution, hearing requests shall be no later than three (3) working days after the agency receives from the ~~MCE~~CCO the case file and information for any ~~a~~Appeal of a denial of a service as indicated by the ~~MCE~~CCO;¶
(B) For ~~recipients of Fee For Service~~Open Card Members the expedited state contested hearing requests, no later than seven (7) working days after the agency receives a request for expedited fair hearing responding to any request for the following reasons:¶
(i) Claim for services is denied or is not acted upon with reasonable promptness;¶
(ii) Requests because the ~~c~~Claimant believes the agency has taken an ~~a~~Action erroneously;¶
(iii) Requests because the ~~c~~Claimant believes a skilled nursing facility or nursing facility has erroneously determined that they must be transferred or discharged;¶
(iv) Requests because the ~~c~~Claimant believes the state has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act; or¶
(v) For expedited state administrative hearing for claims related to prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under CFR §435.912, based on the date the application is submitted to any insurance affordability program.¶
(g) The Authority shall take final administrative action on a ~~c~~Contested ~~h~~Case Hearing request within the time limits set forth in 42 CFR Part 431 and Part 435 except in unusual circumstances when:¶
(A) The Authority may not reach a decision because the appellant requests a delay or fails to take a required action; or¶
(B) There is an administrative or other emergency beyond the Authority's control.¶
(6) Informal conference:¶
(a) The Authority hearing representative and the ~~c~~Claimant, and their legal ~~r~~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 Authority and the ~~c~~Claimant to settle the matter;¶
(B) Provide an opportunity to make sure the ~~c~~Claimant understands the reason for the ~~a~~Action that is the subject of the hearing request;¶
(C) Give the ~~c~~Claimant and the Authority an opportunity to review the information that is the basis for that ~~a~~Action;¶
(D) Inform the ~~c~~Claimant of the rules that serve as the basis for the contested action;¶
(E) Give the ~~c~~Claimant and the Authority the chance to correct any misunderstanding of the facts;¶
(F) Determine if the ~~c~~Claimant wishes to have any witness subpoenas issued for the hearing; and¶
(G) Give the Authority an opportunity to review its ~~a~~Action.¶
(b) The ~~c~~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 their sole discretion that the additional informal discussion shall facilitate the hearing process or resolution of disputed issues;¶
(c) The Authority may provide to the ~~c~~Claimant the relief sought at any time before the ~~F~~final ~~O~~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 ~~c~~Claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Authority or the ALJ, whichever is first. The ALJ shall send a ~~F~~final ~~O~~order confirming the withdrawal to the ~~c~~Claimant's last known address. The ~~c~~Claimant may cancel the withdrawal up to the tenth day following the date such an order is effective.¶
(8) Contested ~~c~~Case ~~h~~Hearings are closed to non-participants in the hearing; however, a ~~client~~Member may choose to have another individual present.¶
(9) Proposed and ~~F~~final ~~O~~orders:¶
(a) In a ~~c~~Contested ~~c~~Case, an ALJ assigned by the Office of Administrative Hearings shall serve a proposed order on all parties and the Authority, unless prior to the hearing the Authority notifies the ALJ that a final order may be served. The proposed order issued by the ALJ shall become a final order if no exceptions are filed within the time specified in subsection (b)(A) below, unless the Authority notifies the parties and the ALJ that the Authority shall issue the final order;¶
(b) If the ALJ issues a proposed order, a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for the Authority's consideration:¶
(A) The exceptions must be in writing and reach the Authority not later than ~~ten~~10 working days after date the proposed order is issued by the ALJ;¶
(B) After receiving the exceptions, if any, the Authority may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Authority shall 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 Authority shall 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 unable to attend the hearing and unable to request a postponement.¶
(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the ~~c~~Claimant's withdrawal of the hearing request is effective the date the ~~c~~Claimant withdraws. When the ~~c~~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 ~~c~~Contested ~~c~~Case ~~h~~Hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.¶
[NOTE: Forms referenced are available from the agency.]
Statutory/Other Authority: ORS 183.341, 413.042
Statutes/Other Implemented: ORS 183.411 - 183.471, 411.408, 414.025, 414.065

AMEND: 410-120-1865

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1865
Denial, Reduction, or Termination of Services ¶

(1) The purpose of this rule is to describe the requirements governing the denial, reduction, or termination of medical assistance and access to the Authority administrative hearings process for ~~client~~Open Card Members requesting or receiving medical assistance services paid for by the Authority on a fee-for-service basis. Grievance, complaint, and ~~a~~Appeal procedures for ~~clients receiving services from an MCE~~CCO Members shall be governed exclusively by the procedures in OAR 410-141-3260 and where applicable OAR 410-141-3475.¶
(2) When the Authority authorizes a course of treatment or ~~c~~Covered ~~s~~Service, but subsequently acts (as defined in 42 CFR 431.201) to ~~t~~Terminate, ~~s~~Suspend, or reduce the course of treatment or a ~~c~~Covered ~~s~~Service, the Authority or its designee shall mail a written notice to the ~~client~~Member at least ~~ten~~10 days before the date of the termination or reduction of the ~~c~~Covered ~~s~~Service unless there is documentation that the ~~client~~Member had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.¶
(3) The written ~~client~~ notice must inform the ~~client~~Member of the ~~a~~Action the Authority has taken or intends to take and reasons for the ~~a~~Action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the ~~client~~Member's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Authority for additional information. The Authority is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all ~~recipient~~Members.¶
(4) The Authority shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:¶
(a) If the ~~client~~Member requests an administrative hearing by the tenth day following the date of the ~~client~~Member notice, or before the effective date of the ~~a~~Action proposed in the notice, if applicable, and requests that the services be continued, the Authority shall continue the services. The service shall be continued until whichever of the following occurs first, but may not exceed ~~ninety~~90 days from the date of the ~~client~~Member's request for an administrative hearing~~)~~:¶
(A) The current authorization expires; or¶
(B) A decision is rendered about the case that is the subject of the administrative hearing; or¶
(C) The ~~client~~Member is no longer eligible for medical assistance benefits or the health service, supply, or item that is the subject of the administrative hearing is no longer a covered benefit in the ~~client~~Member's medical assistance ~~b~~Benefit ~~p~~Package; or¶
(D) The sole issue is one of federal or state law or policy, and the Authority promptly informs the ~~client~~Member in writing that services are to be terminated or reduced pending the hearing decision.¶
(b) The ~~Division~~Authority shall notify the ~~client~~Member in writing that it is continuing the service. The notice shall inform the ~~client~~Member that if the hearing is resolved against the ~~client~~Member, the cost of any services continued after the effective date of the ~~client~~Member notice may be recovered from the ~~client~~Member pursuant to 42 CFR 431.230(b);¶
(c) The Authority shall reinstate services if:¶
(A) The Authority takes an ~~a~~Action without providing the required notice and the ~~client~~Member requests a hearing;¶
(B) The Authority does not provide the notice in the time required under section (2) of this rule and the ~~client~~Member requests a hearing within 10 days of the mailing of the notice of action; or¶
(C) The post office returns mail directed to the ~~client~~Member, but the ~~client~~Member's whereabouts become known during the time the ~~client~~Member is still eligible for services;¶
(D) The reinstated services must be continued until a hearing decision, unless at the hearing it is determined that the sole issue is one of federal or state law or policy.¶
(d) The Authority shall promptly correct the ~~a~~Action taken up to the limit of the original authorization, retroactive to the date the ~~a~~Action was taken, if the hearing decision is favorable to the ~~client~~Member, or the Authority decides in the ~~client~~Member's favor before the hearing.
Statutory/Other Authority: 413.042
Statutes/Other Implemented: 411.408, 414.025, 414.065

AMEND: 410-120-1875

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1875
Agency Hearing Representatives ¶

(1) Subject to the approval of the Attorney General, an agency officer or employee is authorized to appear (but not make legal argument) on behalf of the Authority in the following classes of hearings:¶
(a) Contested ~~c~~Case ~~h~~Hearings requested by ~~client~~Members in accordance with OAR 410-120-1860 and 410-130-1865; and¶
(b) Contested ~~c~~Case ~~h~~Hearings involving Providers in accordance with OAR 410-120-1560 to 410-120-1~~700~~865.¶
(2) Subject to the approval of the Attorney General, the Authority Audit Manager responsible for the Division of Medical Assistance Programs (Division) audits is authorized to appear (but not make legal argument) on behalf of the Authority in the following classes of hearings:¶
(a) Division Overpayment determinations made in an audit under OAR 943-120-1505 (Provider audit);¶
(b) Division Provider Sanction decisions made in conjunction with or in lieu of an ~~o~~Overpayment determination in OAR 943-120-1505~~ (Provider audit)~~.¶
(3) Legal argument as used in ORS 183.452 and this rule has the same meaning as defined in OAR 137-003-0008(1)(c) and (d) 137-003-0545.¶
(4) When a Authority officer or employee, or the Authority Audit Manager, represents the Authority, the presiding officer will advise such representative of the manner in which objections may be made and matters preserved for ~~a~~Appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer will provide reasonable opportunity for the Authority officer or employee, or the Authority Audit Manager, to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after the conclusion of the hearing.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1940

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1940
Interest Payments on Overdue Claims ¶

(1) Upon request by the ~~p~~Provider, the Division will pay interest on an overdue claim:¶
(a) A claim is considered "overdue" if Division does not make payment within 45 days of receipt of a ~~v~~Valid ~~c~~Claim;¶
(b) The interest rate shall be the usual rate charged by the ~~p~~Provider to the ~~p~~Provider's clientele, but not more than 2/3 percent per month or eight percent per year.¶
(2) When billing Division for interest on an overdue ~~v~~Valid ~~c~~Claim the ~~p~~Provider must furnish the following information in writing:¶
(a) Name of the service and the location the service was provided;¶
(b) The name of the ~~client~~Member who received the service;¶
(c) ~~Client~~Member ID Number;¶
(d) Date of service;¶
(e) Date of initial valid billing of the Division;¶
(f) Amount of billing on initial ~~v~~Valid ~~c~~Claim;¶
(g) Division Internal Control Number (ICN) of claim;¶
(h) Certification, signed by the ~~p~~Provider or the ~~p~~Provider's authorized ~~a~~Agent, that the amount claimed does not exceed the usual overdue account charges assessed by the ~~p~~Provider to the ~~p~~Provider's clientele.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-120-1960

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1960
Payment of Private Insurance Premiums ¶

(1) Private Insurance Premium (PHI) and Health Insurance Premium Payment (HIPP) are cost saving programs administered by the Authority and the Department for Medicaid enrollees. When a Medicaid ~~client~~Member or eligible enrollee is covered by employer sponsored group health insurance or private health insurance, the Authority or Department may choose to reimburse all or a portion of the insurance premium, if it is determined to be ~~c~~Cost ~~e~~Effective for the Authority or Department.¶
(2) The Authority or Department may pay health insurance policy premiums or otherwise enter into agreements with other health insurance plans that comply with ORS 414.115 to 414.145 on behalf of eligible individuals when:¶
(a) The ~~client~~Member is enrolled in a full coverage Medicaid program approved by the Authority or Department (excluding CHIP and CWM);¶
(b) The policy is a comprehensive major medical insurance plan (comparable to the Medicaid State Plan coverage) and at a minimum provides the following:¶
(A) Physician services;¶
(B) Hospitalization (inpatient and outpatient);¶
(C) Outpatient lab, x-ray, immunizations; and¶
(D) Full prescription drug coverage.¶
(c) The payment of premiums, co-insurance, and deductibles is likely to be ~~c~~Cost ~~-e~~ Effective, as determined under section (5) of this rule;¶
(d) An eligible applicant may be a non-Medicaid individual living in or outside the household. The Authority or Department may pay the entire premium (excluding the employer's portion) if payment of the premium including the non-Medicaid individual is ~~c~~Cost ~~-e~~ Effective and if it is necessary to include that individual in order to enroll the ~~client~~Member in the health plan.¶
(3) The Authority or Department ~~shall~~may not pay private health insurance premiums for:¶
(a) Non-SSI institutionalized and waivered ~~client~~Members whose income deduction is used for payment of health insurance premiums;¶
(b) A policy that has limited benefits where the Authority or Department's annual cost for the premiums exceeds the benefit limits of the policy;¶
(c) Medicaid eligible ~~client~~Members enrolled in Medicare Part A, Part B, and Part C;¶
(d) Non-major medical stand-alone policies such as dental, vision, cancer, or accident only;¶
(e) When the purpose of the policy is providing court ordered health insurance.¶
(4) The Authority or Department shall assure that all Medicaid covered services continue to be made available to Medicaid-eligible individuals for whom the Authority or Department elects to purchase all or a portion of their private or employer-sponsored health insurance.¶
(5) Assessment of ~~c~~Cost ~~-e~~ Effectiveness shall include:¶
(a) The Medical Savings Chart (MSC) is used to obtain the cost effectiveness rate for each Medicaid eligible ~~client~~Member;¶
(b) In cases where there is more than one Medicaid eligible ~~client~~Member covered by a single insurance policy, the cost effectiveness rates are combined and compared to the cost of the insurance premium. If the combined cost effectiveness rate total is greater than the cost of the premium, it is approved as cost effective;¶
(c) If the monthly premium exceeds the allowable amount on the MSC, the Authority or Department may elect to review the current and probable future health status of the Medicaid ~~client~~Member based upon their existing medical conditions, previous medical history, age, number of dependents, and other relevant health status indicators. The Authority or Department may apply a special conditions rate in addition to the cost-effectiveness rate on the MSC to determine if their premium is ~~c~~Cost ~~e~~Effective.¶
(6) The Authority or Department may purchase documents or records necessary to establish or maintain the ~~client~~Member's eligibility for other insurance coverage.¶
(7) The Authority or Department may not make payments for any benefits covered under the private health insurance plan except as follows:¶
(a) The Authority or Department shall calculate the allowable payment for a service. The amount paid by the other

insurer shall be deducted from the allowable. If the allowable exceeds the ~~t~~Third ~~p~~-Party payment, the Authority or Department shall pay the ~~p~~Provider of service the difference;¶
(b) The payment may not exceed any co-insurance, copayment, or deductible due;¶
(c) The Authority or Department shall make payment of co-insurance, copayments, or deductibles due only for ~~c~~Covered ~~s~~Services provided to Medicaid eligible ~~client~~Members.¶
(8) Any change of insurance coverage shall be reported to the Authority or Department within ~~ten~~10 days of the change. If the Authority or Department determines reimbursement of premiums was made on behalf of the ~~client~~Member for a policy no longer in effect, the payee shall be liable for repayment to the Authority or Department for the full amount of any overpayment established. To minimize any overpayment made on the ~~client~~Member's behalf, changes that must be reported include but are not limited to:¶
(a) Private or employer-sponsored insurance no longer active;¶
(b) Family member added or dropped from health insurance plan;¶
(c) Change in health insurance plan or health plan coverage;¶
(d) Change in employer resulting in change in health insurance plan;¶
(e) Change in health plan premium cost;¶
(f) Change in employment status (lay off or termination, short-term disability);¶
(g) Address changes.¶
(9) As a condition of eligibility, ~~client~~Members must pursue assets (OAR 461-120-0330) and obtain medical coverage (OAR 461-120-0345). Failure to notify the Authority or Department of insurance coverage or changes in coverage and failure to provide periodic required documentation for PHI/HIPP may impact continued eligibility.¶
(10) If it is determined that reimbursement of premiums is ~~c~~Cost ~~-e~~ Effective, payments shall begin in the next new month following the determination; however, the Authority or Department may approve a retroactive payment when appropriate.¶
(11) Cancellation of premium payment shall result when:¶
(a) A ~~client~~Member is no longer eligible for a medical program approved by the Authority or Department;¶
(b) A ~~client~~Member is no longer covered by the employer-sponsored or private health insurance plan;¶
(c) A health insurance premium is no longer cost effective for the Authority or Department;¶
(d) Failure to submit or complete redetermination forms or provide documentation required by the Authority or Department to complete redetermination;¶
(e) A ~~client~~Member or eligible applicant fails to use the Authority or Department's premium payment reimbursement to pay for their private insurance, if they are required to pay the insurance directly;¶
(f) The policy-type changes (primary policy changes to a supplemental policy) or the ~~client~~Member's eligibility changes to a category that does not meet the requirements in section (2) of this rule.¶
(12) The Authority or Department shall determine where approved premium payments shall be sent to: the policy holder (or authorized representative), the employer, insurance carrier, or some other entity.¶
(13) The ~~client~~Member or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment or reimbursement of ~~client~~Member-paid insurance premium. If insurance is canceled because payment was used for purposes other than premium payment, an overpayment may occur.¶
(14) Redetermination for HIPP/PHI reimbursement shall occur:¶
(a) Annually for continued cost effectiveness and may also be reviewed more frequently to ensure insurance is active;¶
(b) When changes with medical program, insurance eligibility, or employment have been reported or identified;¶
(c) Other reasons determined by the Authority or Department.¶
(15) Payment of premiums is a reimbursement and not a medical benefit; therefore, ~~client~~Members do not have hearing rights for a denial of private insurance premium payment. The Authority or Department's decision to place a ~~client~~Member in the PHI/HIPP program is a reimbursement and not an eligibility determination nor denial of a medical program benefit.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135, 414.145

AMEND: 410-120-1990

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping updates.

CHANGES TO RULE:

410-120-1990
Telehealth
(1) The following definitions apply ~~to t~~with respect to telehealth in this rule. The Oregon Health Authority (Authority) a~~dministrative rules applicable to the medical assistance programs:~~lso incorporates the definitions in OAR 410-120-0000 for any terms not defined in this rule.¶
(a) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telehealth services may include audio and video, audio without video, ~~client or m~~Member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages;¶
(b) "Audio ~~o~~Only" means the use of audio technology, permitting real-time communication between a health care ~~p~~Provider and a ~~m~~Member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are normally delivered by audio telephone technology and normally not billed as separate services by a health care ~~p~~Provider, such as the sharing of laboratory results;¶
(c) "Meaningful ~~a~~Access" as defined in Oregon Administrative Rule (OAR) 410-120-0000;¶
(d) "Synchronous" means an interaction between a ~~p~~Provider and a ~~client or m~~Member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring. Synchronous encounters are considered to meet face-to-face requirements;¶
(e) "Telecommunication ~~t~~Technologies" means the use of devices and services for telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted using landlines, and wireless communications, including the ~~i~~internet and telephone networks;¶
(f) "Telehealth" includes telemedicine and ~~also includes~~ the use of electronic information and ~~t~~Telecommunications ~~t~~Technologies to support remote clinical healthcare, ~~client or m~~Member and professional health-related education, public health, and health administration;¶
(g) "Telemedicine" means the mode of delivering remote clinical health services using information and ~~t~~Telecommunication ~~t~~Technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a ~~client or m~~Member's healthcare;¶
(h) "Trauma ~~i~~Informed ~~a~~Approach" as defined in OAR 410-120-0000;¶
(i) "Trauma ~~i~~Informed ~~s~~Services" as defined in OAR 410-120-0000.¶
(2) Communications may be between ~~p~~Providers, or between one or more ~~p~~Providers and one or more ~~clients or members, family member~~Members, relatives, caregivers and guardians.¶
(3) School-Based Health Services required by the Individuals with Disabilities Education Act (IDEA), Section 504 Plan, under the Rehabilitation Act of 1973, or any other documented individualized health or behavioral health plan or as otherwise determined ~~m~~Medically ~~n~~Necessary provided in school programs and settings provided to eligible children in their education program settings by public education enrolled ~~p~~Providers billing for these services to Medicaid are exempt from this rule. See chapter 410, division 133 for School-Based Health Services OARs.¶
(4) CCOs and F~~FS p~~ee-for-Service Providers must ensure Oregon Health Plan (OHP) ~~clients or m~~Members are offered a choice of how services are received, including services offered using ~~t~~Telehealth modalities and in-person services, except where the Authority issues explicit guidance during a declared state of emergency or if a facility has implemented its facility disaster plan.¶
(5) Providers unable to offer in-person services:¶
(a) F~~FS p~~ee-for-Services Providers unable to offer in-person services must develop, maintain and carry out policies and procedures to offer local ~~p~~Provider options to a ~~client or m~~Member when an in-person visit is clinically indicated or when the ~~client or m~~Member requests in-person services. This may include but is not limited to ~~c~~Care ~~c~~Coordination or completing ~~r~~Referral paperwork;~~-~~¶
(b) CCOs must ensure that ~~p~~Providers unable to offer in-person services have access to the CCO Provider ~~D~~directory.~~-~~CCOs must include in applicable ~~p~~Provider contract language that ~~p~~Providers unable to offer in-person services shall, as needed, inform the CCO upon ~~r~~Referring a ~~m~~CCO Member to another ~~p~~Provider so the CCO can provide any ~~c~~Care ~~c~~Coordination services necessary to support the ~~m~~CCO Member in accessing care.¶
(6) ~~Client or m~~Member choice and accommodation for ~~t~~Telehealth must encompass the following standards and services:¶

(a) Providers who offer ~~t~~Telehealth delivered services must offer ~~m~~Meaningful ~~a~~Access to services by completing a capacity assessment of the ~~client or m~~Member in the use of specific approved methods of ~~t~~Telehealth delivery that comply with accessibility standards including alternate formats, and provides the optimal quality of care for the ~~client or m~~Member given considerations of ~~client or m~~Member access to necessary devices, access to a private and safe location, adequate internet, digital literacy, cultural appropriateness of services delivered using ~~t~~Telehealth, and other considerations of ~~client or m~~Member readiness to use ~~t~~Telehealth;¶
(b) Providers must offer ~~m~~Meaningful ~~a~~Access to health care services for ~~clients or m~~Members and their families who experience ~~L~~limited English ~~P~~proficiency (LEP) or hearing impairment by working with qualified or certified ~~h~~Health ~~c~~Care ~~i~~Interpreters, to provide language access services as described in OAR 333-002-0040 and 410-120-0001. These services must not be significantly restricted, delayed, or inferior as compared to programs or activities provided to English proficient individuals;¶
(c) Providers must collaborate with ~~clients or m~~Members to identify and offer modalities for delivering health care services which best meets the needs of the ~~m~~Member and considers the ~~client or m~~Member's choice and readiness for the modality of service selected;¶
(d) Providers must offer ~~t~~Telehealth services which are consistent with ~~"m~~Meaningful ~~a~~Access~~"~~ as defined in OAR 410-120-0000.¶
(7) Privacy and security standards for ~~t~~Telehealth services must be met by satisfying the following:¶
(a) Prior to the delivery of services using a ~~t~~Telehealth modality, a ~~client or m~~Member's written, oral, or recorded consent to receive services using a ~~t~~Telehealth delivery method in the language that the ~~client or m~~Member understands must be obtained and documented by the health system, clinic or ~~p~~Provider in the ~~client or m~~Member's health record. Consent must include an assessment of ~~client or m~~Member readiness to access and participate in ~~t~~Telehealth delivered services, including conveying all other options for receiving the health care service to the ~~client or m~~Member. Consent must be updated at least annually thereafter. For ~~clients or m~~Members and their families who experience LEP or hearing impairment ~~clients~~, ~~p~~Providers must use qualified or certified ~~h~~Health ~~c~~Care ~~i~~Interpreters when obtaining ~~client or m~~Member consent;¶
(b) Consistent with Oregon Revised Statute (ORS) 109.640, provision of birth control information and services using a ~~t~~Telehealth modality must be provided to any person regardless of age without consent of parent or legal guardian;¶
(c) Consistent with ORS 109.640, provision of any other medical or dental diagnosis and treatment using a ~~t~~Telehealth modality must be provided to any person 15 years of age or older without consent of parent or legal guardian;¶
(d) Consistent with ORS 109.675, provision of outpatient diagnosis or treatment of a mental or emotional disorder or a chemical dependency using a ~~t~~Telehealth modality must be provided to any person 14 years of age or older without consent of parent or legal guardian;¶
(e) Consistent with ORS 109.610, provision of diagnosis or treatment of certain sexually transmitted infections using a ~~t~~Telehealth modality must be provided to a person regardless of age without consent of parent or legal guardian;¶
(f) Services provided using a ~~t~~Telehealth platform must comply with Health Insurance Portability and Accountability Act (HIPAA), ~~https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996,~~ and with the Authority's Privacy and Confidentiality Rules (chapter 943, division 14) except as noted in section (10) of this rule below;¶
(g) There is no limitation on the location of the ~~client or m~~Member;¶
(h) OHP enrolled ~~p~~Providers may be located in any location where ~~client or m~~Member privacy and confidentiality can be ensured;¶
(i) Persons providing interpretive services and supports must be in a location where ~~client or m~~Member privacy and confidentiality can be ensured.¶
(8) Providers who offer ~~t~~Telehealth delivery of services must meet the following requirements:¶
(a) Must hold an unencumbered Oregon license;¶
(b) Must be enrolled with the Authority as an Oregon Health Plan (OHP) ~~p~~Provider, per OAR 410-120-1260;¶
(c) Must provide services using ~~t~~Telehealth that are within their respective certification or licensing board's scope of practice and comply with ~~t~~Telehealth requirements including, but not limited to:¶
(A) Documenting ~~client or m~~Member and ~~p~~Provider agreement of consent to receive services.¶
(B) Allowed physical locations of ~~p~~Provider and ~~client or m~~Member.¶
(C) Establishing or maintaining an appropriate ~~p~~Provider-~~client or m~~ Member relationship.¶
(d) Comply with HIPAA and the Authority's Privacy and Confidentiality Rules and security protections for the ~~m~~Member in connection with the ~~t~~Telehealth communication and related records requirements (OAR chapter 943 division 14 and 120, OAR 410-120-1360 and 1380, 42 CFR Part 2, if applicable, and ORS 646A.600 to 646A.628 ~~(~~[Oregon Consumer Identity Theft Protection Act]) except as noted in section (10) of this rule;¶
(e) Obtain and maintain technology used in ~~t~~Telehealth communication that is compliant with privacy and security

standards in HIPAA and the Authority's Privacy and Confidentiality Rules described in subsection (~~A~~7)(a) except as noted in section (10) of this rule;¶
(f) Develop and maintain policies and procedures to prevent a breach in privacy or exposure of ~~client or m~~Member health information or records (whether oral or recorded in any form or medium) to unauthorized persons and timely breach reporting as described in OAR 943-014-0440;¶
(g) Maintain clinical and financial documentation related to ~~t~~Telehealth services as required in OAR 410-120-1360 and any program specific rules in OAR chapter 309 and chapter 410;¶
(h) Comply with all federal and state statutes as required in OAR 410-120-1380.¶
(9) CCOs and the Authority ~~wi~~shall reimburse ~~t~~Telehealth delivered services only when all the following requirements are met:¶
(a) Services provided must be ~~c~~Covered ~~s~~Services according to the ~~client or m~~Member's ~~b~~Benefit ~~p~~Package as described in OAR 410-120-1210 and be provided in a manner compliant with relevant guideline notes included in the ~~Health Evidence Review Commission's~~OHA Prioritized List of Health Services as described in OAR 410-141-3830;¶
(b) CCOs and the Authority must provide reimbursement for ~~t~~Telehealth services at the same reimbursement rate as if the professional services were provided in~~-~~-person.~~-~~¶
(A) As a condition of reimbursement, F~~FS p~~ee-for-Service Providers must agree to reimburse Certified and Qualified Health Care Interpreters (HCIs) as defined in OAR 333-002-0010 for interpretation services provided using ~~t~~Telehealth at the same rate, excluding travel expenses, as if interpretation services were provided in-person.~~-~~¶
(B) CCOs must also reimburse Certified and Qualified HCIs for interpretation services provided using ~~t~~Telehealth at the same reimbursement rate, excluding travel expenses, as if it were provided in~~-~~-person. These requirements do not supersede the CCOs direct agreement(s) with ~~p~~Providers, including but not limited to, alternative payment methodologies, quality and performance measures or ~~V~~value ~~B~~based ~~P~~payment methods described in the CCO contract. Administrative rules and CCO ~~D~~direct ~~A~~agreements do not supersede any federal or state requirements with regard to the provision and coverage of health care interpreter services.¶
(c) When allowed by individual certification or licensing board's scope of practice standards, qualifying ~~t~~Telehealth delivered services are covered:¶
(A) When provided to established ~~clients or m~~Members;¶
(B) When provided to new ~~clients or m~~Members; and¶
(C) When consistent with applicable program specific OARs within chapter 410.¶
(d) All physical, behavioral and dental ~~t~~Telehealth services except School Based Health Services (SBHS) must include Place of Service code 02 when the ~~client or~~ member is located in a place other than their home. When the ~~client or~~ member is located in their home, the claim must include ~~P~~place of ~~S~~service code 10;¶
(e) All claim types except dental services must include modifier 95 when the ~~t~~Telehealth delivered service utilizes a real-time interactive audio and video telecommunication system. When provision of the same service utilizes a real-time interactive audio only, the claim must include modifier 93.¶
(10) In the event of a declared emergency or changes in federal requirements, the Authority may adopt flexibilities to remove administrative barriers and support ~~t~~Telehealth delivered services:¶
(a) The Authority must follow guidance from the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR), which may allow enforcement discretion related to privacy or security requirements.¶
(b) The Authority may expand network capacity through remote care and ~~t~~Telehealth services provided across state lines.¶
(c) The Authority may exercise flexibilities in network adequacy requirements as described in OAR 410-141-3515.
Statutory/Other Authority: ORS 413.032, 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.723