DIVISION 1

PROCEDURAL RULES

DIVISION 50

TAX RULES

DIVISION 120

MEDICAL ASSISTANCE PROGRAMS

DIVISION 121

PHARMACEUTICAL SERVICES

DIVISION 122

DURABLE MEDICAL EQUIPMENT, PROSTHETICS ORTHOTICS AND SUPPLIES (DMEPOS)

DIVISION 123

DENTAL/DENTURIST SERVICES

DIVISION 124

TRANSPLANT SERVICES

DIVISION 125

HOSPITAL SERVICES

DIVISION 127

HOME HEALTH CARE SERVICES

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

DIVISION 130

MEDICAL-SURGICAL SERVICES

DIVISION 131

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

DIVISION 132

PRIVATE DUTY NURSING SERVICES

DIVISION 133

SCHOOL-BASED HEALTH SERVICES

DIVISION 136

MEDICAL TRANSPORTATION SERVICES

DIVISION 138

TARGETED CASE MANAGEMENT

DIVISION 140

VISUAL SERVICES

DIVISION 141

OREGON HEALTH PLAN

DIVISION 142

HOSPICE SERVICES

DIVISION 145

COOPERATIVE TRANSPLANT PROGRAM APPROVAL AND MONITORING

DIVISION 146

AMERICAN INDIAN/ALASKA NATIVE

DIVISION 147

FQHC AND RHC SERVICES

DIVISION 148

HOME ENTERAL/PARENTERAL NUTRITION AND IV SERVICES

DIVISION 150

ADMINISTRATIVE EXAMINATION AND BILLING SERVICES

DIVISION 160

LAW ENFORCEMENT LIABILITY ACCOUNT (LEMLA)

DIVISION 165

OREGON MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

DIVISION 500

RURAL MEDICAL PRACTITIONERS INSURANCE SUBSIDY PROGRAM

DIVISION 1

PROCEDURAL RULES

410-001-0000
Model Rules of Procedure

Oregon Health Authority (Authority), Division of Medical Assistance Programs, chapter 410, will adhere to Authority rules in chapter 943 regarding Model Rules of Procedure.

Stat. Auth.: ORS 183.335, 183.341 & 413.042
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 414.025 & 414.065
Hist.: HR 3(Temp), f. & ef. 12-29-76; HR 5, f. & ef. 3-10-77; HR 2-1978, f. & ef. 3-3-78; HR 5-1980, f. & ef. 9-17-80; HR 6-1982, f. & ef. 7-1-82; HR 1-1986, f. & ef. 4-2-86; HR 1-1988, f. & cert. ef. 1-4-88; HR 7-1991, f. & cert. ef. 1-25-91; OMAP 9-2006, f. 5-3-06, cert. ef. 6-1-06

410-001-0005
Notice of Proposed Rulemaking and Adoption of Temporary Rules

Oregon Health Authority (Authority), Division of Medical Assistance Programs, chapter 410, will comply with Authority rules in chapter 943 for Notices of Rulemaking and adoption of Temporary rules.

Stat. Auth.: ORS 183.335, 183.341 & 413.042
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 414.025 & 414.065
Hist.: HR 3(Temp), f. & ef. 12-29-76; HR 5, f. & ef. 3-10-77; HR 2-1978, f. & ef. 3-3-78; HR 5-1980, f. & ef. 9-17-80; OMAP 9-2006, f. 5-3-06, cert. ef. 6-1-06

410-001-0020
Delegation of Rulemaking Authority

Oregon Health Authority (Authority), Division of Medical Assistance Programs, chapter 410, will comply with Authority rules in chapter 943 for Delegation of Rulemaking Authority.

Stat. Auth.: ORS 183.335, 183.341 & 413.042
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 414.025 & 414.065
Hist.: HR 6(Temp), f. & ef. 7-1-77; HR 7, f. & ef. 9-1-77; OMAP 9-2006, f. 5-3-06, cert. ef. 6-1-06

DIVISION 50

TAX RULES

410-050-0700
Definitions

The following definitions apply to OAR 410-050-0700 to 410-050-0870:

(1) "Authority" means the Oregon Health Authority.

(2) "Bad Debt" means the current period charge for actual or expected uncollectible accounts resulting from the extension of credit on inpatient and outpatient hospital services. Bad debt charges shall be offset by any recoveries received on accounts receivable during that current period, subject to final assessment reporting and reconciliation processes required in these rules.

(3) "Charges for Inpatient Care" means gross inpatient charges generated from room, board, general nursing, and ancillary services provided to patients, who are expected to remain in the hospital at least overnight, and occupy a bed (as distinguished from categories of health care items or services identified in 42 CFR 433.56(a)(2)-(19) that are not charges for inpatient hospital services). Charges for inpatient care include all payors, and are not limited to Medicaid patients.

(4) "Charges for Outpatient Care" means gross outpatient charges, generated from services provided by the hospital to a patient who is not confined overnight. These services include all ancillary and clinic facility charges (as distinguished from categories of health care items or services identified in 42 CFR 433.56(a)(1) and (3)-(19) that are not charges for outpatient hospital services). Charges of outpatient care include all payors and are not limited to Medicaid charges.

(5) "Charity Care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services. Charity care results from a hospital's policy as reflected in its official financial statements to provide inpatient or outpatient hospital care services free of charge or at a reduced charge to individuals who meet financial criteria. Charity care does not include any amounts above the payments by the Authority that constitute payment in full under ORS 414.065(3), or above the payment rate established by contract with a prepaid managed care health services organization or health insurance entity for inpatient or outpatient care provided pursuant to such contract, or above the payment rate established under ORS 414.743 for inpatient or outpatient care reimbursed under that statute.

(6) "Contractual Adjustments" means the difference between the amounts charged based on the hospital's full, established charges and the amount received or due from the payor.

(7) "Declared Fiscal Year" means the fiscal year declared to the Internal Revenue Service (IRS).

(8) "Deficiency" means the amount by which the assessment, as correctly computed, exceeds the assessment, if any, reported and paid by the hospital. If, after the original deficiency has been assessed, subsequent information shows the correct amount of assessment to be greater than previously determined, an additional deficiency arises.

(9) "Delinquency" means the hospital failed to file a report when due as required under these rules or failed to pay the assessment as correctly computed when the assessment was due.

(10) "Director" means the Director of the Authority.

(11) "Hospital" means a hospital with an organized medical staff, with permanent facilities that include inpatient beds, and with medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for, but not limited to, acutely ill patients and accident victims, or to provide treatment for the mentally ill. Hospital, as used in this section, does not include special inpatient care facilities as that term is defined in ORS 442.015. For purposes of these rules, the hospital shall be identified by using the federal payer identification number for the hospital.

(12) "Net Revenue" means the total amount of charges for inpatient or outpatient care provided by the hospital to patients, less charity care, bad debts, and contractual adjustments. Net revenue does not include revenue derived from sources other than inpatient or outpatient operations, including but not limited to, interest and guest meals and any revenue that is taken into account in computing a long term care assessment under the long term facility assessment.

(13) "Waivered Hospital" means a Type A or Type B hospital as described in ORS 442.470, or a hospital that provides only psychiatric care.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 33-2009, f. & cert. ef. 10-1-09; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0710
General Administration

(1) The purpose of these rules is to implement the assessment imposed on hospitals in Oregon.

(2) The Authority shall administer, enforce, and collect the hospital assessment. The Authority may assign employees, auditors, and other agents as designated by the Director to assist in the administration, enforcement, and collection of the assessments.

(3) The Authority may adopt forms and reporting requirements, and change the forms and reporting requirements, as necessary, to administer, enforce, and collect the assessments.

(4) The Authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in Section 9, Chapter 736, Oregon Laws 2003 as amended by Section 2, Chapter 757, Oregon Laws 2005.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0720
Disclosure of Information

(1) Except as otherwise provided by law, the Authority may not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the assessments. Particulars include but are not limited to social security numbers, employer numbers, or other hospital identification numbers, and any business records required to be submitted to or inspected by the Authority or its designee to allow it to determine the amounts of any assessments, delinquencies, deficiencies, penalties, or interest payable or paid, or otherwise administer, enforce, or collect a health care assessment to the extent that such information shall be exempt from disclosure under ORS 192.501(5) or other basis for exemption under Oregon's public records law.

(2) The Authority may:

(a) Furnish any hospital, or its authorized representative, upon request of the hospital or representative, with a copy of the hospital's report filed with the Authority for any quarter, or with a copy of any report filed by the hospital in connection with the report, or with a copy of any other information the Authority considers necessary;

(b) Publish information or statistics so classified as to prevent the identification of income or any particulars contained in any report or return;

(c) Disclose and give access to an officer or employee of the Authority or its designee, or to the authorized representatives of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Controller General of the United States, the Oregon Secretary of State, the Oregon Department of Justice, the Oregon Department of Justice Medicaid Fraud Control Unit, and other employees of the state or federal government to the extent the Authority deems disclosure or access necessary or appropriate for the performance of official duties in the Authority's administration, enforcement, or collection of the assessments.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0730
Entities Subject to the Hospital Assessment

Each hospital in Oregon is subject to the hospital assessment except:

(1) Hospitals operated by the United States Department of Veterans Affairs;

(2) Pediatric specialty hospitals providing care to children at no charge; and

(3) Waivered hospitals, as that term is defined in OAR 410-050-0700.

Stat. Auth.: ORS 413.042, 410.070, 411.060
Stats. Implemented: 2015 HB 2395§ 2
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0740
The Hospital Assessment: Calculation, Report, Due Date

(1) The amount of the assessment equals the assessment rate multiplied by the hospital's net revenue, consistent with OAR 410-050-0750, 410-050-0860, and 410-050-0861. The assessment shall be imposed on net revenues earned by the hospital on or after January 1, 2004, based on calendar quarters. The first calendar quarter begins on January 1; the second calendar quarter begins on April 1; the third calendar quarter begins on July 1; and the fourth calendar quarter begins on October 1.

(2) The assessment rate shall be determined in accordance with OAR 410-050-0860 and 410-050-0861.

(3) The hospital shall file the quarterly report on a form approved by the Authority on or before the 75th day following the end of the calendar quarter for which an assessment is due. The quarterly payment is due and shall be paid at the same time required for filing the quarterly report. The hospital shall provide all information required on the quarterly report when due. Failure to file or pay when due shall be a delinquency.

(4) The assessment becomes operative on July 1, 2004. The first due date for a quarterly assessment and report shall be 75 days from September 30, which is December 13, 2004.

(5) The fiscal year reconciliation report, including the financial statement and reconciliation statement, is due and shall be submitted to the Authority no later than the final day of the sixth calendar month after the hospital's declared fiscal year end. The fiscal year reconciliation assessment payment is due and shall be paid at the same time required for filing the fiscal year reconciliation report. The hospital shall provide all information required on the fiscal year reconciliation report when due. Failure to file or pay when due shall be a delinquency.

(6) Any report, statement, or other document required to be filed under any provision of these rules must be certified by the hospital's chief financial officer or designee. The certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the document.

(7) Payments may be made electronically or by paper check. If the hospital pays electronically, the accompanying report may either be faxed to the Authority at the fax number provided on the report form or mailed to the address provided on the report form. If the hospital pays by paper check, the accompanying report shall be mailed with the check to the address provided on the report form.

(8) The Authority may charge the hospital a fee of $100 if, for any reason, the check, draft, order, or electronic funds transfer request is dishonored. This charge is in addition to any penalty for nonpayment of the assessment that may also be due.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395

Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0750
Reporting Total Net Revenue, Use of Estimated Revenue for Quarterly Reports

(1) A hospital shall submit quarterly reports and quarterly payments for the calendar quarters for which an assessment is due consistent with sections (2) and (5) of this rule, and shall submit a fiscal year reconciliation report that includes a reconciliation statement, audited financial statement, and any fiscal year reconciliation assessment payment based on the hospital's declared fiscal year end consistent with sections (3) and (5) of this rule.

(2) The quarterly reports and quarterly assessment payments shall be based on estimated net revenue, which shall be referred to as estimated assessment. Estimated assessment is the amount of assessment the hospital expects to owe for the current calendar quarter. The hospital shall calculate the estimated assessment based on net revenues using the hospital's interim financial results for the quarter for which the assessment is due. An estimated quarterly report is due for each calendar quarter for which an assessment is due, based on the rate of assessment applicable to that quarter. The quarterly payment is due and shall be paid at the same time required for filing the quarterly report.

(3) The fiscal year reconciliation report and fiscal year reconciliation assessment payment shall be based on the amount of assessment the hospital actually owes based on annual net revenue for all calendar quarters for which an estimated assessment payment is due during the hospital's declared fiscal year. The hospital shall calculate the annual net revenue for the hospital's declared fiscal year. The fiscal year reconciliation assessment payment due shall be the calculated assessment (using the assessment rate applicable to the appropriate quarter, described in subsection (c) below for fiscal year reconciliation assessment calculation purposes) on the annual net revenue reduced by the estimated assessment payments made for each assessment quarter of the hospital's declared fiscal year. The hospital shall provide all information required in the fiscal year reconciliation report when due, even if no fiscal year reconciliation assessment payment is owed:

(a) When the fiscal year reconciliation report is submitted, it shall be accompanied by the hospital's declared fiscal year end audited financial statement for the declared fiscal year on which the fiscal year reconciliation report and fiscal year reconciliation assessment payments are based;

(b) The fiscal year reconciliation report shall include a reconciliation statement describing the relationship between the audited financial statement and annual net revenues subject to the assessment. The reconciliation statement may be descriptive in form and shall be consistent with the accounting principles used in the audited financial statement;

(c) The rate applicable to the final assessment shall be calculated as follows:

(A) If all assessment quarters were subject to the same rate established in OAR 410-050-0160 and 410-050-0861, then the rate applicable to the final reconciliation is the assessment rate applicable to all such quarters. For example, if the hospital's declared fiscal year is July 1, 2004 to June 30, 2005, then the assessment rate is .93 percent of annual net revenue;

(B) If different assessment rates apply to calendar quarters in the hospital's declared fiscal year, the hospital shall apply a blended rate to the total annual net revenue to determine the fiscal year reconciliation assessment due. A blended rate is the average of the rates applicable to all assessment quarters. The Authority shall notify the hospital of the amount of the applicable blended rate. For example, if the hospital's declared fiscal year overlaps two quarters assessed at a rate of .93 percent and two quarters assessed at .50 percent, then the blended rate for purposes of the annual reconciliation is .715 percent. For purposes of calculating the fiscal year reconciliation assessment due, the hospital shall multiply the annual net revenue by the blended rate.

(d) If the total estimated assessment payments already paid by the hospital for the declared fiscal year exceed the amount of the fiscal year reconciliation assessment actually due, the fiscal year reconciliation report shall identify the difference and the hospital shall adjust the fiscal year reconciliation assessment due amount in the fiscal year reconciliation report for that assessment year;

(e) The fiscal year reconciliation report, audited financial statement, and reconciliation statement shall be due and submitted to the Authority no later than the final day of the sixth calendar month after the hospital's declared fiscal year end. The fiscal year reconciliation assessment payment (if owed) is due and shall be paid at the same time required for filing the fiscal year reconciliation report. Failure to file or pay when due shall be a delinquency;

(f) If the declared fiscal year end audited financial statement for the hospital is not available within the time required in subsection (e), a fiscal year reconciliation assessment payment (if owed) and fiscal year reconciliation report must be submitted within the time period specified under subsection (e). The hospital may use interim financial statements to determine the amount of the fiscal year reconciliation assessment due and may submit a justification statement with the fiscal year reconciliation report due no later than the date specified in subsection (e) signed by the hospital's chief financial officer informing the Authority when the audited financial statement is due and certifying that an amended fiscal year reconciliation report, including the reconciliation statement, shall be provided to the Authority within 30 days of the hospital's receipt of the audited financial statement. Reports and payments made after the time period required in subsection (e) shall be submitted in compliance with OAR 401-050-0760;

(g) If the hospital does not receive audited financial statements, then internal financial statements signed by the hospital's chief financial officer shall be submitted where these rules otherwise require audited financial statements;

(h) If the effective date of the assessment is not at the start of the hospital's declared fiscal year, then the annual net revenue for the first fiscal year reconciliation report shall be calculated based on the number of quarters subject to the assessment versus the total number of quarters in the hospital's declared fiscal year. For example, if the assessment is effective on July 1, 2004 for a hospital with a declared fiscal year ending December 31, 2004, the annual net revenues shall be calculated as follows: total net revenues for the declared fiscal year divided by two (two of four quarters subject to the assessment).

(4) The Authority may not find a payment deficiency for estimated quarterly assessments as long as the hospital paid the estimated assessments and submitted the quarterly report no later than the quarterly due date and the estimated assessment amount was not less than the equivalent of the assessment payment that would have been determined based on the hospital's annual net revenue for its most recent prior declared fiscal year divided by four and multiplied times the assessment rate for the quarter in which the actual estimated assessment is due. Annual net revenue for purposes of section (4) of this rule means the twelve month period in which the hospital's most recent prior declared fiscal year occurred, regardless of whether the prior quarters were subject to an assessment. For example, if the annual net revenue for the most recent prior declared fiscal year was $4 million; divide that total by 4 ($1 million) and multiply the product times the current assessment rate for the assessment quarter (.93 percent). In this example, the estimated quarterly assessment payment may not be less than $9,300 in order to receive the benefit of section (4) of this rule:

(a) If the hospital seeks to use the process in section (4) of this rule, no later than the date on which the first quarterly estimated assessment and report is due (for example, December 13, 2004, for the first assessment quarter), the hospital shall provide the Authority with a copy of the hospital's audited financial statement for the hospital's most recent prior declared fiscal year and identify the hospital's annual net revenue amount for that declared fiscal year, regardless of whether any assessments were due for that year;

(b) If the hospital does not receive audited financial statements, then internal financial statements from the hospital's most recent

prior declared fiscal year signed by the chief financial officer may be used for this purpose.

(5) All of the due dates for filing reports or paying assessments are established in OAR 410-050-0740, unless the Authority permits a later payment date. If a hospital requests an extension, the Authority, in its sole discretion, shall determine whether to grant an extension. There shall be a delinquency for each quarter the hospital fails to pay the estimated assessment or file the quarterly report when due. There shall be a delinquency if the hospital fails to pay the fiscal year reconciliation assessment or file the fiscal year reconciliation report, including financial statements and reconciliation statement, when due.

(6) A hospital shall declare the date of the hospital's declared fiscal year end for purposes of establishing final assessment reporting requirements under this rule. The declaration shall be filed with the Authority no later than December 13, 2004, or the first date that an estimated quarterly report and assessment is due. The hospital shall notify the Authority within 30 days of a change to the hospital's declared fiscal year end. A change in declared fiscal year end shall be applied to the hospital's next future declared fiscal year for purposes of calculating the final assessment and filing the final report.

Stat. Auth.: ORS 413.042

Stats. Implemented: 2015 HB 2395

Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 13-2008(Temp), f. & cert. ef. 6-12-08 thru 12-8-08; DMAP 29-2008, f. 8-29-08, cert. ef. 9-1-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0760
Filing an Amended Report

(1) A hospital that submits a fiscal year reconciliation report without an audited financial statement shall submit an amended fiscal year reconciliation report, an audited financial statement, and such additional fiscal year reconciliation payment (if owed) for assessments and deficiencies. The information shall be submitted within 180 days after the fiscal year reconciliation report due date.

(2) Claim for Refund:

(a) If the amount of the assessment in the amended fiscal year reconciliation report is less than the amount paid by the hospital, the Authority may refund the overpayment. A refund may not exceed the assessment amount actually paid by the hospital;

(b) The hospital shall provide all information required on the report. No refunds shall be made prior to the Authority receiving the hospital's audited financial statement for the declared fiscal year. The Authority may audit the hospital, request additional information, or request an informal conference prior to granting a refund or as part of its review;

(c) If there is an amount due from the hospital to the Authority for any past due assessments or penalties, any refund otherwise allowable shall first be applied to the unpaid assessments and penalties, and the hospital notified;

(d) A hospital may not deduct from current, prospective, or future assessment payments an amount to which it claims to be entitled as a refund for a prior period. The claim for refund shall be made to the Authority. .

(3) Payment of Delinquency:

(a) If the amount of the annual assessment imposed is more than the amount paid by the hospital, the hospital shall file an amended fiscal year reconciliation report and pay the additional fiscal year reconciliation assessment and deficiency. The penalty under OAR 410-050-0800 shall stop accruing after the Authority receives the amended fiscal year reconciliation report, the annual audited financial statement, and payment of the total fiscal year reconciliation assessment and deficiency for year; except to the extent provided in OAR 410-050-0750(4)(a);

(b) No refunds shall be made prior to the Authority receiving the hospital audited financial statement for the declared fiscal year. The Authority may audit the hospital, request additional information, or request an informal conference prior to granting a refund or as part of its review;

(c) If there is an error in the determination of the assessment due, the hospital may describe the circumstances of the late additional payment with the filing of the amended report. The Authority, in its sole discretion, may determine that the late additional payment does not constitute a failure to file a report or pay an assessment giving rise to the imposition of a penalty. In making this determination, the Authority shall consider the circumstances, including but not limited to: nature and extent of the error; hospital explanation of the circumstances related to the error; evidence of prior errors; and evidence of prior penalties (including evidence of informal dispositions or settlement agreements). This provision only applies if the hospital has filed a timely original report and paid the assessment identified in the report.

(4) If the Authority discovers or identifies information in the administration of these assessment rules that it determines could give rise to the issuance of a notice of proposed action, the Authority shall issue notification pursuant to OAR 410-050-0810.

Stat. Auth.: ORS 413.042

Stats. Implemented: 2015 HB 2395

Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0770
Determining the Date Filed

(1) For the purposes of these rules, any reports, requests, appeals, payments, or other response by the hospital shall be received by the Authority either:

(a) Before the close of business on the date due; or

(b) If mailed, postmarked before midnight of the due date.

(2) When the due date falls on a Saturday, Sunday, or a legal holiday, the date filed is on the next business day following the Saturday, Sunday, or legal holiday.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0780
Records Audit by the Authority

(1) The hospital shall maintain financial records necessary and adequate to determine the net revenue for any calendar period for which an assessment may be due.

(2) The Authority or its designee may audit the hospital's records at any time for a period of five years following the date the assessment is due to verify or determine the hospital's net revenue.

(3) The Authority may issue a notice of deficiency or issue a refund based upon its audit findings.

(4) Any audit, finding, or position may be reopened if there is evidence of fraud, malfeasance, concealment, misrepresentation of material fact, omission of income, or collusion either by the hospital or by the hospital and a representative of the Authority.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0790
Determining Assessment for Hospital Failure to File

(1) The law places an affirmative duty on the hospital to file a timely and correct report.

(2) In the case of a failure by the hospital to file a report or to maintain necessary and adequate records, the Authority shall determine the hospital's assessment liability according to the best of its information and belief. Best of its information and belief means the Authority shall use evidence available to the Authority at the time of the determination on which a reasonable person would rely on in determining the assessment. The Authority's determination of assessment liability shall be the basis for the assessment due in any notice of proposed action.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0800
Financial Penalty for Failure to File a Report or Failure to Pay Tax When Due

(1) A hospital that fails to file a quarterly report or pay a quarterly assessment when due shall be subject to a penalty of up to $500 per day of delinquency. The Authority, in its sole discretion, shall determine the penalty for failure to pay the assessment or file a report. In making this determination, the Authority shall consider evidence such as prior late payments, prior penalties, and circumstances related to delinquency. The penalty accrues from the date of delinquency, notwithstanding the date of any notice under these rules.

(2) A hospital that fails to file a fiscal year reconciliation report when due is subject to a penalty of up to $500 per day of delinquency. The Authority, in its sole discretion, shall determine the penalty for failure to pay the assessment or file a report. In making this determination, the Authority shall consider evidence such as prior late payments, prior penalties, and circumstances related to delinquency. The penalty accrues from the date of delinquency, notwithstanding the date of any notice under these rules.

(3) A hospital that files a fiscal year reconciliation report, but fails to pay a fiscal year reconciliation assessment when due is subject to a penalty of up to $500 per day of delinquency up to a maximum of five percent of the amount due. The Authority, in its sole discretion, shall determine the penalty for failure to pay the reconciliation assessment payment or file a fiscal year reconciliation report. In making this determination, the Authority shall consider evidence such as prior late payments, prior penalties, and circumstances related to delinquency. The penalty accrues from the date of delinquency, notwithstanding the date of any notice under these rules.

(4) The total amount of penalty imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which penalty is being imposed.

(5) The Authority shall collect any penalties imposed under this section and deposit the funds in the Authority's account established under ORS 413.101.

(6) Penalties paid under this section are in addition to the hospital's assessment liability.

(7) If the Authority determines that a hospital is subject to a penalty, the Authority shall issue a notice of proposed action as described in OAR 410-050-0810.

(8) If a hospital requests a contested case hearing pursuant to OAR 410-050-0830, the Director, at the Director's sole discretion, may waive or reduce the amount of penalty assessed.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 33-2009, f. & cert. ef. 10-1-09; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0810
Notice of Proposed Action

(1) Prior to issuing a notice of proposed action, the Authority shall notify the hospital of the potential deficiency or failure to report that could give rise to the imposition of a penalty. The Authority shall issue a notification letter within 30 calendar days of the report or payment due date. The hospital shall have 30 calendar days from the date of the notice to respond. The Authority may consider the response and any amended final report under OAR 410-050-0760 in its notice of proposed action. In all cases that the Authority has determined that a hospital has an assessment deficiency or failure to report, the Authority shall issue a notice of proposed action. The Authority may not issue a notice of proposed action if the issue is resolved satisfactorily within 59 days from the date of mailing the notification letter.

(2) The Authority shall issue a notice of proposed action within 60 calendar days from the date of mailing the notification letter.

(3) Contents of the notice of proposed action shall include:

(a) The applicable reporting period;

(b) The basis for determining the corrected amount of assessment;

(c) The corrected assessment due as determined by the Authority;

(d) The amount of assessment paid by the hospital;

(e) The resulting deficiency, which is the difference between the amount received by the Authority and the corrected amount due as determined by the Authority;

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of delinquency;

(h) Date upon which the penalty began to accrue;

(i) Date the penalty stopped accruing or circumstances under which the penalty shall stop accruing;

(j) The total penalty accrued up to the date of the notice;

(k) Instructions for responding to the notice; and

(l) A statement of the hospital's right to a hearing.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP

29-2008, f. 8-29-08, cert. ef. 9-1-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-

410-050-0820
Required Notice

(1) The Authority shall send any required notice to the address and contact person identified by the hospital on its most recently filed report.

(2) Any notice required to be sent to the Authority shall be sent to the point of contact identified on the communication from the Authority to the hospital.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0830
Hearing Process

(1) Any hospital that receives a notice of proposed action may request a contested case hearing under ORS 183.

(2) The hospital may request a hearing by submitting a written request within 20 days of the date of the notice of proposed action.

(3) Prior to the hearing, the hospital shall meet with the Authority for an informal conference:

(a) The informal conference may be used to negotiate a written settlement agreement.

(b) If the settlement agreement includes a reduction or waiver of penalties, the agreement shall be approved and signed by the Director.

(4) Except as provided in section (5) of this rule, if the case proceeds to a hearing, the administrative law judge shall issue a proposed order. The Authority shall issue a final order.

(5) Nothing in this section shall preclude the Authority and the hospital from agreeing to informal disposition of the contested case at any time, consistent with ORS 183.415(5).

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0840
Final Order of Payment

A final order of payment is a final Authority action, expressed in writing, based on a notice of proposed action where a payment amount is due to the Authority. The Authority shall issue a final order of payment for deficiencies or penalties when:

(1) The hospital did not make a timely request for a hearing;

(2) Any part of the deficiency and penalty was upheld after a hearing; or

(3) Upon the agreement of the hospital and the Authority.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0850
Remedies Available after Final Order of Payment

Any amounts due and owing under the final order of payment and any interest thereon may be recovered by Oregon as a debt to the state, using any available legal and equitable remedies. These remedies include, but are not limited to:

(1) Collection activities including, but not limited to, deducting the amount of the final deficiency or penalty from any sum then or later owed to the hospital by the Authority; and

(2) Every payment obligation owed by the hospital to the Authority under a final order of payment shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the final order of payment and continuing until the payment obligation, including interest, has been discharged.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0860
Director Determines Assessment Rate

(1) The Director shall determine the assessment rate.

(2) The assessment rate for the period beginning January 1, 2004 through June 30, 2004 is 0 percent. The assessment rate for the period beginning July 1, 2004 through December 31, 2004 is .95 percent.

(3) The Director may reduce the rate of assessment to the maximum rate allowed under federal law if the reduction is required to comply with federal law. If the rate is reduced pursuant to this section, the Director shall notify the hospitals as to the effective date of the rate reduction.

(4) A hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services will equal or exceed the amount of the assessment paid by the hospital.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 91-2004(Temp), f. & cert. ef. 12-3-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; OMAP 28-2005(Temp), f. & cert. ef. 5-10-05 thru 11-5-05; OMAP 34-2005, f. 7-8-05, cert. ef. 7-11-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

410-050-0861
Assessment Rate

(1) The assessment rate for the period beginning January 1, 2005, and ending June 30, 2006, is .68 percent.

(2) The assessment rate for the period beginning July 1, 2006, and ending December 31, 2007, is .82 percent.

(3) The assessment rate for the period beginning January 1, 2008, and ending June 30, 2009, is .63 percent.

(4) The assessment rate for the period of January 1, 2008 through June 30, 2009 does not apply to the period beginning July 1, 2009.

(5) The assessment rate for the period beginning July 1, 2009, and ending September 30, 2009, is .15 percent.

(6) The assessment rate for the period beginning October 1, 2009, and ending June 30, 2010, is 2.8 percent.

(7) The assessment rate for the period beginning July 1, 2010, and ending June 30, 2011, is 2.32 percent.

(8) The assessment rate for the period beginning July 1, 2011, and ending September 30, 2011, is 5.25 percent.

(9) The assessment rate for the period beginning October 1, 2011, and ending December 31, 2011, is 5.08 percent.

(10) The assessment rate for the period beginning January 1, 2012, and ending March 31, 2013, is 4.32 percent.

(11) The assessment rate for the period beginning April 1, 2013, and ending September 30, 2014, is 5.30 percent.

(12) The assessment rate for the period beginning October 1, 2014, and ending March 31, 2016, is 5.80 percent.

(13) The assessment rate for the period beginning April 1, 2016, is 5.30 percent.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 28-2005(Temp), f. & cert. ef. 5-10-05 thru 11-5-05; OMAP 34-2005, f. 7-8-05, cert. ef. 7-11-05; OMAP 14-2006, f. 6-1-06, cert. ef. 7-1-06; DMAP 29-2007, f. 12-31-07, cert. ef. 1-1-08; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 24-2009, f. & cert. ef. 7-1-09; DMAP 25-2009(Temp), f. & cert. ef. 7-15-09 thru 1-10-10; DMAP 27-2009, f. & cert. ef. 9-1-09; DMAP 33-2009, f. & cert. ef. 10-1-09; DMAP 21-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 16-2011(Temp), f. & cert. ef. 7-1-11 thru 11-1-11; DMAP 26- 2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 11-1-11; DMAP 31-2011, f. 10-28-11, cert. ef. 11-1-11; DMAP 50-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 4-30-12; DMAP 8-2012, f. 2-27-12, cert. ef. 3-1-12; DMAP 15-2013(Temp), f. & cert. ef. 4-1-13 thru 9-27-13; DMAP 41-2013, f. & cert. ef. 8-1-13; DMAP 58-2014(Temp), f. & cert. ef. 10-1-14 thru 3-29-15; DMAP 68-2014, f. & cert. ef. 12-1-14; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 15-2016(Temp), f. 3-31-16, cert. ef. 4-1-16 thru 9-27-16; DMAP 51-2016, f. 8-9-16, cert. ef. 9-1-16

410-050-0870
Sunset Provisions

The hospital assessment applies to net revenue received by hospitals on or after January 1, 2004 and before October 1, 2019.

Stat. Auth.: ORS 413.042
Stats. Implemented: 2015 HB 2395
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; DMAP 3-2008, f. & cert. ef. 1-25-08; DMAP 33-2009, f. & cert. ef. 10-1-09; DMAP 53-2013(Temp), f. & cert. ef. 10-1-13 thru 3-29-14; DAMP 17-2014, f. & cert. ef. 3-25-14; DMAP 52-2015, f. 9-22-15, cert. ef. 10-1-15

DIVISION 120

MEDICAL ASSISTANCE PROGRAMS

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), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000 Acronyms and Definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411 or 413 administrative rules; or contact the Division.

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

(2) "Action" means a termination, suspension, or reduction of eligibility or covered services. For the definition as it is related to a CCO member, refer to OAR 410-141-0000.

(3) "Acupuncturist" means a person 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 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

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

(10) "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.

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

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

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

IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.

(14) "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), federally recognized American Indian tribes).

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

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

(17) "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).

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

(19) "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.

(20) "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).

(21) "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.

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

(23) "Appeal" means a request for review of an action.

(24) "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.

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

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

(27) "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.

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

(29) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

(30) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.

(31) "Behavioral Health Case Management" means services provide to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

(32) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

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

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

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

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

(37) "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 will facilitate evaluation.

(38) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, 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 members to community services and supports that may include referrals to Allied Agencies.

(39) "Certified Traditional Health Worker" means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.

(40) "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.

(41) "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.

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

(43) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.

(44) "Citizen/Alien-Waived Emergency Medical (CAWEM)" means aliens granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210 (4)(d).

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

(46) "Client" means an individual found eligible to receive OHP health services.

(47) "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.

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

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

(50) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

(51) "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.

(52) "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or 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 need;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

(53) "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.

(54) "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-V); 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, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

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

(a) A client or member or their representative;

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

(c) A PHP or CCO.

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

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

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

(59) "Coordinated Care Organization (CCO)" as defined in OAR 410-141-0000.

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

(61) "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.

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

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

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

(65) "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.

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

(67) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her 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.

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

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

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

(71) "Denturist" means a person licensed to practice denture technology pursuant to state law.

(72) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.

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

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

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

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

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

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

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

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

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

(78) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(79) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.

(80) "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 physician or other professional diagnostic or evaluative services.

(81) "Division (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.

(82) "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.

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

(84) "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 943-120-0100 through 943-120-0200, EDI does not include electronic transmission by web portal.

(85) "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.

(86) "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.

(87) "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.

(88) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(4)(d)(C).

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

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

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

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

(93) "Family Planning Services" means services for clients 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.

(94) "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.

(95) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

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

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

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

(99) "Health Care Interpreter" Certified or Qualified as defined in ORS 413.550.

(100) "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.

(101) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — 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 (CDT) codes for the reporting of dental care services and procedures.

(102) "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.

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

(104) "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.

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

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

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

(108) "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.

(109) "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's home.

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

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

(112) "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 (Authority), Public Health Division.

(113) "Hospital" means a facility licensed by the Office of Public Health Systems 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 will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

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

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

(116) "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.

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

(118) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.

(119) "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.

(120) "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 813.602(5).

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

(122) "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.)

(123) "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 nursing 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.

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

(125) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (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.

(126) "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 laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity

derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).

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

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

(129) "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.

(130) "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.(131) "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).

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

(133) "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.

(134) "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.

(135) "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.

(136) "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).

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

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

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

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

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

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

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a Division client or CCO member in the Division or CCO's judgment.

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

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

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

(c) Prescription drug coverage (Part D) means covered Part D drugs 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.

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

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

(143) "Member" means an OHP client enrolled with a prepaid health plan or coordinated care organization.

(144) "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.

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

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

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

(148) "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.

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

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

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

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

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

(e) Any other applicable Division administrative rules.

(150) "Non-Emergent Medical Transportation Services (NEMT)"means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000(76) and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

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

(152) "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.

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

(154) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

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

(156) "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.

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

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

(159) "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.

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

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

(162) "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

(163) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.

(164) "Optometrist" means a person licensed to practice optometry pursuant to state law.

(165) "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 medical assistance 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 Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.

(166) "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.

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

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

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

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

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

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

(171) "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.

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

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

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

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

(176) "Peer Wellness 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.

(177) "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 will assist the patient in achieving the goals.

(178) "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 in light of the patient's needs, lifestyle, combination of conditions, and desired outcome.

(179) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his or her scope of practice.

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

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

(182) "Physical Therapist" means a person licensed by the relevant state licensing authority to practice physical therapy.

(183) "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.

(184) "Physician" means a person licensed to practice medicine pursuant to state law of the state in which he or she practices medicine or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.

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

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

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

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

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

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

(191) "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)

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

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

(194) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.

(195) "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.

(196) "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 physician to an individual who is not in a health care facility.

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

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

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

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

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

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

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)

(199) "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.

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

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

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

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

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

(205) "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.

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

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

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

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

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

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

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

(213) "Request for Hearing" means a clear expression in writing by an individual or representative that the person wishes to

appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

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

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

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

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

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

(219) "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 physician or other licensed practitioner.

(220) "Self-Sufficiency" means the division in the Department of Human Services (Department) that administers programs for adults and families.

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

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

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

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

(225) "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.

(226) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

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

(228) "Subrogation" means right of the state to stand in place of the client in the collection of third party resources (TPR).

(229) "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 American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

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

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

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

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

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

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

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

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

(236) "Transportation" means medical transportation.

(237) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.

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

(239) "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.

(240) "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.

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

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

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

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

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

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

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

(245) "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.

(246) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for pay-

ment of covered health care services rendered to an eligible client that:

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

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

(247) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.

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

(249) "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.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 81-1982, f. 8-30-82, ef. 9-1-82; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 13-1987, f. 3-31-87, ef. 4-1-87; AFS 7-1988, f. & cert. ef. 2-1-88; AFS 69-1988, f. & cert. ef. 12-5-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0005; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2000, f. & cert. ef. 6-23-00; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007 f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 13-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 11-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 5-2015, f. & cert. ef. 2-10-15; DMAP 29-2015, f. & cert. ef. 5-29-15; DMAP 55-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 30-2016, f. 6-29-16, cert. ef. 7-1-16; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16; DMAP 63-2016(Temp), f. & cert. ef. 11-10-16 thru 5-8-17

410-120-0003
OHP Standard Benefit Package

The OHP Standard benefit package is eliminated effective January 1, 2014. Although references to OHP Standard exist elsewhere in rule, the benefit package currently is not funded and is not offered as a benefit. Those enrolled in OHP Standard are enrolled in other existing benefit packages.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.706

Hist.: DAMP 74-2013, f. 12-31-13, cert. ef. 1-1-14

410-120-0006
Medical Eligibility Standards

As the state Medicaid and CHIP agency, the Oregon Health Authority (Authority) is responsible for establishing and implementing eligibility policies and procedures consistent with applicable law. As outlined in OAR 943-001-0020, the Authority and the Department of Human Services (Department) work together to adopt rules to assure that medical assistance eligibility procedures and determinations are consistent across both agencies.

(1) The Authority adopts and incorporates by reference the rules established in OAR Chapter 461 for all overpayment, personal injury liens and estates administration for Authority programs covered under OAR chapter 410, division 200.

(2) Any reference to OAR chapter 461 in contracts of the Authority are deemed to be references to the requirements of this rule and shall be construed to apply to all eligibility policies, procedures and determinations by or through the Authority.

(3) For purposes of this rule, references in OAR chapter 461 to the Department or to the Authority shall be construed to be references to both agencies.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.065

Hist.: DMAP 10-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 18-2011(Temp), f. & cert. ef. 7-15-11 thru 1-11-12; DMAP 21-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-11-12; DMAP 25-2011(Temp), f. 9-28-11, cert. ef. 10-1-11 thru 1-11-12; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 1-2012(Temp), f. & cert. e.f 1-13-12 thru 7-10-12; DMAP 2-2012(Temp), f. & cert. ef. 1-26-12 thru 7-10-12; DMAP 3-2012(Temp), f. & cert. ef. 1-31-12 thru 2-1-12; DMAP 4-2012(Temp), f. 1-31-12, cert. ef. 2-1-12 thru 7-10-12; DMAP 9-2012(Temp), f. & cert. ef. 3-1-12 thru 7-10-12; DMAP 21-2012(Temp), f. 3-30-12, cert. ef. 4-1-12 thru 7-10-12; DMAP 25-2012(Temp), f. & cert. ef. 5-1-12 thru 7-10-12; Administrative correction 8-1-12; DMAP 35-2012(Temp), f. & cert. ef. 7-20-12 thru 1-15-13; DMAP 45-2012(Temp), f. & cert. ef. 10-5-12 thru 1-19-13; DMAP 50-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 53-2012(Temp), f. & cert. ef. 11-1-12 thru 4-29-13; DMAP 56-2012(Temp), f. 11-30-12, cert. ef. 12-1-12 thru 4-1-13; DMAP 60-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 65-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 2-2013(Temp), f. & cert. ef. 1-8-13 thru 6-29-13; DMAP 3-2013(Temp), f. & cert. ef. 1-30-13 thru 6-29-13; DMAP 5-2013(Temp), f. & cert. ef. 2-20-13 thru 6-29-13; DMAP 7-2013(Temp), f. & cert. ef. 3-1-13 thru 6-29-13; DMAP 12-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 17-2013, f. & cert. ef. 4-10-13; DMAP 24-2013, f. & cert. ef. 5-29-13; DMAP 32-2013, f. & cert. ef. 6-27-13; DMAP 39-2013(Temp), f. 7-26-13, cert. ef. 8-1-13 thru 1-28-14; DMAP 44-2013(Temp), f. 8-21-13, cert. ef. 8-23-13 thru 1-28-14; DMAP 51-2013, f. & cert. ef. 10-1-13; DMAP 52-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 55-2013(Temp), f. & cert. ef. 10-2-13 thru 3-31-14; DMAP 59-2013(Temp), f. 10-31-13, cert. ef. 11-1-13 thru 3-31-14; DMAP 9-2014(Temp), f. 1-31-14, cert. ef. 2-1-14 thru 3-31-14; DMAP 18-2014, f. 3-28-14, cert. ef. 3-31-14; DMAP 41-2014, f. & cert. ef. 7-1-14; DMAP 54-2014, f. & cert. ef. 9-23-14; DMAP 12-2015(Temp), f. 3-5-15, cert. ef. 3-19-15 thru 9-14-15; DMAP 33-2015, f. 6-24-15, cert. ef. 7-1-15; DMAP 49-2015, f. 9-3-15, cert. ef. 10-1-15; DMAP 70-2015, f. 12-8-15, cert. ef. 1-1-16; DMAP 32-2016, f. 6-29-16, cert. ef. 7-1-16; DMAP 46-2016, f. 7-18-16, cert. ef. 8-1-16; DMAP 58-2016, f. 9-30-16, cert. ef. 10-1-16

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 medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.651(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 clients, including but not limited to authorization and delivery of service or denials of authorization or services, the Division, clients, enrolled providers, Coordinated Care Organizations, and the Prepaid Health Plans shall apply the following order of precedence:

(A) Oregon Revised Statutes governing medical assistance programs;

(B) Consistent with ORS 413.071,those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare

and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(C) Generally for Coordinated Care Organizations, the requirements applicable to the providing covered medical assistance to Division clients are found in OAR 410-141-3000 through 410-141-3485; and where applicable, 410-120-0000 through 410-120-1980; and the 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 clients are found in OAR 410-141-0000 through 410-141-0860; and where applicable, 410-120-0000 through 410-120-1980; and the provider rules applicable to the category of medical service;

(E) Generally for enrolled fee-for-service providers or other contractors, the requirements applicable to providing covered medical assistance to Division clients are found in OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage set forth in410-141-0480 to 410-141-0520, and the 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 Oregon Health Authority or Department of Human Services necessary to administer the State of Oregon's medical assistance programs, such as electronic data transaction rules in OAR 943-120-0100 to 943-120-0200; and

(G) The basic framework for provider enrollment in OAR 943-120-0300 through 943-120-0380 that generally apply to providers enrolled with the Authority or Department, subject to more specific requirements applicable to the administration of the Oregon Health Plan and medical assistance programs administered by the Authority. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in paragraphs (A)–(F) of this section.

(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 section (2)(a) of this rule apply to the provision of covered medical assistance to Division clients:

(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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 6-2008(Temp), f. & cert. ef. 3-14-08 thru 9-1-08; DMAP 11-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 48-2013, f. & cert. ef. 9-12-13; DMAP 40-2015, f. & cert. ef. 7-1-15

410-120-0030
Children's Health Insurance Program

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

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

(b) CHIP Pre-natal care expansion program.

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

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

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: DMAP 7-2008(Temp), f. 3-17-08 & cert. ef. 4-1-08 thru 9-15-08; DMAP 14-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 29-2009(Temp), f. 9-15-09, cert. ef. 10-1-09 thru 3-25-10; DMAP 37-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 18-2010, f. 6-23-10, cert. ef. 7-1-10; DMAP 23-2010, f. & cert. ef. 9-1-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 11-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 19-2012, f. 3-30-12, cert. ef. 4-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 67-2013, f. & cert. ef. 12-3-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-120-0035
Public Entity

(1) This rule pertains to Centers for Medicare and Medicaid (CMS) regulations for payments to and from Oregon Health Authority (Authority) and public entities.

(2) Effective July 1, 2008, unit of government providers responsible by rule or contract for the local match share portion for claims eligible for Federal Financial Participation (FFP) submitted to Medicaid for reimbursement must submit the local match payment prior to the Authority claiming the federal share from CMS:

(a) Before the provider submits its claims to the Authority, the provider must transfer funds from allowable sources to the Authority representing the local match share of the total allowable cost for claimed services;

(b) Upon receipt of provider's transfer of the local match share and the Authority receipt of claims in the Medical Management Information System (MMIS) that are reimbursable to the extent of the transferred local match share amount, the Authority will claim FFP from CMS and reimburse the provider for the total reimbursable allowable claimed amount for the services;

(c) Transfer of the local match share to the Authority means that the provider certifies that for the purposes of 42 CFR 433.51, the funds it transfers to the Authority for the local match share are public funds that are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds; and that all sources of funds are allowable under 42 CFR 433 Subpart B.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: DMAP 27-2008(Temp), f. 6-13-08, cert. ef. 7-1-08 thru 12-28-08; DMAP 30-2008, f. 9-12-08, cert. ef. 9-15-08

410-120-0045
Applications for Medical Assistance at Provider locations

(1) The Oregon Health Authority (Authority) allows Division enrolled providers the opportunity to assist patients applying for public and private health coverage offered through the Authority and the Oregon Health Insurance Exchange (OHIX). To apply for this opportunity, providers fill out and submit form OHA 3128, Application Assistance by Provider Staff; this is an addendum to the provider's agreement to provide Medicaid reimbursed services. Once the provider is determined certified by the Authority to provide application assistance, providers shall receive an approval letter, requirements for assister certification, training requirements, and other information.

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

(a) Hospitals;

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

(c) County health departments;

(d) Substance Use Disorder adult and adolescent treatment and recovery centers;

(e) Tribal health clinics;

(f) Family Planning clinics;

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

(3) The site may sign the Application Assistance by Provider Staff (OHA 3128) addendum indicating the site's willingness to

provide on-site application assistance. The addendum outlines site and application assister standards as well as conflict of interest protections. The site shall require employees that will be assisting to participate in mandatory training sessions for application assistance certification. Employees must pass tests before initiating application assistance service. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Authority. For purposes of this rule, certified staff shall be referred to as "application assisters."

(4) Application assisters shall utilize authorized methods to provide enrollment assistance. Regardless of which form of application is used, the application assister shall write the date the application was started and the assister's assigned assister identification number in the appropriate space on the application. Application assisters shall maintain copies of all eligibility verification documents and all records related to enrollment assistance, including the required, current OHA-provided Consent Form for six years, whether in paper, electronic, or other forms in a secure and locked location. Assistance will support patients potentially eligible for public and private health coverage offered through the Authority and OHIX. Sites are not under an obligation to provide application assistance to individuals other than those for whom they are providing service. Once written on the application, the date can never be changed, altered, or backdated.

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

(6) The application assister shall provide information to applicants about public medical programs and private insurance products so each applicant can make an informed choice when enrolling into a health insurance product. Language interpreters or interpreter services or referrals must be provided if requested by applicants including linguistically and culturally appropriate materials:

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

(A) General eligibility criteria for public and private coverage accessible through the Authority and OHIX;

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

(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 (OHA 3128):

(a) The application assister shall treat all information they obtain for public medical programs and private insurance as confidential and privileged communications. The application assister may not disclose such information without the written consent of the individual, his or her delegated authority, attorney, or responsible parent of a minor child or child's guardian. Nothing prohibits the disclosure of information in summaries, statistical or other form, that does not identify particular individuals;

(b) The Authority 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 applicants and recipients 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 Authority shall be responsible for the following:

(a) The Authority shall provide training to application assisters on public medical programs and private insurance products, 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), health insurance coverage options, assister identification number instructions, reporting guidance, and other necessary forms;

(c) The Authority shall process all applications in accordance with Authority and OHIX standards;

(d) The Authority shall process completed applications that have satisfactory verification information within the time requirements set forth 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 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. However, the parties acknowledge the exchange and receipt of other valuable considerations in the spirit of cooperation to the benefit of all by collaborating and authorizing the performance of the work. The Authority does not guarantee a particular volume of business under these rules.

(10) The provider may terminate enrollment at any time as outlined in OAR 410-120-1260(15).

Stat. Auth.: ORS 413.042
Statutes Implemented: ORS 414.041
Hist.: DMAP 12-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 48-2013, f. & cert. ef. 9-12-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 52-2016, f. 8-26-16, cert. ef. 9-1-16

410-120-0250
PHP or Coordinated Care Organizations

(1) The Authority provides clients with health services, through contracts with a Prepaid Health Plan (PHP) or a Coordinated Care Organization (CCO).

(2) The PHP or CCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law, the PHP or CCO's contract with the Authority and the OHP administrative rules governing PHPs and CCOs (OAR 410 division 141).

(3) All PHP or CCOs 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 PHP or CCOs. It is the providers' responsibility to comply with the PHP or CCO's Prior Authorization requirements or other policies necessary for reimbursement from the PHP or CCO, before providing services to any OHP client enrolled in a PHP or CCO.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065, 414.631 & 414.651
Hist.: OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 67-2005, f. 12-21-05, cert. ef. 1-1-06; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12

410-120-1140
Verification of Eligibility and Coverage

(1) To ensure Division reimbursement of services, providers are responsible to verify the following before rendering services:

(a) Client eligibility: That the person is an eligible Oregon Health Plan (OHP) client on the date(s) services are rendered; and

(b) Benefit coverage: That the person 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 benefit 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 identification (ID) only list the client's name, Oregon Medicaid ID number (prime number), and the date the ID was issued. They do not guarantee client 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 eligibility and benefit coverage through one of the following (For instructions see the Division General Rules Supplemental Information available on the web at http://www.oregon.gov/oha/healthplan/pages/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 electronic data interchange (EDI) eligibility inquiry (270) and response (271) transactions;

(5) The client may also present one of the following Temporary Oregon Health IDs; both are full-page forms:

(a) DMAP form 1086: This document guarantees eligibility and benefit coverage for seven days from the beginning dates of coverage entered in Part 1 of the form. This temporary ID is issued only if the client needs immediate care but their eligibility and coverage information is not yet available for verification as described in part (4) of this rule. Providers must honor the Temporary Oregon Health ID when presented within seven (7) days of the beginning date of coverage entered on the form;

(b) 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 of the exact date by which the Division must receive their full Medicaid application so that they may be evaluated for ongoing eligibility.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025 & 411.400

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 14-1979, f. 6-29-79, ef. 7-1-79; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82, for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 43-1986(Temp), f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 53-1987, f. 10-29-87, ef. 11-1-87; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0040; Renumbered from 461-013-0103 & 461-013-0109, HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93; OMAP 10-1999, f. & cert. ef. 4-1-99, Renumbered from 410-120-0080; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 42-2014, f. & cert. ef. 7-3-14

410-120-1160
Medical Assistance Benefits and Provider Rules

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

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

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

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

(c) Substance Use Disorder treatment services:

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

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

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

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

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

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

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

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

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

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

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

(l) Home and community-based waiver services as described in the Authority and the Department's OARs of Child Welfare (CW), Self-Sufficiency Program (SSP), Addictions and Mental Health Division (AMH), and Aging and People with Disabilities Division (APD);

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

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

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

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

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

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

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

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

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

(v) When a client's benefit package includes mental health, the mental health services provided will be based on the Health Evidence Review Commission (HERC) Prioritized List of Health Services;

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

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

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

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

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

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

(cc) Physical therapy as described in the Physical and Occupational Therapy and the Hospital Services program rules (OAR chapter 410, division 131 and 125);

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

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

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

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

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

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

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

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

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

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

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

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 14-1979, f. 6-29-79, ef. 7-1-79; AFS 73-1980(Temp), f. & ef. 10-1-80; AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 71-1981, f. 9-30-81, ef. 10-1-81; Renumbered from 461-013-0000, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 94-1982(Temp), f. & ef. 10-18-82; AFS 103-1982, f. & ef. 11-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 62-1983, f. 12-19-83, ef. 1-1-84; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 25-1984, f. 6-8-84, ef. 7-1-84; AFS 14-1985, f. 3-14-85, ef. 4-1-85; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 67-1986(Temp), f. 9-26-86, ef. 10-1-86; AFS 76-1986(Temp), f. & ef. 12-8-86; AFS 16-1987(Temp), f. & ef. 4-1-87; AFS 17-1987, f. 5-4-87, ef. 6-1-87; AFS 32-1987, f. 7-22-87, ef. 8-1-87; AFS 6-1988, f. & cert. ef. 2-1-88; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 69-1988, f. & cert. ef. 12-5-88; AFS 70-1988, f. & cert. ef. 12-7-88; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 8-1989(Temp), f. 2-24-89, cert. ef. 3-1-89; AFS 14-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0102; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0440; HR 2-1994, f. & cert. ef. 2-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14

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

(1) Out-of-state Providers must enroll with the Division as described in OARs 943-120-0320 and 410-120-1260, Provider Enrollment. Out-of-state Providers must provide services and bill in compliance with all of these Rules and the OARs for the appropriate type of service(s) provided.

(2) Payment rates for out-of-state providers are established in the individual provider rules, through contracts or service agreements and in accordance with OAR chapter 943 division 120 and OAR 410-120-1340, Payment.

(3) For enrolled non-contiguous, out-of-state providers, the Division reimburses for covered services under any of the following conditions:

(a) For clients enrolled in a CCO or PHP:

(A) The service was authorized by a CCO or PHP and payment to the out-of-State provider is the responsibility of the CCO or PHP;

(B) If a client has coverage through a CCO or PHP, the request for non-emergency services must be referred to the CCO or PHP. Payment for these services is the responsibility of the CCO or PHP;

(C) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-State provider is cost effective, as determined by the CCO or PHP.

(b) For clients not enrolled in a CCO or PHP:

(A) The service to a Division client was emergent; or

(B) A delay in the provision of services until the client 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 was otherwise authorized in accordance with Payment Authorization requirements in the individual provider rules or in the General Rules;

(D) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage.

(4) The Division may give prior authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:

(a) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage, or

(b) The Division covers the service or item under the specific client's benefit package; and

(c) The service or item is not available in the State of Oregon or provision of the service or item by an out-of-state provider is cost effective, as determined by the Division; and

(d) The service or item is deemed medically appropriate and is recommended by a referring Oregon physician;

(5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered 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.

(6) The Division makes no reimbursement for services provided to a Client outside the territorial limits of the United States. 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.

(7) The Division will reimburse, within limits described in these General rules and in individual provider rules, all services provided by enrolled providers to children:

(a) Who the Authority has placed in foster care;

(b) Who the Department has placed in a subsidized adoption outside the State of Oregon; or

(c) Who are in the custody of the Department and traveling with the consent of the Department.

(8) The Division does not require authorization of non-emergency services for the children covered by (7), except as specified in the individual provider rules.

(9) Payment rates for out-of-state providers are established in the individual provider rules, through contracts or service agreements and in accordance with OAR 943-120-0350 and 410-120-1340, Payment.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065 & 414.025
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 27-1978(Temp), f. 6-30-78, ef. 7-1-78; AFS 39-1978, f. 10-10-78, ef. 11-1-78; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0130, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 21-1985, f. 4-2-85, ef. 5-1-85; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0045 & 461-013-0046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0120, 410-120-0140 & 410-120-0160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1190
Medically Needy Benefit Program

The Medically Needy Program is eliminated effective February 1, 2003. Although references to this benefit exist elsewhere in rule, the program currently is not funded and is not offered as a benefit.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065
Hist.,: OMAP 2-2003, f. 1-31-03, cert. ef. 2-1-03

410-120-1195
SB 5548 Population

Effective for services rendered on or after January 1, 2004.

(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by the Authority with specific health-related conditions as outlined in the Joint Ways and Means budget note accompanying Senate Bill 5548 (2003) shall be referred to as SB 5548 clients.

(2) SB 5548 clients are eligible for a State-funded, limited, prescription drug benefit for covered drugs described in subsection (3) of this rule.

(3) Eligibility for and access to covered drugs for SB 5548 clients:

(a) SB 5548 clients must have been participating in the former OSIP-MN Medically Needy Program as of January 31, 2003, and as of that date had a medical diagnosis of HIV or organ transplant status;

(b) SB 5548 clients receiving anti-retroviral and other prescriptions necessary for the direct support of HIV symptoms:

(A) Must agree to participate in the Authority's CareAssist Program in order to obtain access to this limited prescription drug benefit; and

(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at http://www.oregon.gov/oha/pharmacy/CAREAssist/Pages/providers.aspx;

(c) SB 5548 clients receiving prescriptions necessary for the direct support of organ transplants are limited:

(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infective or other prescriptions necessary for the direct support of organ transplants;

(B) Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.

(4) Reimbursement for covered prescription drugs is limited by the terms and conditions described in this rule. This limited drug benefit provides State-funded reimbursement to pharmacies choosing to participate according to the terms and conditions of this rule:

(a) The Authority will send SB 5548 clients a letter from the Authority, instead of a Medical Care Identification, which will document their eligibility for this limited drug benefit;

(b) Retail pharmacies choosing to participate will be reimbursed for covered prescription drugs for the direct support of organ trans-

plants described in subsection (3)(c) of this rule based upon Oregon Medicaid reimbursement levels as specified in the Division's Pharmaceutical Services Program administrative rules 410-121-0155 and 410-121-0160.

(c) The Authority pharmacy benefits manager, will process retail pharmacy drug benefit reimbursement claims for SB 5548 clients;

(d) Mail order reimbursement will be subject to the Authority contract rates;

(e) Prescription drugs through the CareAssist program will be subject to the Authority contract rates;

(f) Reimbursement for this limited drug benefit is not subject to the following rules:

(A) 410-120-1230, Client Copayments;

(B) 410-121-0300, Federal Upper Limit (FUL) for prescription drugs.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 28-2003(Temp), f. & cert. ef. 4-1-03 thru 9-1-03; OMAP 44-2003, f. & cert. ef. 6-30-03; OMAP 45-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 89-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11

410-120-1200
Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in 410-141-0520 and the individual program chapter 410 OARs. If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

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

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

(b) Determined not medically or dentally appropriate by Division staff or authorized representatives, including DMAP's contracted utilization review organization, or are not covered by the Health Evidence Review Commission Prioritized List of Health Services;

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

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

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

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

(B) Is directly employed by the client under the Department of Human Services (Department) Aging and People with Disabilities division (APD) Home and Community Based Services or the APD administrative rules, OAR 411-034-0000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

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

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

(g) Needed for purchase, repair, or replacement of materials or equipment caused by adverse actions of adult clients age 21 and over to personally owned goods or equipment or to items or equipment that the Division rented or purchased;

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

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

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

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

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

(m) Whose primary intent is to improve appearances, exceptions subject to the HERC coverage and guidelines;

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

(o) For the purpose of establishing or reestablishing fertility or pregnancy;

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

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

(r) Educational or training classes that are not intended to improve a medical condition;

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

(t) Post-mortem exams or burial costs;

(u) Radial keratotomies

(v) Recreational therapy;

(w) Telephone calls except for:

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

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

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

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

(x) Services that have no standard code set as established according to 45 CFR 162.1000 to 162.1011, unless the Division has assigned a procedure code to a service authorized in rule;

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

(z) Immunizations prescribed for foreign travel;

(aa) Services that are requested or ordered but not provided to the client, unless specified otherwise in individual program rules;

(bb) Missed appointments, an appointment that the client fails to keep. Refer to 410-120-1280;

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

(dd) Alcoholics Anonymous (AA) and other self-help programs;

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

(ff) Services provided outside of the United States. Refer to OAR 410-120-1180.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76, Renumbered from 461-013-0030; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-82; AFS 15-1983(Temp), f. & ef. 4-20-83; AFS 31-1983(Temp), f. 6-30-83, ef. 7-1-83; AFS 43-1983, f. 9-2-83, ef. 10-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 29-1987(Temp), f. 7-15-87, ef. 7-17-87; AFS 54-1987, f. 10-29-87, ef. 11-1-87; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 70-1988, f. & cert. ef. 12-7-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0055; 461-013-0103, 461-013-0109 & 461-013-0112; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 23-1990(Temp), f. & cert. ef. 7-20-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 27-1991 (Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0420, 410-120-0460 & 410-120-0480; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 6-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 12-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 22-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 8-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 17-2003(Temp), f. 3-13-03, cert. ef. 3-14-03 thru 8-15-03; OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 15-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14

410-120-1210

Medical Assistance Benefit Packages and Delivery System

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

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

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

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

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

(C) Coverage includes:

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

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

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

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

(v) Hospice;

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

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

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

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

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

(b) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

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

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

(D) Limitations:

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

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

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

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

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

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

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

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

(A) Benefit Package identifier code MED;

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

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

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

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

(A) Benefit Package identifier CWM;

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

(C) Coverage is limited to:

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

ardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

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

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

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

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

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

(e) CAWEM Plus:

(A) Benefit Package identifier code CWX;

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

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

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

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

(ii) Sterilization;

(iii) Abortion;

(iv) Death with dignity services;

(v) Hospice.

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

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

(a) Coordinated Care Organization (CCO):

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

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

(b) Prepaid Health Plan (PHP):

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

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

(c) Physician Care Organization (PCO):

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

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

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

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

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

Stat. Auth.: ORS 413.042

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

Hist.: OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 63-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 31-2013, f. & cert. ef. 6-27-13; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-120-1230
Client Co-payment

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

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

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

(b) Family planning services and supplies;

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

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

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

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

(a) Pregnant women;

(b) Children under age 19;

(c) Young adults in substitute care and in the former Foster Care Youth Medical program;

(d) Clients receiving services under the Medicaid-funded home and community-based services program;

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

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

(g) Individuals receiving hospice care;

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

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

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

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

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

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

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

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

(a) Unless specified otherwise in individual program rules and to the extent permitted under 42 CFR 447.58 and 447.60, the Division does not require CCOs, PHPs, or PCOs to bill or collect a co-payment from the Medicaid client. The CCO, PHP, or PCO may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the CCO, PHP, or PCO;

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

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

(9) Table 120-1230-1.

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

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 414.025, 414.065

Hist.: OMAP 73-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2004(Temp), f. 6-14-04 cert. ef. 6-19-04 thru 11-30-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 5-2008, f. 2-28-08, cert. ef. 3-1-08; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 52-2016, f. 8-26-16, cert. ef. 9-1-16

410-120-1260
Provider Enrollment

(1) This rule applies to providers enrolled with or seeking to enroll with the Division of Medical Assistance Programs (Division).

(2) Providers signing the Provider Enrollment Agreement constitute agreement to comply with all applicable Division provider rules and federal and state laws and regulations.

(3) Providers enrolled by the Division include:

(a) A non-payable provider, meaning a provider who is issued a provider number for purposes of data collection or non-claims-use such as, but not limited to:

(A) Ordering or referring providers whose only relationship with the Division is to order, refer, or prescribe services for Division clients;

(B) A billing agent or billing service submitting claims or providing other business services on behalf of a provider but not receiving payment in the name of or on behalf of the provider;

(C) An encounter only provider: A provider contracted with a PHP or CCO.

(b) A payable provider, meaning a provider who is issued a provider number for the purpose of submitting health care claims for reimbursement from the Division. A payable provider may be:

(A) The rendering provider;

(B) An individual, agent, business, corporation, clinic, group, institution, or other entity that, in connection with the submission of claims, receives or directs the payment on behalf of a rendering provider;

(4) When an entity is receiving or directing payment on behalf of the rendering provider, the billing provider must:

(a) Meet one of the following standards as applicable:

(A) Have a relationship with the rendering provider described in 42 CFR 447.10(g) and have the authority to submit the rendering provider enrollment application and supporting documentation on behalf of the rendering provider;

(B) Is a contracted billing agent or billing service that has enrolled with the Division to provide services in connection with the submission of claims and to receive or direct payment in the name of the rendering provider pursuant to 42 CFR 447.10(f).

(b) Maintain and make available to the Division upon request records indicating the billing provider's relationship with the rendering provider. This includes:

(A) Identify all rendering providers for whom they bill or receive or direct payments at the time of enrollment;

(B) Notify the Division within 30 days of a change to the rendering provider's name, date of birth, address, Division provider numbers, NPIs, Social Security Number (SSN), or the Employer Identification Number (EIN).

(c) Prior to submission of any claims or receipt or direction of any payment from the Division, obtain signed confirmation from the rendering provider that the billing entity or provider has been authorized by the rendering provider to submit claims or receive or direct payment on behalf of the rendering provider. This authorization, and any limitations or termination of such authorization, must be maintained in the provider's files for at least five years following the submission of claims or receipt or direction of funds from the Division.

(5) In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements for providers:

(a) The Division requires non-payable and payable providers to be enrolled consistent with the provider enrollment process described in this rule;

(b) If the rendering provider uses electronic media to conduct transactions with the Division or authorizes a non-payable provider, e.g. billing service or billing agent, to conduct such electronic transactions, the rendering provider must comply with the Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. Enrollment as a payable or non-payable provider is a necessary requirement for submitting electronic claims, but the provider must also register as an EDI trading partner and identify the EDI submitter in order to submit electronic claims.

(6) To be enrolled and able to bill as a provider, an individual or organization must:

(a) Meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules;

(b) Comply with all Oregon statutes and regulations for provision of Medicaid and CHIP services;

(c) If providing services within the State of 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.

(7) An Indian Health Service facility meeting enrollment requirements will be accepted on the same basis as any other qualified provider. However, when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.

(8) An individual or organization that is currently subject to sanction by the Division, another state's Medicaid program, or the federal government is not eligible for enrollment (see OAR 410-120-1400, 943-120-0360, Provider Sanctions).

(9) Required information: All providers must meet the following requirements before the Division can issue or renew a provider number and must provide documentation at any time upon written request by the Division:

(a) Disclosure requirements: The provider must disclose to the Division:

(A) The identity of any person employed by the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or CHIP program in the last ten years;

(B) If the provider is an entity other than an individual practitioner or group of practitioners, disclose the following:

(i) The name, date of birth, address, and tax identification number of each person with an ownership or control interest in the

provider or in any subcontractor in which the provider has a direct or indirect ownership interest of 5 percent or more. When disclosing tax identification numbers:

(I) For corporations, use the federal Tax Identification Number;

(II) For individuals in a solo practice or billing as an individual practitioner, use the Social Security Number (SSN);

(III) All other providers use the Employer Identification Number (EIN);

(IV) The SSN or EIN of the rendering provider cannot be the same as the Tax Identification Number of the billing provider;

(V) Pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041, SSN's and EIN's 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 provider for payment and collection activities;

(ii) Whether any of the persons so named:

(I) Is related to another as spouse, parent, child, sibling, or other family members by marriage or otherwise; and

(II) Has an ownership or control interest in any other entity.

(C) A provider must submit within 35 days of the date of a request full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period ending on the date of the request;

(b) Provider screening and enrollment requirements: The provider must submit the following information to the Division:

(A) For non-payable providers, a complete Non-Paid Provider Enrollment Request;

(B) For payable providers, a complete Provider Enrollment Request, Provider Enrollment Attachment, Disclosure Statement, and Provider Enrollment Agreement;

(C) Application fee if required under 42 CFR 455.460;

(D) Consent to criminal background check when required;

(E) To fulfill federal provider screening requirements pursuant to 42 CFR 455.436 and upon request, the name, date of birth, address, Division provider numbers, NPIs, and Social Security Number (SSN) of any provider who is enrolled or seeking enrollment with the Division.

(c) Verification of licensing or certification: Loss of the appropriate licensure or certification will result in immediate disenrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Required updates: Enrolled providers must notify the Division in writing of material changes 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) Failure to notify the Division of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual rendering providers may result in the imposition of a $50 fine:

(i) If the Division notifies a provider about an error in their Federal Tax Identification, including Social Security Numbers or Employer Identification Numbers for individual rendering providers, the provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the Division's notice.

(ii) Failure to comply with this requirement may result in the Division imposing a fine of $50 for each such notice. Federal Tax Identification requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(B) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a provider enrollment form, provider enrollment agreement, provider certification, or other related documentation.

(C) In the event of bankruptcy proceedings, the provider shall immediately notify the Division administrator in writing;

(D) Claims submitted by or payments made to providers who have not furnished the notification required by this rule or to a provider that has failed to submit a new application as required by the Division under this rule may be denied or recovered.

(10) Rendering providers may be enrolled retroactive to the date services were provided to a Division client only if:

(a) The provider was appropriately licensed, certified, and otherwise met all Division requirements for providers at the time services were provided;

(b) Services were provided fewer than 12 months prior to the date the application for provider status was received by the Division as evidenced by the first date stamped on the paper claim submitted with the application materials for those services, either manually or electronically;

(11) The Division reserves the right to retroactively enroll the provider prior to the 12-month period based upon extenuating circumstances outside the control of the provider, consistent with federal Medicaid regulations, and with approval of the Division's Provider Enrollment Unit Manager.

(12) There are two types of provider numbers:

(a) Oregon Medicaid provider number: The Division issues provider numbers to establish an individual or organization's enrollment as an Oregon Medicaid provider.

(A) This number designates specific categories of services covered by the Division Provider Enrollment Attachment. For example, a pharmacy provider number applies to pharmacy services but not to durable medical equipment, which requires a separate provider application attachment and establishes a separate Oregon Medicaid provider number;

(B) For providers not subject to NPI requirements, this number is the provider identifier for billing the Division;

(b) National Provider Identifier (NPI) and taxonomy: The Division requires compliance with NPI requirements in 45 CFR Part 162. For providers subject to NPI requirements:

(A) The NPI and taxonomy codes are the provider identifier for billing the Division;

(B) Currently enrolled providers that obtain a new NPI are required to update their records with the Division's Provider Enrollment Unit;

(C) Provider applicants must obtain an NPI and include it in their provider enrollment request to the Division.

(13) Enrollment of out-of-state providers: Providers of services outside the State of Oregon will be enrolled as a provider if they comply with the requirements in OAR 410-120-1260 and under the following conditions:

(a) The provider is appropriately licensed or certified and meets standards for participation in the Medicaid program. Disenrollment or sanction from other states' Medicaid program or exclusion from any other federal or state health care program is a basis for disenrollment, termination, or suspension from participation as a provider in Oregon's medical assistance programs;

(b) Noncontiguous out-of-state pharmacy providers must be licensed by the Oregon Board of Pharmacy to provide pharmacy services in Oregon. In instances where clients are out of the state due to travel or other circumstances that prevent them from using a pharmacy licensed in Oregon and prescriptions need to be filled, the pharmacy is required to be licensed in the state they are doing business where the client filled the prescription and must be enrolled with the Division in order to submit claims. Out-of-state Internet or mail order, except the Division's mail order vendor, prescriptions are not eligible for reimbursement;

(c) The provider bills only for services provided within the provider's scope of licensure or certification;

(d) For noncontiguous out-of-state providers, the services provided must be authorized in the manner required under these rules for out-of-state services (OAR 410-120-1180) or other applicable Authority rules:

(A) The services provided are for a specific Oregon Medicaid client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) Services provided are for foster care or subsidized adoption children placed out of state; or

(C) The provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) clients;

(D) The services for which the provider bills are covered services under the Oregon Health Plan (OHP).

(e) Facilities including but not restricted to hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, psychiatric hospitals, and residential care facilities will be enrolled as providers only if the facility is enrolled as a Medicaid provider in the state in which the facility is located or is licensed as a facility provider of services by the State of Oregon;

(f) Out-of-state providers may provide contracted services per OAR 410-120-1880.

(g) Out-of-state billing providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 943-120-0320(15)(f).

(14) Absentee Physicians: When a substitute physician is retained to take over another physician's professional practice while he or she is absent or unavailable, the following shall apply:

(a) The Division recognizes that absentee physicians may retain substitute physicians as a locum tenens or as part of a reciprocal billing arrangement. For purposes of this rule:

(A) A "locum tenens" means a substitute physician retained to take over another physician's professional practice while he or she is absent (i.e., absentee physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.;

(B) A locum tenens cannot be retained to take over a deceased physician's professional practice without becoming enrolled with the Division;

(C) A "reciprocal billing arrangement" means a substitute physician retained on an occasional basis;

(b) Substitute physicians are not required to enroll with the Division; however, the Division may enroll such providers at the discretion of the Division's provider enrollment manager if the provider submits all information required for provider enrollment as described in this rule;

(c) In no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;

(d) The absentee physician must be an enrolled Division provider and must bill with their individual Division assigned provider number and receive payment for covered services provided by the substitute physician:

(A) Services provided by the locum tenens must be billed with a modifier Q6;

(B) Services provided in a reciprocal billing arrangement by the substitute physician must be billed with a modifier Q5;

(C) In entering the Q5 or Q6 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection and are services for which the absentee physician is authorized to submit a claim;

(D) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled provider's right to receive payment or to submit claims may be revoked.

(e) These requirements do not apply to substitute arrangements among physicians in the same medical practice when claims are submitted in the name of the practice or group name.

(f) Nothing in this rule prohibits physicians sharing call responsibilities from opting out of the substitute provider arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled rendering providers and as long as duplicate claims for services are not submitted.

(15) Provider termination:

(a) The provider may terminate enrollment at any time. The request must be in writing and signed by the provider. The notice shall specify the Division assigned provider number to be terminated and the effective date of termination. Termination of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;

(b) The Division may terminate or suspend providers when a provider fails to meet one or more of the requirements governing a provider's participation in Oregon's medical assistance programs such as, but not limited to:

(A) Breaches of provider agreement;

(B) Failure to submit timely and accurate information as requested by the Division;

(C) Failure to submit fingerprints in a form determined by the Division within 30 days of request;

(D) Failure to permit access to provider locations for site visits;

(E) Failure to comply with federal or state statutes and regulations or policies of the Division that are applicable to the provider;

(F) No claims have been submitted in an 18-month period. The provider must reapply for enrollment;

(G) Any person who has an ownership or control interest in the provider or who is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid CHIP, or the Title XX services program in the last 10 years;

(H) Failure to fully and accurately make any disclosure required under this section (9) of this rule.

(16) If a provider's enrollment in the OHP program is denied, suspended, or terminated or a sanction is imposed under this rule, the providers may request a contested case hearing pursuant to OAR 410-120-1600 and 410-120-1860.

(17) The provision of health care services or items to Division clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81, Renumbered from 461-013-0060; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 73-1989, f. & cert. ef. 12-7-89; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0063, 461-013-0075 & 461-013-0180; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 51-1991(Temp), f. 11-29-91, cert. ef. 12-1-91; HR 5-1992, f. & cert. ef. 1-16-92; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0020, 410-120-0040 & 410-120-0060; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 9-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14

410-120-1280
Billing

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

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

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

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

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

(a) For any applicable coinsurance, copayments and deductibles expressly authorized in OAR chapter 410, divisions 120 and 141, or any other Division program rules;

(b) The client did not inform the provider of their OHP coverage, enrollment in a PHP or CCO, or third party insurance coverage at the time of or after a service was provided, therefore, the provider could not bill the appropriate payer for reasons including, but not limited to, the lack of prior authorization, or the time limit to submit the claim for payment has passed. The provider must verify eligibility, pursuant to OAR 410-120-1140, and document attempts to obtain coverage information prior to billing the client;

(c) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service);

(d) A third party payer made payments directly to the client for services provided;

(e) The client has the limited Citizen Alien Waived Emergency Medical benefit package. CAWEM clients have the benefit package identifier of CWM. Clients receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits. (See OAR 410-120-1210 for coverage.) The provider must document that the client was informed in advance that the service or item would not be covered by the Division. An OHP 3165 is not required for these services;

(f) The client has requested a continuation of benefits during the contested case hearing process and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service, on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 pursuant to section (3)(h) of this rule before providing these services;

(g) In exceptional circumstances, a client may decide to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:

(A) The requested service is a covered service, and the appropriate payer (the Division, PHP, CCO or third party payer) would pay the provider in full for the covered service; and

(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay; and

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

(D) The provider documents in writing, signed by the client or the client's representative, indicating that the provider gave the client the information described in section (3)(g)(A-C); and that the client had an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative; and the client agreed to privately pay for the service by signing an agreement incorporating all of the information described above. The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Division or to the client's PHP, CCO or third party payer that is subject to the agreement.

(h) A provider may bill a client for services that are not covered by the Division, PHP, or CCO (see definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165), or a facsimile containing all of the information and elements of the OHP 3165 as shown in Table 3165 of this rule. The completed OHP 3165, or facsimile, is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. Providers must make a copy of the completed OHP 3165, or facsimile, available to the Division, PHP or CCO upon request.

(4) Code Set requirements:

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

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

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

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

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

(5) Claims:

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

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

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

(d) Claims must be submitted on the appropriate form as described in the individual Division program rules or electronically in a manner authorized in OAR chapter 943, division 120;

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

(f) Unless otherwise specified, claims must be submitted after:

(A) Delivery of service; or

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

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

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

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

(A) Any false claim for payment;

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

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

(D) Any claim for furnishing specific care, items, or services that has not been provided.

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

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

(6) Diagnosis code requirement:

(a) A primary diagnosis code is required on all claims, using the ICD-10-CM diagnosis code set, unless specifically excluded in individual Division program rules;

(b) The primary diagnosis code must be the code that most accurately describes the client's condition;

(c) All diagnosis codes are required to the highest degree of specificity;

(d) Hospitals must follow national coding guidelines and bill using the 7th digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.

(7) Procedure code requirement:

(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;

(b) For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim must be the code that most accurately describes the services provided. Hospitals must follow national coding guidelines;

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

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

(8) Third party Liability (TPL):

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

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:

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

(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing.

(c) Except as noted in section (8)(d)(A through E) below, when third party coverage is known to the provider prior to billing the Division the provider must:

(A) Bill the TPL; and

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

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

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

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

(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);

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

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

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

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

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

(A) In the circumstances outlined in section (8)(d)(A) through (E) above, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall process the claim and, if applicable, pay the Division's allowable rate for these services and seek reimbursement from the liable third party insurance plan;

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

(f) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation must be on file in the provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual provider rules for further information on services that must be billed to Medicare first;

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

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

(B) Any provider who accepts third party payment for furnishing a service or item to a Division client after having billed the Division shall:

(i) Submit an Individual Adjustment Request indicating the amount of the third party payment. Follow instructions in the individual Division program rules and supplemental billing; or

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

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

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

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

(h) The Division may make a claim against any third party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it

deems this a more efficient approach. Pursuing alternate resources includes, but is not limited to, requesting the provider to bill the third party and to refund the Division in accordance with this rule;

(i) For services provided to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment, and the provider must honor that request. Under federal regulation, a provider may not charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;

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

(9) Full use of alternate resources:

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

(b) Except as provided in subsection (10) of this rule, alternate resources may be available:

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

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

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

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

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

(iii) Medicare Parts A and B.

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

(E) Through other reasonably available resources.

(10) Exceptions:

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

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

(11) Table 120-1280 – TPR codes.

(12) Table – OHP Client Agreement to Pay for Health Services, OHP 3165.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81, Renumbered from 461-013-0050, 461-013-0060, 461-013-0090 & 461-013-0020; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 45-1983, f. 9-19-83, ef. 10-1-83; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 36-1984, f. & ef. 8-20-84; AFS 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; AFS 43-1986, f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 14-1987, f. 5-31-87, ef. 4-1-87; AFS 38-1988, f. 5-17-88, cert. ef. 6-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0140, 461-013-0150, 461-013-0175 & 461-013-0180; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0260, 410-120-0280, 410-120-0300 & 410-120-0320; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-10-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 30-2001, f. 9-24-01, cert. ef 10-1-01; OMAP 23-2002, f. 6-14-02 cert. ef. 8-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 73-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 67-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 61-2013, f. 10-31-13, cert. ef. 11-1-13; DMAP 40-2015, f. & cert. ef. 7-1-15; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 53-2016, f. 8-26-16, cert. ef. 9-1-16

410-120-1295
Non-Participating Provider

(1) For purposes of this rule, a provider enrolled with the Division of Medical Assistance Programs (Division) that does not have a contract with a Division-contracted Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) is referred to as a non-participating provider.

(2) For covered services that are subject to reimbursement from the CCO or PHP, a non-participating provider, other than a hospital governed by (3) below, must accept from the Division-contracted CCO or PHP, as payment in full, the amount that the provider would be paid from the Division if the client was fee-for-service (FFS).

(3) For covered services provided on and after October 1, 2011, the Division-contracted CCO or Fully Capitated Health Plan (FCHP) 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 CCO or FCHP shall reimburse a non-participating Type A and Type B hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the CCO for the contract period or for the capitation rates paid to the FCHP for the contract period.(ORS 414.727);

(b) All other non-participating hospitals (not designated as a rural access or Type A and Type B hospital): As specified in ORS 414.743, the CCO or FCHP 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 CCO or FCHP's, excluding any supplemental payments.

(i) 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;

(ii) 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.

(4) A non-participating hospital must notify the CCO or FCHP within 2 business days of an CCO or FCHP patient admission when the CCO or FCHP 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 benefit package;

(d) The CCO or FCHP contract and the Division's administrative rules.

(5) After notification from the non-participating hospital, the CCO or FCHP may:

(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the CCO or FCHP 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 CCO or FCHP and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.025, 414.065, 414.743
Hist.: OMAP 10-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 22-2004, f. & cert. ef. 3-22-04; OMAP 23-2004(Temp), f. & cert. ef. 3-23-04 thru 8-15-04; OMAP 33-2004, f. 5-26-04, cert. ef. 6-1-04; OMAP 75-2004(Temp), f. 9-30-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 4-2005(Temp), f. & cert. ef. 2-9-05 thru 7-1-05; OMAP 33-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 35 2005, f. 7-21-05, cert. ef. 7-22-05; OMAP 49-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-15-06; OMAP 63-2005, f. 11-29-05, cert. ef. 1-1-06; OMAP 66-2005(Temp), f. 12-13-05, cert. ef. 1-1-06 thru 6-28-06; OMAP 72-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-28-06; OMAP 28-2006, f. 6-22-06, cert. ef. 6-23-06; OMAP 42-2006(Temp), f. 12-15-06, cert. ef. 1-1-07 thru 6-29-07; DMAP 2-2007, f. & cert. ef. 4-5-07; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 28-2009(Temp), f. 9-11-09, cert. ef. 10-1-09 thru 3-25-10; DMAP 35-2009(Temp), f. & cert. ef. 12-4-09 thru 3-25-10; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 4-2010, f. & cert. ef. 3-26-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 30-2011(Temp), f. & cert. ef. 10-20-11 thru 3-25-12; DMAP 15-2012, f. & cert. ef. 3-22-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1300
Timely Submission of Claims

(1) All claims for services must be submitted within 12 months of the date of service. The date of service for an Inpatient Hospital stay is considered the date of discharge.

(2) A claim that was submitted within 12 months of the date of service, but that was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to the Division of Medical Assistance Programs (Division) at the address listed in the Provider Contacts document. The Provider must present documentation acceptable to Division verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual Provider rules. Acceptable documentation is:

(a) A remittance advice from Division 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 Division.

(3) Exceptions to the 12-month requirement that may be submitted to Division are as follows:

(a) When Division or the client's branch office has made an error that caused the Provider not to be able to bill within 12 months of the date of service. Division must confirm the error;

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

(c) When the Authority determines a client is retroactively eligible for Division medical coverage and more than 12 months have passed between the date of service and the determination of the client's eligibility.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: PWC 683, f. 7-198-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 46-1980, f. & ef. 8-1-80; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0080, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 17-1985, f. 3-27-85, ef. 5-1-85; AFS 55-1987, f. 10-29-87, ef. 11-1-87; HR 2-1990, f. 12-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0145; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0340; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1320
Authorization of Payment

(1) Some services or items covered by the Division of Medical Assistance Programs (Division) require authorization before the service can be provided. See the appropriate Division rules for information on services requiring authorization and the process to be followed to obtain authorization.

(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 Division rules.

(3) The Division will authorize for the level of care or type of service that meets the client's medical need. Only services which are medically appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the provider to determine medical appropriateness or appropriateness of the service.

(4) The Division will not make payment for authorized services under the following circumstances:

(a) The client was not eligible at the time services were provided. The provider is responsible for checking the client's eligibility each time services are provided;

(b) The 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 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the 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 medically 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 Rules and in the appropriate provider rules.

(5) Retroactive authorizations:

(a) Authorization for payment may be given for a past date of service if:

(A) The client was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules, and;

(C) The request for authorization is received within 90 days of the date of service;

(b) Any requests for authorization after 90 days from date of service require documentation from the Provider that authorization could not have been obtained within 90 days of the date of service.

(7) Payment authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the Client's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.

(8) When clients have other health care coverage (third-party resources, or TPR), the Division only requires payment authorization for the services that TPR does not cover. Examples include::

(a) When Medicare is the primary payer for a service, no payment authorization from the Division is required, unless specified in the appropriate Division program rules;

(b) When other TPR is primary, such as Blue Cross, CHAMPUS, etc., the Division requires payment authorization when the other insurer or resource does not cover the service or reimburses less than the Division rate.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 14-1979, f. 6-29-79, ef. 7-1-79; AFS 5-1981, f. 1-23-81, ef. 3-1-81, Renumbered from 461-013-0060; AFS 13-1981, f. 2-27-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0041, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 7-1984(Temp), f. 2-28-84, ef. 3-15-84; AFS 11-1984(Temp), f. 3-14-84, ef. 3-15-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 38-1986, f. 4-29-86, ef. 16-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0106 & 461-013-0180; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0180; HR 22-1994, f. 5-31-94, cert. ef. 6-1-94; HR 40-1994, f. 12-30-

94, cert. ef. 1-1-95; HR 6-1996, f. 5-31-96, cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1340
Payment

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

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

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

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

(a) The amount billed;

(b) The Division maximum allowable amount or;

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

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

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

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2016 Total RVU weights published in the Federal Register, Vol. 80, November 16, 2015 to be effective for dates of services on or after January 1, 2016:

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

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

(C) The Division applies the following conversion factors:

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

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

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

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

(D) Rate calculation: Effective January 1, 2016, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) Work RVU) X (Work GPCI of 1) + (Practice Expense RVU) X (Practice GPCI of 0.974) + (Malpractice RVU) X (Malpractice GPCI of 0.708);

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

(b) Non RVU based rates:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 413.042

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

Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; Renumbered from 461-013-0061, PWC 833, f. 3-18-77, ef. 4-1-77; Renumbered from 461-013-0061; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 50-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0081, 461-013-0085, 461-013-0175 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0220, 410-120-0200, 410-120-0240 & 410-120-0320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 35-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 41-2012(Temp), f. 8-22-12, cert. ef. 9-1-12 thru 2-28-13; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 14-2013(Temp), f. & cert. ef. 3-29-13 thru 9-25-13; DMAP 49-2013, f. & cert. ef. 9-25-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 24-2014, f. & cert. ef. 4-4-14; DMAP 83-2014(Temp), f. 12-23-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 11-2015, f. & cert. ef. 3-4-15; DMAP 86-2015(Temp), f. 12-24-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 9-2016, f. 2-24-16, cert. ef. 3-1-16

410-120-1350
Buying-Up

(1) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (Division) or a managed care plan for a covered service:

(a) When a non-covered service has been provided; and

(b) Additional payment is sought or accepted from the Division client.

(2) Examples include, but are not limited to, charging the client an additional payment to obtain a gold crown (non covered) instead of the stainless steel crown (covered) or charging an additional client payment to obtain eyeglass frames not on the Division or managed care plan contract.

(3) If a client wants to purchase a non-covered service or item, the client must be responsible for full payment. The Division or managed care plan payment for a covered service cannot be credited toward the non-covered service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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 provider or the provider's designated billing 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 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's diagnosis and the medical need for the service. The client'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 provider or practitioner and any additional standards for documentation found in this rule, the individual provider rules, and any relevant contracts;

(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 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 (a) and (b) of this rule for at least five years from the date(s) of service.

(3) Upon written request from the Authority, the Medicaid Fraud Unit, Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives furnish requested documentation immediately or within the timeframe 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 Fraud Unit, or DHHS may review and copy the original documentation in the provider's place of business. Upon the written request of the 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 reasons the deadline cannot be met;

(e) The degree of control that the 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 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 payment authorization and related services;

(e) To investigate a client's contested case hearing request;

(f) To facilitate investigation by the Medicaid Fraud 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 overpayment determination may subject the provider to possible denial or recovery of payments made by the Division or to sanctions.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135, 414.145

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81, Renumbered from 461-013-0060; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 40-2015, f. & cert. ef. 7-1-15

410-120-1380
Compliance with Federal and State Statutes

(1) When a Provider submits a claim for medical services or supplies provided to a Division of Medical Assistance Programs (Division) client, Division will deem the submission as a representation by the medical Provider to the Medical Assistance Program of the medical Provider's compliance with the applicable sections of the federal and state statutes referenced in this rule:

(a) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973;

(b) 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories).

(c) Unless exempt under 45CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, the Provider must comply and, as indicated, cause all sub-contractors to comply with the following federal requirements to the extent that they are applicable to the goods and services governed by these rules. For purposes of these rules, all references to federal and state laws are references to federal and state laws as they may be amended from time to time:

(A) The Provider must comply and cause all subcontractors to comply with all federal laws, regulations, executive orders applicable to the goods and services provided under these rules. Without limiting the generality of the foregoing, the Provider expressly agrees to comply and cause all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the goods and services provided under these rules:

(i) Title VI and VII of the Civil Rights Act of 1964, as amended;

(ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended;

(iii) The Americans with Disabilities Act of 1990, as amended;

(iv) Executive Order 11246, as amended;

(v) The Health Insurance Portability and Accountability Act of 1996;

(vi) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended;

(vii) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (viii) all regulations and administrative rules established pursuant to the foregoing laws;

(viii) All other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations;

(ix) All federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the goods and services governed by these rules and required by law to be so incorporated. No federal funds may be used to provide services in violation of 42 USC 14402.

(B) Any Provider that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall:

(i) Establish written policies for all employees of the entity (including management), and of any contractor, subcontractor, or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(C) If the goods and services governed under these rules exceed $10,000, the Provider must comply and cause all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60);

(D) If the goods and services governed under these rules exceed $100,000, the Provider must comply and cause all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act—33 U.S.C. 1251 to 1387), specifically including, but not limited to, Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations must be reported to the Authority, the federal Department of Health and Human Services (DHHS) and the appropriate Regional Office of the Environmental Protection Agency. The Provider must include and cause all subcontractors to include in all contracts with subcontractors

receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section;

(E) The Provider must comply and cause all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163);

(F) The Provider certifies, to the best of the Provider's knowledge and belief, that:

(i) No federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement;

(ii) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Provider must complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions;

(iii) The Provider must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and subcontractors must certify and disclose accordingly;

(iv) This certification is a material representation of fact upon which reliance was placed when this Provider agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Provider agreement imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(G) If the goods and services funded in whole or in part with financial assistance provided under these rules are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), the Provider agrees to deliver the goods and services in compliance with HIPAA. Without limiting the generality of the foregoing, goods and services funded in whole or in part with financial assistance provided under these rules are covered by HIPAA. The Provider must comply and cause all subcontractors to comply with the following:

(i) Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between the Provider and the Authority for purposes directly related to the provision to clients of services that are funded in whole or in part under these rules. However, the Provider must not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate Authority Privacy Rules, OAR 410-014-0000 et. seq., or Authority Notice of Privacy Practices, if done by the Authority. A copy of the most recent Authority Notice of Privacy Practices is posted on the Authority Web site or may be obtained from the Authority;

(ii) If the Provider intends to engage in Electronic Data Interchange (EDI) transactions with the Authority in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, the Provider must execute an EDI Trading Partner Agreement with the Authority and must comply with the Authority EDI rules;

(iii) If a Provider reasonably believes that the Provider's or the Authority's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, the Provider must promptly consult the Authority Privacy Officer. The Provider or Authority may initiate a request to test HIPAA transactions, subject to available resources and the Authority testing schedule.

(H) The Provider must comply and cause all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Parts 247;

(I) The Provider must comply and, if applicable, cause a subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations;"

(J) The Provider must not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and Providers and subcontractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold must provide the required certification regarding their exclusion status and that of their principals prior to award;

(K) The Provider must comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace:

(i) The Provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in the Provider's workplace or while providing services to Authority clients. The Provider's notice must specify the actions that will be taken by the Provider against its employees for violation of such prohibitions;

(ii) Establish a drug-free awareness program to inform its employees about the dangers of drug abuse in the workplace, the Provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

(iii) Provide each employee to be engaged in the performance of services under these rules a copy of the statement mentioned in paragraph (J)(i) above;

(iv) Notify each employee in the statement required by paragraph (J)(i) that, as a condition of employment to provide services under these rules, the employee will abide by the terms of the statement and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

(v) Notify the Authority within ten (10) days after receiving notice under subparagraph (J)(iv) from an employee or otherwise receiving actual notice of such conviction;

(vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

(vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (J)(i) through (J)(vi);

(viii) Require any subcontractor to comply with subparagraphs (J)(i) through (J)(vii);

(ix) Neither the Provider, nor any of the Provider's employees, officers, agents or subcontractors may provide any service required under these rules while under the influence of drugs. For purposes

of this provision, "under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Provider or Provider's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Provider or Provider's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to Authority clients or others. Examples of abnormal behavior include, but are not limited to hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech, difficulty walking or performing job activities;

(x) Violation of any provision of this subsection may result in termination of the Provider agreement under these rules.

(L) The Provider must comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.);

(M) The Provider must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. Seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

(i) Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and must furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR 431.107(b)(1) & (2); 42 CFR 457.950(a)(3);

(ii) Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B); 42 CFR 457.950(a)(3);

(iii) Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396a(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I;

(iv) Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. The Provider must acknowledge Provider's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(2) Hospitals, Nursing Facilities, Home Health Agencies (including those providing personal care), Hospices and Health Maintenance Organizations will comply with the Patient Self-Determination Act as set forth in Section 4751 of OBRA 1991. To comply with the obligation under the above listed laws to deliver information on the rights of the individual under Oregon law to make health care decisions, the named Providers and organizations will give capable individuals over the age of 18 a copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1993, by the Oregon State Bar Health Law Section. Out-of-State Providers of these services should comply with Medicare, Medicaid and CHIP regulations in their state. Submittal to the Division of the appropriate billing form requesting payment for medical services provided to a Medicaid/CHIP eligible client shall be deemed representation to the Division of the medical Provider's compliance with the above-listed laws.

(3) Providers described in ORS chapter 419B are required to report suspected child abuse to their local Authority Children, Adults and Families office or police, in the manner described in ORS 419.

(4) The Clinical Laboratory Improvement Act (CLIA), requires all entities that perform even one laboratory test, including waived tests on, "materials derived 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" to meet certain federal requirements. If an entity performs tests for these purposes, it is considered, under CLIA to be a laboratory.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065
Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0160 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040 & 410-120-0400; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10

410-120-1385
Compliance with Public Meetings Law

(1) Advisory committees with the authority to make decisions for, conduct policy research for, or make recommendations on administration or policy related to the medical assistance programs operated by the Authority pursuant to ORS Chapter 414 must comply with provisions of ORS 192.610 to 192.690 — Public Meetings Law.

(2) This rule applies to those advisory committees of the medical assistance programs operated under ORS Chapter 414 that are both:

(a) Created by state constitution, statutes, administrative rule, order, intergovernmental agreement, or other official act, including direct or delegated authority from the Director of the Authority; and

(b) Comprised of at least two committee members who are not employed by a public body.

(3) Advisory committees subject to this rule must comply with the following provisions:

(a) Meetings must be open to public attendance unless an executive session is authorized. Committees must meet in a place accessible to persons with disabilities and, upon request, shall make a good faith effort to provide a sign language interpreter for persons with hearing impairment;

(b) Groups must provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the Authority Division of Medical Assistance Programs (Division) will be sufficient compliance of the advanced notice requirement. Interested persons, including news media, may request hard copy notices by contacting the Division's communications unit;

(c) Groups must take minutes at meetings and make them available to the public upon request to the contact person identified on the public notice;

(d) Any meeting that is held through the use of telephone or other electronic communication must be conducted in accordance with the Public Meetings Law.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065 & 414.227
Hist.: OMAP 62-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1390
Premium Sponsorships

(1) Premium donations made for the benefit of one or more specified the Division of Medical Assistance Programs (Division) clients will be referred to as a Premium Sponsorship and the donor shall be referred to as a sponsor.

(2) The Authority may accept Premium 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 Authority under this rule.

(3) This rule does not create or establish any Premium Sponsorship program. The Authority does not operate or administer a Premium Sponsorship program. The Authority does not find sponsors for clients or take requests or applications from clients to be sponsored.

(4) This rule does not create a right for any Division client to be sponsored. Premium Sponsorship is based solely on the decisions of sponsors. The Authority only applies the Premium 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 Premium Sponsorship program are solely the responsibility of the sponsoring entity.

(5) A Premium Sponsorship amount that is not actually received by the Division client will not be deemed to be cash or other resource attributed to the Division client, except to the extent otherwise required by federal law. A Division client's own payment of his or her obligation, or payment made by an authorized representative of the Division client, is not a sponsorship except to the extent that the authorized representative is otherwise subject to subsection (8) of this rule.

(6) Nothing in this rule alters the Division client's personal responsibility for assuring that his or her 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 Premium Sponsorship payment for the benefit of a specified client, the Authority or its designee will credit the amount of the sponsorship payment toward any outstanding amount owed by the specified client. The Authority or its designee is not responsible for notifying the client that a Premium 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 Premium Sponsorships that are not "bona fide donations" within the meaning of 42 CFR 433.54. A Premium 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 or contracting with a Prepaid Health Plan for services to Oregon Health Plan clients.

(c) Premium 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 Premium Sponsorship to the Authority, the organization will be referred to as an organizational sponsor. The Authority may accept Premium 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 Provider, Provider-related entity, or a unit of local government;

(e) All organizational sponsors that make Premium 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 Premium 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 Premium 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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 38-2004(Temp), f. 5-28-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 72-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

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 provider payments. Our program integrity goal is to pay the correct amount to a properly enrolled provider for covered, medically appropriate services provided to an eligible client according to the client's benefit package of health care services in effect on the date of service. Types of program integrity activities include but are not limited to the following activities:

(a) Medical review and prior 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 General 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 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 provider and Hospital billings will also be denied or subject to recovery.

(5) When the Authority determines that an overpayment has been made to a provider, the amount of 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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12

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 these rules 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 these rules includes requests for payment under a Provider enrollment agreement or contract, whether submitted as a claim or invoice or other method for requesting payment 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 (DMAP 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 third 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's benefit 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:

(i) The Provider will suffer irreparable injury if the Overpayment repayment is not delayed;

(ii) There is a plausible reason to believe that the 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;

(iii) 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.

(iv) Granting the delay will not result in substantial public harm;

(v) Affidavits containing evidence relied upon in support of the request for stay:

(vi) 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);

(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 overpayment, the Authority may impose a Sanction on the Provider in connection with the actions that resulted in the overpayment. 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 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.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 413.351, 414.805, 416.350

Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08

410-120-1400
Provider Sanctions

(1) The Authority recognizes two classes of provider sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.

(2) Except as otherwise noted, the Authority will impose provider sanctions at the discretion of the Authority Director or the Administrator of the Division whose budget includes payment for the services involved.

(3) The Division of Medical Assistance Programs (Division) will impose mandatory sanctions and suspend the provider from participation in Oregon's medical assistance programs:

(a) When a provider of medical services has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws;

(b) When a provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services or from the Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services. The provider will be excluded and suspended from participation with Division for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General;

(c) If the provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the provider submits a provider enrollment application or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(4) The Division may impose discretionary sanctions when the Division determines that the provider fails to meet one or more of the Division's requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary sanction include, but are not limited to, when a provider has:

(a) Been convicted of fraud related to any federal, state, or locally financed health care program or committed fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;

(b) Been convicted of interfering with the investigation of health care fraud;

(c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(d) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity either:

(A) Had his or her health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrendered his or her license while a formal disciplinary proceeding is pending before such licensing authority.

(e) Been suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(f) Billed excessive charges (i.e., charges in excess of the usual charge); furnished items or services substantially in excess of the Division client's needs or in excess of those services ordered by a medical provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;

(g) Failed to furnish medically necessary services as required by law or contract with the Division if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the Division client;

(h) Failed to disclose required ownership information;

(i) Failed to supply requested information on subcontractors and suppliers of goods or services;

(j) Failed to supply requested payment information;

(k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of the Division or the State of Oregon's Medicaid Fraud Unit conducting their regulatory or statutory functions;

(l) In the case of a Hospital, failed to take corrective action as required by the Division, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Division;

(m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The Division:

(A) Must have made a reasonable effort to secure payment;

(B) Must take into account access of beneficiaries to services; and

(C) Will not exclude a community's sole physician or source of essential specialized services.

(n) Repeatedly submitted a claim with required data missing or incorrect:

(A) When the missing or incorrect data has allowed the provider to:

(i) Obtain greater payment than is appropriate;

(ii) Circumvent prior authorization requirements;

(iii) Charge more than the provider's usual charge to the general public;

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

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

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

(o) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;

(p) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records that support information submitted on a cost report;

(r) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;

(s) Submitted claims or written orders contrary to generally accepted standards of medical practice;

(t) Submitted claims for services that exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical provider;

(u) Breached the terms of the provider contract or agreement. This includes failure to comply with the terms of the provider certifications on the medical claim form;

(v) Rebated or accepted a fee or portion of a fee or charge for a the Division client referral; or collected a portion of a service fee from the client, and billed the Division for the same service;

(w) Submitted false or fraudulent information when applying for a the Division assigned provider number, or failed to disclose information requested on the provider enrollment application;

(x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from the Division;

(y) Submitted any claim for payment for which payment has already been made by the Division or any other source unless the amount of the payment from the other source is clearly identified;

(z) Threatened, intimidated or harassed clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the Division;

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

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

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

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

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

(ff) Failure to comply with the requirements listed in OAR 410-120-1280, Billing.

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

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.019, 414.025 & 414.065

Hist.: AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1983, f. 9-2-83, ef. 10-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0095; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0600; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 61-2013, f. 10-31-13, cert. ef. 11-1-13

410-120-1460
Type and Conditions of Sanction

(1) The Division of Medical Assistance Programs (Division) may impose mandatory Sanctions on a Provider pursuant to OAR 410-120-1400(3), in which case:

(a) The Provider will be either Terminated or Suspended from participation in Oregon's medical assistance programs;

(b) If Suspended, the minimum duration of suspension will be determined by the Secretary of the Department of Health and Human Services (DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The State may suspend a Provider from participation in Oregon's medical assistance programs longer than the minimum suspension determined by the DHHS Secretary.

(2) The Division may impose the following discretionary Sanctions on a Provider pursuant to OAR 410-120-1400(4):

(a) The provider may be Terminated from participation in Oregon's medical assistance programs;

(b) The provider may be suspended from participation in Oregon's medical assistance programs for a specified length of time, or until specified conditions for reinstatement are met and approved by Division;

(c) The Division may withhold payments to a provider;

(d) The Provider may be required to attend provider education sessions at the expense of the Sanctioned Provider;

(e) The Division may require that payment for certain services are made only after the Division has reviewed documentation supporting the services;

(f) The Division may recover investigative and legal costs;

(g) The Division may provide for reduction of any amount otherwise due the Provider; and the reduction may be up to three times the amount a Provider sought to collect from a client in violation of OAR 410-120-1280;

(h) Any other Sanctions reasonably designed to remedy or compel future compliances with federal, state or Division regulations.

(3) The Division will consider the following factors in determining the Sanction(s) to be imposed (this list includes but is not limited to these factors):

(a) Seriousness of the offense(s);

(b) Extent of violations by the Provider;

(c) History of prior violations by the Provider;

(d) Prior imposition of Sanctions;

(e) Prior Provider education;

(f) Provider willingness to comply with program rules;

(g) Actions taken or recommended by licensing boards or a Quality Improvement Organization (QIO); and

(h) Adverse impact on the health of Division clients living in the Provider's service area.

(4) When a Provider fails to meet one or more of the requirements identified in this rule the Division, at its sole discretion, may immediately suspend the provider's Division assigned billing number to prevent public harm or inappropriate expenditure of public funds:

(a) The provider subject to immediate suspension is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1700 to determine whether the provider's Division assigned number will be revoked;

(b) The notice requirements described in section (5) of this rule do not preclude immediate suspension at the Division's sole discretion to prevent public harm or inappropriate expenditure of public funds. Suspension may be invoked immediately while the notice and contested case hearing rights are exercised.

(5) If the Division decides to Sanction a Provider, the Division will notify the provider by certified mail or personal delivery service of the intent to sanction. The notice of immediate or proposed sanction will identify:

(a) The factual basis used to determine the alleged deficiencies;

(b) Explanation of actions expected of the Provider;

(c) Explanation of subsequent actions the Division intends to take;

(d) The Provider's right to dispute the Division's allegations, and submit evidence to support the provider's position; and

(e) The Provider's right to appeal Division's proposed actions pursuant to OARs 410-120-1560 through 410-120-1700.

(6) If the Division makes a final decision to Sanction a provider, the Division will notify the Provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(7) The provider may appeal the Division's immediate or proposed Sanction(s) or other action(s) the Authority intends to take, including but not limited to the following list. The provider must appeal these actions separately from any appeal of audit findings and overpayments:

(a) Termination or suspension from participation in the Medicaid-funded medical assistance programs;

(b) Termination or suspension from participation in the Division's state-funded programs;

(c) Revocation of the provider's the Division assigned provider number.

(8) Other provisions:

(a) When a Provider has been Sanctioned, all other Provider entities in which the Provider has ownership (five percent or greater) or control of, may also be Sanctioned;

(b) When a provider has been Sanctioned, the Division may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon Health Plan Prepaid Health Plans and the National Practitioner Data Base of the findings and the Sanctions imposed;

(c) At the discretion of the Division, providers who have previously been Terminated or Suspended may or may not be re-enrolled as Division providers;

(d) Nothing in this rule prevents the Authority from simultaneously seeking monetary recovery and imposing Sanctions against the provider;

(e) If the Division discovers continued improper billing practices from a provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices and has had an opportunity for a contested case hearing, that provider will be liable to the Division for up to triple the amount of the Division's established overpayment received as a result of such violation.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0050, AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0095 & 461-013-0140; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0260 & 410-120-0660; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1510
Fraud and Abuse

(1) This rule sets forth requirements for reporting, detecting and investigating fraud and abuse. The terms fraud and abuse are defined in OAR 410-120-0000. For the purpose of these rules, the following definitions apply:

(a) "Credible allegation of fraud" means an allegation of 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 Department of Human Services (Department) shall not reimburse a specific provider who has defrauded or abused the Authority or Department for items or services which that 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 provider who has been convicted of a program-related offense in a federal, state, or local court for items or services which that provider furnished.

(2) Cases involving one or more of the following situations shall constitute sufficient grounds for a provider fraud referral:

(a) Billing for services, supplies, or equipment that are not provided to or used for Medicaid patients;

(b) Billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;

(c) Claiming costs for non-covered or non-chargeable 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 that appears to be a deliberate attempt to obtain additional reimbursement; and

(f) Arrangements by 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 provider shall promptly refer all suspected fraud and abuse, including fraud or 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/healthplan/Pages/general-rules.aspx.

(4) If the provider is aware of suspected fraud or abuse by an Authority or Department client, the 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/healthplan/Pages/general-rules.aspx.

(5) The 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 fraud or abuse. When a provider fails to provide immediate access to records, Medicaid payments may be withheld or suspended.

(6) Providers and their fiscal agents shall disclose ownership and control information and disclose information on a 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 provider enrollment agreement, and the provider shall update that information with an amended 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 fraud or abuse; or where there exists a credible allegation of fraud or 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 provider's alleged fraud or abuse.

(9) The Authority or Department may take the actions necessary to investigate and respond to credible allegations of fraud and abuse, including but not limited to suspending or terminating the provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the provider, or imposing other 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 covered 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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 40-2015, f. & cert. ef. 7-1-15

410-120-1560
Provider Appeals

(1) For purposes of Division provider 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 appeal in relation to health care, items, drugs, or services provided or requested to be provided to a client 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 provider with the Division, but the application has not been approved;

(c) "Prepaid Health Plan" has the meaning set forth in OAR 410-141-0000, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to provider grievances and 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 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 enrolled with an MHO shall be governed by the provider grievance and appeal procedures administered by the Authority's Addictions and Mental Health Division;

(e) The "Provider Appeal Rules" refers to the rules in OAR 410-120-1560 to 410-120-1700, describing the availability of appeal procedures and the procedures applicable to each;

(f) "Non-participating provider" has the meaning set forth in OAR 410-141-0000;

(g) Coordinated Care Organization (CCO) has the meaning set forth in OAR 410-141-0000.

(2) A Division enrolled provider may appeal a Division decision in which the 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 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 provider or provider entity; and

(e) Division overpayment determinations made under OAR 410-120-1397.

(3) Client appeals of actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865.

(4) A provider appeal is initiated by filing a timely request in writing for review with the Division:

(a) A provider appeal request is not required to follow a specific format as long as it provides a clear written expression from a provider or provider applicant expressing disagreement with a Division decision or from a CCO or PHP 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 appealed and the reason the provider disagrees with that decision.

(c) A provider 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 provider completes the CCO or PHP appeal process.

(5) Types and methods for provider appeals are:

(a) Claim redeterminations: A Division denial of or limitation of payment allowed, including prior authorization decision, or Division overpayment determination for services or items provided to a client must be appealed as claim re-determinations under OAR 410-120-1570.

(b) Contested Case: A notice of sanctions imposed or intended to be imposed, the effect of the notice of sanction is, or will be, to deny, suspend, or revoke a provider number necessary to participate in the medical assistance on a provider, or provider applicant is entitled to appeal under OAR 410-120-1600. A provider that may appeal a notice of sanction as a contested case may choose to request administrative review instead of contested case hearing if the provider submits a written request for administrative review and agrees in writing to waive the right to a contested case hearing and the Division agrees to review the appeal as an administrative review.

(c) Administrative review: All provider appeals of Division decisions not described in section (5)(a) or (b) are handled as administrative reviews in accordance with OAR 410-120-1580, unless the Division issues an order granting a contested case hearing.

(6) Decisions that adversely affect a 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 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 provider. Those providers are subject to the provider grievance or appeal processes applicable to those payment or program areas;

(c) Some decisions that adversely affect a 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 medical assistance 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 medical assistance programs. For these decisions made on behalf of the division in which the Division has legal authority to make the final decision in the matter, a provider may 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 provider appeals for CCO or PHP providers or non-participating providers concerning a decision by a CCO or PHP. In general, the relationship between a CCO or PHP and their providers is a contract matter between them. Client appeals are governed by the client appeal rules, not provider appeal rules.

(A) The CCO or PHP provider seeking a provider appeal must have a current valid provider enrollment agreement with the Division and, unless the provider is a non-participating provider, must also have a contract with the CCO or PHP; and

(B) The CCO or PHP provider or non-participating provider must have exhausted the applicable appeal procedure established by the CCO or PHP, and the request for provider appeal must include a copy of the CCO or PHP written decision that is being appealed and a copy of any CCO or PHP policy being applied in the appeal; and

(C) The CCO or PHP provider appeal or non-participating provider 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 Prioritized List, guidelines, and in the OHP Benefit package. The Division provider appeal process does not include CCO or PHP payment or claims reimbursement amount issues, except in relation to non-participating provider matters governed by Division rule;

(D) A timely provider request for 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 provider appeal. In every provider appeal involving a CCO or PHP decision, the CCO or PHP shall be treated as a participant in the appeal.

(7) If a provider's request for appeal is not timely, the Division shall determine whether the failure to file the request was caused by circumstances beyond the control of the provider, provider applicant, or CCO or PHP 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 provider appeal is on the provider, provider applicant, CCO, or PHP 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 covered services for the client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the 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 appeal proceedings, if any, shall be held in Salem, unless otherwise stipulated to by all parties and agreed to by the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0780; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 13-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 11-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 40-2015, f. & cert. ef. 7-1-15

410-120-1570
Claim Re-Determinations

(1) If a provider disagrees with an initial claim determination made by the Division of Medical Assistance Program (Division), the provider may request a review for re-determination of the denied claim payment.

(2) This rule does not apply to determinations that:

(a) Result in a "Notice of Action" that must be provided to the OHP client. If the decision under review requires any notice to the OHP client under applicable rules (OAR 410-120-1860, 410-414-0263), the procedures for notices and hearings must be followed; or

(b) Are made by a CCO or PHP regarding services to a CCO or PHP member. The provider must contact the CCO or PHP in accordance with 410-120-1560.

(3) How to request a redetermination review:

(a) To request a review, the provider must submit a written request to the Division Provider Services Unit within 180 days of the original claim adjudication date.

(b) The written request must include all information needed to adjudicate the claim or support changing the original claim determination, including but not limited to:

(A) A detailed letter of explanation identifying the specific re-determination denial issue and/or alleged error;

(B) All relevant medical records and evidence-based practice data to support the position being asserted on review;

(C) The specific service, supply or item being denied, including all relevant codes;

(D) Detailed justification for the re-determination of the denied service; and

(E) A copy of the original claim and a copy of the original denial notice or remittance advice that describes the basis for the claim denial under re-determination;

(F) Any information and/or medical documentation pertinent to support the request and to obtain a resolution of the re-determination review dispute.

(4) A provider requesting a re-determination review must demonstrate one or more of the following reasons that would allow coverage in the particular case:

(a) A below-the-line condition/treatment pair is justified under the co-morbid rule OAR 410-141-0480(8);

(b) A treatment that is part of a covered complex procedure and/or related to an existing funded condition;

(c) A service not listed on the HSC Prioritized List that may be covered under OAR 410-141-0480(10);

(d) A service that satisfies the Citizen/Alien-Waived Emergency Medical (CAWEM) emergency service criteria;

(e) Medical documentation of applicable evidence-based practice literature that is consistent with the condition or service under review;

(f) A service that satisfies the prudent layperson definition of emergency medical condition;

(g) A service intended to prolong survival or palliate symptoms, due to expected length of life consistent with the HSC Statement of Intent for Comfort/Palliative Care;

(h) A service that should be covered where denial was due to technical errors and omissions with the Oregon Health Services Commission's (HSC) Prioritized List of approved Health Services

(i) Misapplication of a fee schedule;

(j) A denied duplicate claim that the provider believes were incorrectly identified as a duplicate;

(k) Incorrect data items, such as provider number, use of a modifier or date of service, unit changes or incorrect charges;

(l) Errors with the Medicaid Management Information System (MMIS), such as a code is missing in MMIS that the Oregon Health Services Commission (HSC) has placed on the Prioritized List of Health Services;

(m) Services provided without the required prior-authorization, except for those authorizations subject to provision outlined in OAR 410-120-1280(2)(a)(C);

(n) A covered diagnostic service.

(5) The Division will review all re-determination requests as follows:

(a) The review is based on the Division review of supplied documentation and applicable law(s);

(b) The Division may request additional information from the provider that it finds relevant to the request under review;

(c) The Division does not provide a face-to-face meeting with providers as part of the re-determination review process.

(d) The Division will notify a provider requesting review that the re-determination request has been denied if:

(A) The provider did not submit a timely request;

(B) The required information is not provided at the same time the request is submitted; and/or

(C) The provider fails to submit any additional requested information within 14 business days of request.

(7) The Division's final decision under this rule is the final decision on appeal. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Division's final decision under this rule.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 13-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1580
Provider Appeals — Administrative Review

(1) An administrative review is a provider 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 provider, provider applicant, Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) provider, where administrative review is appropriate and consistent with these provider appeal rules OAR 410-120-1560.

(2) Administrative review is an 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 contested case, or client appeal.

(a) If the Division finds that the appeal should be handled as a different form of provider appeal or as a client appeal, the Administrator or designee will notify the provider of this determination.

(b) Within the time limits established by the Division in the administrative review, the provider, provider applicant, CCO or PHP 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 appeal.

(3) If the Administrator or designee decides that a meeting between the provider, 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 provider requesting the review of the date, time, and place the meeting is scheduled;

(b) Notify the CCO or PHP (when client 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 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 provider, provider 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 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 appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a contested 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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0191 & 461-013-0220; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0800; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 13-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1600
Provider Appeals — Contested Case Hearings

(1) A contested case procedure is a hearing that is conducted by the Office of Administrative Hearings where a contested case is appropriate and consistent with the provider appeal rules OAR 410-120-1560. If the request for contested case hearing was timely filed but should have been filed as a claim redetermination or

administrative review, or client appeal, Division will refer the request to the proper appeal procedure and notify the Provider, provider applicant, CCO or PHP provider.

(2) Contested case 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 provider contested case hearing is the provider, provider applicant, CCO or PHP provider who requested the appeal. In the event that Division determines that a CCO or PHP 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 provider, CCO or PHP 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 provider(s) provider applicant, CCO or PHP 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 provider, provider applicant, CCO or PHP 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 provider appeal is on the provider, provider applicant, CCO or PHP provider that requested the 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 covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the 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.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0191 & 461-013-0225; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0820; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 13-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1855
Client's Rights and Responsibilities

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

(a) To be treated with dignity and respect;

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

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

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

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

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

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

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

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

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

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

(l) To obtain covered preventive services;

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

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

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

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

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

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

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

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

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

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

(2) Division clients shall have the following responsibilities:

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

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

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

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

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

(f) To use emergency services appropriately;

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

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

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

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

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

(l) To follow prescribed agreed upon treatment plans;

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13; DMAP 71-2013, f. & cert. ef. 12-27-13

410-120-1860

Contested Case Hearing Procedures

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

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

(3) Complaints and appeals for clients requesting or receiving medical assistance from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OARs 410-141-3260 to 410-141-3262 and 410-141-0260 to 410-141-0262. This rule describes the procedures applicable when those clients request and are eligible for a Division contested case hearing.

(4) Contested Case Hearing Requests:

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

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

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

(b) To be timely, a request for a hearing is complete when the Division receives the Division approved appeal and hearing forms not later than the 45th day following the date of the decision notice;

(c) In the event a request for hearing is not timely, the Division will determine whether the client showed there was good cause, as defined in OAR 137-003-0501(7) for their failure to timely file the hearing request. In determining whether to accept a late hearing request, the Division requires the request to be supported by a written statement that explains why the request for hearing is late. The Division may conduct such further inquiry as the Division deems appropriate. If the Division finds that the client has good cause for late filing, the Division will refer the case to the OAH for a contested case hearing. The following factual disputes will be referred to the OAH for a hearing:

(A) Whether the hearing request was received timely;

(B) Whether the client received the notice of action;

(C) The information included in the client's statement of good cause.

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

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

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

(5) Expedited hearings:

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

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

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

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

(6) Informal conference:

(a) The Division hearing representative and the claimant, and their legal representative if any, may have an informal conference, without the presence of the Administrative law Judge (ALJ), to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Division and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is subject of the hearing request;

(C) Give the claimant and the Division an opportunity to review the information that is the basis for that action;

(D) Inform the claimant of the rules that serve as the basis for the contested action;

(E) Give the claimant and the Division the chance to correct any misunderstanding of the facts;

(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and

(G) Give the Division an opportunity to review its action.

(b) The claimant may, at any time prior to the hearing date, request an additional informal conference with the Authority representative, which may be granted if the Authority representative finds, in his or her sole discretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;

(c) The Division may provide to the claimant the relief sought at any time before the Final Order is served;

(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by the Division or the ALJ, whichever is first. The ALJ will send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth calendar day following the date such an order is effective.

(8) Contested case hearings are closed to non-participants in the hearing; however, a client may choose to have another person present.

(9) Proposed and Final Orders:

(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings will serve a proposed order on all parties and the Division, unless, prior to the hearing, the Division notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (b) unless the Division notifies the parties and the ALJ that the Division will issue the final order;

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

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

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

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Division will cancel the dismissal order on request of the party upon the party being able to show good cause, as defined in OAR 137-003-0501(7), as to why they were 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 claimant's withdrawal of the hearing request is effective the date the claimant withdraws. When claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.

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

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

Stat. Auth.: ORS 183.341 & 413.042

Stats. Implemented: ORS 183.411 - 183.471, 411.408, 414.025 & 414.065

Hist.: AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0053; HR 19-1990, f. & cert. ef. 7-9-90; HR 35-1990(Temp), f. & cert. ef. 10-15-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1990, f. & cert. ef. 11-26-90; HR 11-1991(Temp), f. & cert. ef. 3-1-91; HR 34-1991, f. & cert. ef. 8-26-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0760; HR 7-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 6-2012(Temp), f. & cert. ef. 2-1-12 thru 7-4-12; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 61-2013, f. 10-31-13, cert. ef. 11-1-13

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 Division of Medical Assistance Programs (Division) administrative hearings process, for clients requesting or receiving medical assistance services paid for by the Authority on a fee-for-service basis. Complaint and appeal procedures for clients receiving services from a Prepaid Health Plan shall be governed exclusively by the procedures in OAR 410-0141-0260.

(2) When the Authority authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend or reduce the course of treatment or a covered service, the Authority or its designee shall mail a written notice to the client at least ten (10) calendar days before the date of the termination or reduction of the covered service unless there is documentation that the client 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 of the action the Authority has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the client'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 recipients.

(4) The Authority shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the client requests an administrative hearing before the effective date of the client notice 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 in no event should exceed ninety (90) days from the date of the client'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 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's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy and the Authority promptly informs the client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the client in writing that it is continuing the service. The notice shall inform the client that if the hearing is resolved against the client, the cost of any services continued after the effective date of the client notice may be recovered from the client pursuant to 42 CFR 431.230(b);

(c) The Authority shall reinstate services if:

(A) The Authority takes an action without providing the required notice and the client requests a hearing;

(B) The Authority does not provide the notice in the time required under section (2) of this rule and the client 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, but the client's whereabouts become known during the time the client 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 action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the client, or the Authority decides in the client's favor before the hearing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 411.408, 414.025 & 414.065
Hist.: OMAP 30-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1870
Client Premium Payments

(1) All non-exempt clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120.

(2) Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 411.408, 414.025 & 414.065
Hist.: HR 7-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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 case hearings requested by clients in accordance with OAR 410-120-1860 and 410-130-1865; and

(b) Contested case hearings involving Providers in accordance with OAR 410-120-1560 to 410-120-1700.

(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 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 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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: HR 8-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 34-2003, f. & cert. ef. 5-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1880
Contracted Services

(1) Except as otherwise provided in OAR 410-120-1260 et seq. applicable to provider enrollment or 410-141-0000, 410-141-3010 et seq. governing CCO or PHPs, insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 may be implemented for covered medical assistance services in any program area(s) of the Oregon Health Authority (Authority) in order to achieve one or more of the following purposes:

(a) To implement and maintain CCO or PHP services;

(b) To ensure access to appropriate Medical Services that would not otherwise be available;

(c) To more fully specify the scope, quantity, or quality of the services to be provided or to specify requirements of the provider or to specify requirements of the Authority in relation to the provider;

(d) To obtain services more cost effectively, (e.g., to reduce the costs of program administration or to obtain comparable services at less cost than the fee-for-service rate).

(2) Contracts, interagency agreements, or intergovernmental agreements under OAR 410-120-1880, subsection (1) funded with federal funds will be subject to applicable federal procurement and contracting requirements, and this rule will be interpreted and applied to satisfy such requirements. To the extent required by the federal funding agency, the Authority will seek prior federal approval of solicitations and/or contracts when the Authority plans to acquire or enhance services or equipment that will be paid in whole or on part with federal funds.

(3) The Authority is exempt from the Public Contracting Code for purposes of source selection pursuant to ORS 279A.025(2). The Authority will use the following source selection procedures when entering into contracts under OAR 410-120-1880, subsection (1). Interagency agreements and intergovernmental agreements are not subject to competitive solicitation as the basis of source selection, and may be selected in accordance with ORS 190.003 to 190.130 and other applicable law or authority. Competition must be used in obtaining contract services to the maximum extent practical, except as otherwise provided in subsection (4):

(a) Small procurement procedure may be used for the procurement of supplies and services less than or equal to $5,000. The Authority may use any method reasonably appropriate to the nature of the supply or service and the business needs of the Authority to identify potential contractors;

(b) Informal solicitation procedure may be used for the procurement of services if the estimated cost or contract price is $150,000 or less. Proposals will be solicited from at least three sources, except as otherwise provided in these rules;

(c) Formal solicitation procedure will be used for the procurement of services when the estimated cost or contract price is more than $150,000. Proposals must be solicited as outlined in these rules.

(4) Selection by negotiation may be used in lieu of a competitive procurement under subsection (3) of this rule for the procurement of goods or services if:

(a) The good or service is available only from a single source or the sole source has special skills that are only available based upon his or her expertise or situation. If the Authority Director, or designee, determines that only a single contractor is available or

practical for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the reasons for using a sole source contract must be placed in the contract file;

(b) Public need, significant risk of interruption of services, or emergency advises against a delay incident to competitive solicitation. If the Authority Director, or designee, determines that an emergency exists for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the nature of the emergency must be placed in the file;

(c) Compliance with federal requirements necessitated proceeding without competitive solicitation. Documentation of the applicable federal requirements must be placed in the contract file;

(d) Other authority including but not limited to statutory authority in ORS 414.115, 414.125, 414.135, and 414.145, or such other authority, exemptions and delegations of authority that may be applicable to the source selection for the procurement: Documentation of the authority must be placed in the contract file.

(5) A Request for Proposal (RFP) or similar solicitation mechanism must be prepared for contracts for which the Formal Solicitation Procedure will be used. The solicitation document should include at a minimum the following elements, when applicable:

(a) Statement of required work, including a clear description of the services to be provided, standards by which performance of the services will be measured and/or conditions affecting the delivery of services;

(b) Minimum standards and qualifications which contractors must meet to be eligible to provide the services;

(c) Information which the prospective contractors must submit in their proposals to support their capability, such as references and experience providing the same or similar services (when, where, for whom, type of service, etc.);

(d) Funding information and budget requirements;

(e) Information about ownership interests in software or hardware designed, acquired, developed or installed with federal funds, in compliance with federal requirements for ownership, management and disposition;

(f) The form and organization of proposals, when and where proposals are to be submitted, whether late proposals may be considered, and when an award of a contract is expected;

(g) The method and criteria to be used in evaluating proposals and the weighting assigned to each criterion;

(h) Provisions stating how and when the solicitation document must be contested, and how and when the final award must be contested;

(i) Notice that all costs incurred in the preparation of a proposal will be the responsibility of the proposer and will not be reimbursed by the Authority; and

(j) Contract provisions, subject to subsection (8) of this rule.

(6) Proposals must be evaluated in a manner consistent with the evaluation criteria in the solicitation document. A written document stating why the selection was made will be placed in the contract file.

(7) Unless exempt under ORS 291.045 to 291.049 or rules adopted there under, the Authority will obtain the review and approval of the solicitation document, contract or agreement by the Department of Justice.

(8) The terms and conditions of the contract to be awarded to a contractor selected using these source selection rules will be governed by the Public Contracting Code, except for interagency agreements or intergovernmental agreements exempt under ORS 279A.025(2), or contracts or agreements under other exemptions from the Public Contracting Code. The Public Contracting Code, if applicable, and such delegation of authority, if any, as may be made by the Department of Administrative Services to the Authority determine contract approval authority.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.115, 414.125, 414.135, 414.145 & 414.740

Hist.: AFS 62-1986, f. 8-22-86, ef. 9-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0172; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0580; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12

410-120-1920
Institutional Reimbursement Changes

(1) The Division of Medical Assistance Programs (Division) is required under federal regulations, 42 CFR 447, to submit specific assurances and related information to the Centers for Medicare and Medicaid Services (CMS) whenever it makes a significant change in its methods and standards for setting payment rates for inpatient hospital services or long-term care facilities.

(2) A "significant change" is defined as a change in payment rates that affects the general method of payment to all providers of a particular type or is projected to affect total reimbursement for that particular type of provider by six percent or more during the 12 months following the effective date.

(3) Federal regulation specifies that a public notice must be published in one of the following:

(a) A state register similar to the Federal Register. For the Oregon Health Authority (Authority), the state register is the Oregon Bulletin published by the Secretary of State;

(b) The newspaper of widest circulation in each city with a population of 50,000 or more;

(c) The newspaper of widest circulation in the state, if there is no city with a population of 50,000 or more;

(d) The Authority web site for public notices.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042

Hist.: AFS 13-1985, f. 3-4-85, ef. 4-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0006; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0380; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12

410-120-1940
Interest Payments on Overdue Claims

(1) Upon request by the provider, the Division Assistance Program (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 valid claim;

(b) The interest rate shall be the usual rate charged by the provider to the 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 valid claim the 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 who received the service;

(c) Client ID Number;

(d) Date of service;

(e) Date of initial valid billing of DAMP;

(f) Amount of billing on initial valid claim;

(g) Division Internal Control Number (ICN) of claim;

(h) Certification, signed by the provider or the provider's authorized agent, that the amount claimed does not exceed the usual overdue account charges assessed by the provider to the provider's clientele.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0185; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0360; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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 or eligible enrollee is covered by employer spon-

sored 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 cost 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 is enrolled in a full coverage Medicaid program approved by the Authority or Department (excluding CHIP and CAWEM);

(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 cost-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 cost-effective and if it is necessary to include that individual in order to enroll the client in the health plan.

(3) The Authority or Department shall not pay private health insurance premiums for:

(a) Non-SSI institutionalized and waivered clients 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 clients 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 cost-effectiveness shall include:

(a) The Medical Savings Chart (MSC) is used to obtain the cost effectiveness rate for each Medicaid eligible client;

(b) In cases where there is more than one Medicaid eligible client 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 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 cost effective.

(6) The Authority or Department may purchase documents or records necessary to establish or maintain the client'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 third party payment, the Authority or Department shall pay the 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 covered services provided to Medicaid eligible clients.

(8) Any change of insurance coverage shall be reported to the Authority or Department within ten days of the change. If the Authority or Department determines reimbursement of premiums was made on behalf of the client 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'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, clients 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 cost-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 is no longer eligible for a medical program approved by the Authority or Department;

(b) A client 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 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's eligibility changes to a category that does not meet the requirements in section (2).

(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 or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment or reimbursement of client-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, clients do not have hearing rights for a denial of private insurance premium payment. The Authority or Department's decision to place a client in the PHI/HIPP program is

a reimbursement and not an eligibility determination nor denial of a medical program benefit.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135 & 414.145
Hist.: AFS 47-1982, f. 4-30-82; AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 38-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0170; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0500 & 410-120-0520; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 40-2015, f. & cert. ef. 7-1-15

410-120-1980
Requests for Information and Public Records

(1) The Division of Medical Assistance Programs (Division) will make non-exempt public records available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) Division may charge a fee for copies of non-exempt public records to cover actual costs per OAR 943-003-0010.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 192.410 - 192.505
Hist.: HR 32-1993, f. & cert. ef. 11-1-93; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 3-2007, f. & cert. ef. 6-1-07

DIVISION 121

PHARMACEUTICAL SERVICES

410-121-0000
Foreword and Definition of Terms

(1) The Division of Medical Assistance Program's (Division) Oregon Administrative Rules (OAR) are designed to assist providers in preparing claims for services provided to the Division's fee-for-service clients. Providers must use Pharmaceutical OARs in conjunction with the General Rules OARs (chapter 410, division 120) for Oregon Medical Assistance Programs.

(2) Pharmaceutical services delivered through managed care plans contracted with the Division, under the Oregon Health Plan (OHP), are subject to the policies and procedures established in the OHP administrative rules (chapter 410, division 141) and by the specific managed health care plans.

(3) Definition of Terms:

(a) Actively Practicing: The active practice of medicine as described in ORS chapter 689, or the active practice of pharmacy as described in ORS chapter 677.

(b) Actual Acquisition Cost (AAC): The cost or basis for reimbursement of supplies. The AAC will be established by the Division or its contractor by rolling surveys of enrolled pharmacies to verify the actual invoice amount paid by the pharmacy or corporate entity to wholesalers, manufacturers, or distribution centers for the product and as such will serve as the basis for reimbursement;

(c) Authority: The Oregon Health Authority, see Oregon Health Authority definition in General Rules (chapter 410, division 120);

(d) Average Actual Acquisition Cost (AAAC): The AAAC will be the average of AAC invoice amounts for individual drug products based on the Generic Sequence Number (GSN);

(e) Average Manufacturer's Price (AMP): The average price that manufacturers sell medication to wholesalers and retail pharmacies, as further clarified in 42 CFR 447;

(f) Bulk Dispensing: Multiple doses of medication packaged in one container labeled as required by pertinent Federal and State laws and rules;

(g) Centers for Medicare and Medicaid Services (CMS) Basic Rebate: The quarterly payment by the manufacturer of a drug pursuant to the Manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(3) of the Social Security act 42 U.S.C. 1396r-8(c)(1) and 42 U.S.C. 1396r-8 (c)(3). See 410-121-0157;

(h) CMS Consumer Price Index (CPI) Rebate: The quarterly payment by the manufacturer pursuant to the Manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(2) of the Social Security act (42 U.S.C. 1396r-8(c)(2);

(i) Compendia: Those resources widely accepted by the medical profession in the efficacious use of drugs, including the following sources:

(A) The American Hospital Formulary Service drug information;

(B) The United States Pharmacopeia drug information;

(C) The American Medical Association drug evaluations;

(D) Peer-reviewed medical literature;

(E) Drug therapy information provided by manufacturers of drug products consistent with the federal Food and Drug Administration requirements;

(j) Community Based Care Living Facility: For the purposes of the Division's Pharmacy Program, a home, facility, or supervised living environment licensed or certified by the state of Oregon that provides 24 hour care, supervision, and assistance with medication administration. These include, but are not limited to:

(A) Supportive Living Facilities;

(B) 24-Hour Residential Services;

(C) Adult Foster Care;

(D) Semi-Independent Living Programs;

(E) Assisted Living and Residential Care Facilities;

(F) Group Homes and other residential services for people with developmental disabilities or needing mental health treatment; and

(G) Inpatient hospice;

(k) Compounded Prescription:

(A) A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid ingredient that must be a reimbursable item or a legend drug in a therapeutic amount;

(B) Compounded prescription is further defined to include the Oregon Board of Pharmacy definition of compounding (see OAR 855-006-0005);

(L) Dispensing: Issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist;

(m) Director: The Director of the Authority;

(n) Drug Order/Prescription:

(A) A medical practitioner's written or verbal instructions for a patient's medications; or

(B) A medical practitioner's written order on a medical chart for a client in a nursing facility;

(o) Durable Medical Equipment and supplies (DME): Equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies;

(p) Estimated Acquisition Cost (EAC): The estimated cost that the pharmacy can obtain the product listed in OAR 410-121-0155;

(q) Intermediate Care Facility: A facility providing regular health-related care and services to individuals at a level above room and board, but less than hospital or skilled nursing levels as defined in ORS 442.015;

(r) Legend Drug: A drug limited by § 503(b)(1) of the Federal Food, Drug, and Cosmetic Act to being dispensed by or upon a medical practitioner's prescription because the drug is:

(A) Habit-forming;

(B) Toxic or having potential for harm; or

(C) Limited in its use to use under a practitioner's supervision by the new drug application for the drug:

(i) The product label of a legend drug is required to contain the statement: "CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION;"

(ii) A legend drug includes prescription drugs subject to the requirement of § 503(b)(1) of the federal Food, Drug, and Cosmetic Act which shall be exempt from § 502(F)(1) if certain specified conditions are met;

(s) Long Term Care Facility: Includes skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455;

(t) Maintenance Medication: Drugs that have a common indication for treatment of a chronic disease and the therapeutic duration is expected to exceed one year. This is determined by a First DataBank drug code maintenance indicator of "Y" or "1";

(u) Mental Health Drug: A type of legend drug defined by the Oregon Health Authority (Authority) by rule that includes, but is not limited to those drugs classified by First DataBank in the following Standard Therapeutic Classes:

(A) Therapeutic Class 7 ataractics-tranquilizers; and Therapeutic Class 11 psychostimulants-antidepressants;

(B) Depakote, Lamictal and their generic equivalents and other drugs that the Division specifically carved out from capitation from Fully Capitated Health Plans (FCHPs) in accordance with OAR 410-141-0070;

(v) Narrow Therapeutic Index (NTI) Drug: A drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring;

(w) Net Price: The amount a drug costs the Division and is calculated using the following formula: "Estimated Acquisition Cost minus CMS Basic Rebate minus CMS CPI Rebate minus State Supplemental Rebate";

(x) Non-Preferred Products: Any medication in a class that has been evaluated and that is not listed on the Practitioner-Managed Prescription Drug Plan Preferred Drug List in OAR 410-121-0030 and may be subject to co-pays;

(y) Nursing Facility: An establishment that is licensed and certified by the Department's Aging and People with Disabilities Division (APD) as a Nursing Facility;

(z) Pharmacist: An individual who is licensed as a pharmacist under ORS chapter 689;

(aa) Physical Health Drug: All other drugs not included in section (u) of this rule;

(bb) Point-of-Sale (POS): A computerized, claims submission process for retail pharmacies that provides on-line, real-time claims adjudication;

(cc) Preferred Drug List (PDL): A PDL consists of prescription drugs in selected classes that the Authority, in consultation with the Pharmacy & Therapeutics Committee (P & T), has determined represent the most effective drug(s) available at the best possible price. (See details for the Division's PMPDP PDL in OAR 410-121-0030):

(A) Enforceable Physical Health Preferred Drug List: The list of drug products used to treat physical health diagnosis that the Division has identified which shall be exempt from client co-pays and may be subject to prior authorization (PA). Drugs prescribed that do not appear on the PDL (non-preferred products) shall be subject to both co-pays and PA as determined to be appropriate by the Division;

(B) Voluntary Mental Health Preferred Drug List: The list of drug products used to treat mental health diagnosis. These drugs are exempt from client co-pay. Any drug prescribed for the treatment of mental health diagnosis shall be exempt from PA requirements by the Division;

(dd) Preferred Products: Products in classes that have been evaluated and placed on the Practitioner Managed Prescription Drug Plan (PMPDP) PDL in OAR 410-121-0030 and are not subject to co-pays;

(ee) Prescriber: Any person authorized by law to prescribe drugs;

(ff) Prescription Splitting: Any one or a combination of the following actions:

(A) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than 34 days, except as needed for Prescription Synchronization (see OAR 410-121-0146);

(B) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing fee for the quantity billed, except as needed for Prescription Synchronization (see OAR 410-121-0146);

(C) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or

(D) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice;

(gg) Prescription Synchronization: The process of, at the client's direction, aligning the refill dates of a client's prescription drugs so drugs that are refilled at the same frequency may be refilled concurrently;

(hh) Prior Authorization Program (PA): The Prior Authorization Program is a system of determining, through a series of therapeutic and clinical protocols, which drugs require authorizations prior to dispensing:

(A) OAR 410-121-0040 lists the drugs or categories of drugs requiring PA;

(B) The practitioner, or practitioner's licensed medical personnel listed in OAR 410-121-0060, may request a PA;

(ii) State Supplemental Rebates: The Division and CMS approved discounts paid by manufacturers per unit of drug. These rebates are authorized by the Social Security Act section 42 USC 1396r-8(a)(1) and are in addition to federal rebates mandated by the Omnibus Budget Rehabilitation Act (OBRA 90) and the federal rebate program;

(jj) Unit Dose: A sealed, single unit container of medication, so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for unit dose dispensing system established by the Oregon Board of Pharmacy;

(kk) Urgent Medical Condition: A medical condition that arises suddenly, is not life-threatening, and requires prompt treatment to avoid the development of more serious medical problems;

(LL) Usual and Customary Price: A pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs including membership based discounts, initiated to reduce prices for product costs available to the general public, a special population, or an inclusive category of customers;

(mm) Wholesale Acquisition Cost (WAC): The price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. WAC is the price of a covered product by the National Drug Code (NDC) as published by First DataBank, MediSpan or Red Book;

(nn) 340B Pharmacy: A federally designated community health center or other federally qualified covered entity that is listed on the Health Resources and Services Administration (HRSA) website.

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

Stat. Auth.: ORS 413.042, 414.065 & 414.325

Stats. Implemented: ORS 414.065

Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 23-2011, f. 8-24-11, cert. ef. 9-1-11; DMAP 27-2011(Temp), f. & cert. ef. 9-30-11 thru 3-15-12; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12, DMAP 76-2015, f. 12-22-15, cert. ef. 1-1-16

410-121-0021

Organizations Authorized to Provide Pharmaceutical Prescription Services

(1) Pharmacies, and Medicare certified independent rural health clinics providing urgent medical services for clients as defined in ORS 414.325(7) may provide drug prescription services for fee-for-service Division of Medical Assistance Programs (Division) clients and receive reimbursement from Division by complying with all the following requirements:

(a) Comply with all applicable Federal and State statutes, regulations and rules;

(b) Meet all current licensing and regulatory requirements;

(c) Be enrolled as a pharmacy provider with Division;

(d) Pharmacies must have a current National Association of the Board of Pharmacy (NABP) number to bill Division;

(e) Medicare certified independent rural health clinics must have a pharmacist, physician, or nurse practitioner, licensed to dispense and bill drug prescriptions; and

(f) Comply with Division pharmacy billing requirements.

(2) Refer to OAR 410-120-1260 for enrollment details.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 41-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08

410-121-0030

Practitioner-Managed Prescription Drug Plan

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that OHP fee-for-service clients have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners, who are informed by the latest peer reviewed research, make decisions concerning the clinical effectiveness of the prescription drugs;

(b) Licensed health care practitioners also consider the client's health condition, personal characteristics, and the client's gender, race, or ethnicity.

(2) PMPDP Preferred Drug List (PDL):

(a) The PDL is the primary tool the Division uses to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL contains a list of prescription drugs that the Division, in consultation with the Drug Use Review (DUR)/Pharmacy & Therapeutics Committee (P&T), has determined represent the most effective drugs available at the best possible price;

(c) The PDL shall include drugs that are Medicaid reimbursable and the Food and Drug Administration (FDA) has determined to be safe and effective.

(3) PMPDP PDL Selection Process:

(a) The Division shall utilize the recommendations made by the P&T that result from an evidence-based evaluation process as the basis for selecting the most effective drugs;

(b) The Division shall ensure the drugs selected in section (3)(a) that are available for the best possible price and shall consider any input from the P&T about other FDA-approved drugs in the same class that are available for a lesser relative price. The Division shall determine relative price using the methodology described in section (4);

(c) The Division shall evaluate selected drugs for the drug classes periodically:

(A) The Division may evaluate more frequently if new safety information or the release of new drugs in a class or other information makes an evaluation advisable;

(B) New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T;

(C) The Division shall make all revisions to the PDL using the rulemaking process and shall publish the changes on the Division's Pharmaceutical Services provider rules website.

(4) Relative cost and best possible price determination:

(a) The Division shall determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) The Division may also consider dosing issues, patterns of use, and compliance issues. The Division shall weigh these factors with any advice provided by the P&T in reaching a final decision.

(5) Pharmacy providers shall dispense prescriptions in the generic form unless:

(a) The practitioner requests otherwise pursuant to OAR 410-121-0155;

(b) The Division notifies the pharmacy that the cost of the brand name particular drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(6) The exception process for obtaining non-preferred physical health drugs that are not on the PDL drugs shall be as follows:

(a) If the prescribing practitioner in their professional judgment wishes to prescribe a physical health drug not on the PDL, they may request an exception subject to the requirements of OAR 410-121-0040;

(b) The prescribing practitioner must request an exception for physical health drugs not listed in the PDL subject to the requirements of OAR 410-121-0060;

(c) Exceptions shall be granted when:

(A) The prescriber in their professional judgment determines the non-preferred drug is medically appropriate after consulting with the Division or the Oregon Pharmacy Call Center; or

(B) Where the prescriber requests an exception subject to the requirement of section (6)(b) and fails to receive a report of PA status within 24 hours, subject to OAR 410-121-0060.

(7) Table 121-0030-1, PMPDP PDL dated October 1, 2016 is adopted and incorporated by reference and is found at: www.orpdl.org.

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

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330 to 414.414, 414.312 & 414.316

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 & 414.354

Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04; OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 48-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 2-2011(Temp), f. & cert. ef. 3-1-11 thru 8-20-11; DMAP 19-2011, f. 7-15-11, cert. ef. 7-17-11; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 26-2012, f. & cert. ef. 5-14-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 1-2014(Temp), f. & cert. ef. 1-10-14 thru 7-9-14; DMAP 15-2014, f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 28-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 37-2014, f. & cert. ef. 6-30-14; DMAP 47-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 52-2014(Temp), f. & cert. ef. 9-16-14 thru 1-11-15; DMAP 64-2014(Temp), f. 10-24-14, cert. ef. 10-29-14 thru 12-30-14; DMAP 77-2014, f. & cert. ef. 12-12-14; DMAP 78-2014(Temp), f. & cert. ef. 12-12-14 thru 6-9-15; DMAP 88-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 10-2015(Temp), f. & cert. ef. 3-3-15 thru 8-29-15; DMAP 26-2015(Temp), f. 4-17-15, cert. ef. 4-18-15 thru 6-26-15; DMAP 35-2015, f. 6-25-15, cert. ef. 6-26-15; DMAP 37-2015(Temp), f. & cert. ef. 7-1-15 thru 12-27-15; DMAP 57-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 12-27-15; DMAP 64-2015(Temp), f. & cert. ef. 11-3-15 thru 12-27-15; DMAP 66-2015(Temp), f. & cert. ef. 11-6-15 thru 12-27-15; DMAP 79-2015, f. 12-22-15, cert. ef. 12-27-15; DMAP 84-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 18-2016(Temp), f. 4-28-16, cert. ef. 5-1-16 thru 6-28-16; DMAP 27-2016, f. 6-24-16, cert. ef. 6-28-16; DMAP 43-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16; DMAP 57-2016(Temp), f. 9-30-16, cert. ef. 10-1-16 thru 3-29-17

410-121-0032

Supplemental Rebate Agreements

(1) The Division of Medical Assistance Programs (Division) has a Centers for Medicare and Medicaid Services (CMS) approved Supplemental Rebate Agreement. This template and instructions are available on the Oregon Health Authority's (Authority) web site at; http://www.oregon.gov/oha/healthplan/tools/Model%20Supplemental%20Rebate%20Agreement.pdf.

(2) The Division negotiates Supplemental Rebate Agreements for specific drug products through the Sovereign States Drug Consortium (SSDC) multi-state pool and pharmaceutical manufacturers. Negotiations are confidential, and shall not be disclosed, except in connection with an agreement/contract or as may be required by law. Confidentiality is required of any third party involved in administration of the agreement/contract.

(3) Manufacturers may submit supplemental rebate offers for consideration to include their drug(s) on the Practitioner's-Managed Prescription Drug Plan (PMPDP) Preferred Drug List (PDL), OAR 410-121-0030 after gaining access to the SSDC secure web-based offer entry system.

(4) Manufacturers must abide by requirements of the SSDC.

(5) The Practitioner-Managed Prescription Drug List (PMPDP) also called the Preferred Drug List (PDL) consist of drugs after the Food and Drug Administration (FDA) has determined to be safe and effective and reimbursable as determined by the Centers for Medicaid and Medicare Services (CMS), and evaluated using an evidence-based review process by the Pharmacy & Therapeutics Committee (P&T). If pharmaceutical manufacturers enter into supplemental rebate agreements with the SSDC, the Authority may include that drug on the PDL.

(6) Acceptance of the offer:

(a) The Division may accept an offer through the SSDC;

(b) The SSDC will notify manufacturers of the status of their offer(s).

(c) Supplemental Agreements will be executed after signed by all parties, approved by CMS if required, and added to the PMPDP Preferred Drug List by the Administrative rule process.

(d) The Division may contract for the functions of tracking utilization, invoicing, and dispute resolution for supplemental rebate products.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 97-2004, f. 12-30-04, cert. ef. 1-1-05; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12

410-121-0033
Polypharmacy Profiling

(1) The Division of Medical Assistance Programs may impose prescription drug payment limitations on clients with more than 15 unique fee-for-service drug prescriptions in a six-month period.

(2) The Division will review the client's drug therapy in coordination with the client's prescribing practitioner to evaluate for appropriate drug therapy.

(3) Appropriate drug therapy criteria will include, but is not limited to, the following:

(a) Overuse of selected drug classes;
(b) Under-use of generic drugs;
(c) Therapeutic drug duplication;
(d) Drug to disease interactions;
(e) Drug to drug interactions;
(f) Inappropriate drug dosage;
(g) Drug selection for age;
(h) Duration of treatment;
(i) Clinical abuse or misuse.

(4) The Division Medical Director in conjunction with the Drug Use Review/Pharmacy & Therapeutics Committee will make final determinations on imposed drug prescription payment limitations relating to this policy.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 1-2004, f. 1-23-04, cert. ef. 2-1-04; DMAP 27-2011(Temp), f. & cert. ef. 9-30-11 thru 3-15-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 42-2012(Temp), f. & cert. ef. 9-12-12 thru 3-10-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13

410-121-0040
Prior Authorization Required for Drugs and Products

(1) Prescribing practitioners shall obtain prior authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060.

(2) All drugs and categories of drugs including, but not limited to, those drugs and categories of drugs that require PA shall meet the following requirements for coverage:

(a) Each drug shall be prescribed for conditions funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services (OAR 410-141-0480 through 410-141-0520). If the medication is for a non-covered diagnosis, the medication may not be covered unless there is a co-morbid condition for which coverage would be allowed. The use of the medication shall meet corresponding treatment guidelines and be included within the client's benefit package of covered services and not otherwise excluded or limited;

(b) Each drug shall also meet other criteria applicable to the drug or category of drug in these pharmacy provider rules, including PA requirements imposed in this rule.

(3) The Authority may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480). The drugs and categories of drugs that the Authority requires PA for this purpose are found in the Oregon Medicaid Fee-for-Service Prior Authorization Approval Criteria (PA Criteria guide) dated October 13, 2016, adopted and incorporated by reference and found at: http://www.oregon.gov/OHA/healthplan/pages/pharmacy-policy.aspx

(4) The Authority may require PA for individual drugs and categories of drugs to ensure medically appropriate use or to address potential client safety risk associated with the particular drug or category of drug, as recommended by the Pharmacy & Therapeutics Committee (P&T) and adopted by the Authority in this rule. The drugs and categories of drugs for which the Authority requires PA for this purpose are found in the Pharmacy PA Criteria Guide.

(5) New drugs shall be evaluated when added to the weekly upload of the First Databank drug file:

(a) If the new drug is in a class where current PA criteria apply, all associated PA criteria shall be required at the time of the drug file load;

(b) If the new drug is indicated for a condition below the funding line on the Prioritized List of Health Services, PA shall be required to ensure that the drug is prescribed for a condition funded by OHP;

(c) PA criteria for all new drugs shall be reviewed by the DUR/P&T Committee.

(6) PA shall be obtained for brand name drugs that have two or more generically equivalent products available and that are not determined Narrow Therapeutic Index drugs by the DUR/P&T Committee:

(a) Immunosuppressant drugs used in connection with an organ transplant shall be evaluated for narrow therapeutic index within 180 days after United States patent expiration;

(b) Manufacturers of immunosuppressant drugs used in connection with an organ transplant shall notify the Authority of patent expiration within 30 days of patent expiration for section (5)(a) to apply;

(c) Criteria for approval are:

(A) If criteria established in section (3) or (4) of this rule applies, follow that criteria;

(B) If section (6)(A) does not apply, the prescribing practitioner shall document that the use of the generically equivalent drug is medically contraindicated and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.

(7) PA shall be obtained for non-preferred Preferred Drug List (PDL) products in a class evaluated for the PDL except in the following cases:

(a) The drug is a mental health drug as defined in OAR 410-121-0000;

(b) The original prescription is written prior to 1/1/10;

(c) The prescription is a refill for the treatment of seizures, cancer, HIV, or AIDS; or

(d) The prescription is a refill of an immunosuppressant.

(8) PA may not be required:

(a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by the Authority;

(b) For over-the-counter (OTC) covered drugs when prescribed for conditions covered under OHP; or

(c) If a drug is in a class not evaluated from the Practitioner-Managed Prescription Drug Plan under ORS 414.334.

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.330 to 414.414, 414.312 & 414.316

Stats. Implemented: 414.065, 414.334, 414.361, 414.371, 414.353 & 414.354

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 2-1990, f. & cert. ef. 1-16-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0170; HR 10-1991, f. & cert. ef. 2-19-91; HR 14-1993, f. & cert. ef. 7-2-93; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 18-1996(Temp), f. & cert. ef. 10-1-96; HR 8-1997, f. 3-13-97, cert. ef. 3-15-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2002, f. & cert. ef. 10-1-02; OMAP 66-2002, f. 10-31-02, cert. ef. 11-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 87-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 71-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 74-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 4-2006(Temp), f. & cert. ef. 3-15-06 thru 9-7-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 41-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 9-2008, f. 3-31-08, cert. ef. 4-1-08; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 27-2011(Temp), f. & cert. ef. 9-30-11 thru 3-15-12; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 23-2012(Temp), f. & cert. ef. 4-20-12 thru 10-15-12; DMAP 27-2012(Temp), f. & cert. ef. 5-14-12 thru 10-15-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 14-2014(Temp), f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 27-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 38-2014, f. & cert. ef. 6-30-14; DMAP 46-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 49-2014(Temp), f. & cert. ef. 8-13-14 thru 1-11-15; DMAP 62-2014(Temp), f. 10-13-14, cert. ef. 10-14-14 thru 1-11-15; DMAP 75-2014, f. & cert. ef. 12-12-14; DMAP 76-2014(Temp), f. & cert. ef. 12-12-14 thru 6-7-15; DMAP 89-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-26-15; DMAP 4-2015(Temp), f. & cert. ef. 2-3-15 thru 6-26-15; DMAP 25-2015(Temp), f. 4-17-15, cert. ef. 4-18-15 thru 6-26-15; DMAP 34-2015, f. 6-25-15, cert. ef 6-26-15; DMAP 36-2015(Temp), f. 6-26-15, cert. ef. 7-1-15 thru 12-27-15; DMAP 41-2015(Temp), f. & cert. ef. 8-7-15 thru 2-2-16; DMAP 44-2015(Temp), f. 8-21-15, cert. ef. 8-25-15 thru 12-27-15; DMAP 58-2015(Temp), f. & cert. ef. 10-9-15 thru 12-27-15; DMAP 80-2015, f. 12-23-15, cert. ef. 12-27-15; DMAP 83-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 6-2016(Temp), f. 2-11-16, cert. ef. 2-12-16 thru 6-28-16; DMAP 19-2016(Temp), f. 4-28-16, cert. ef. 5-1-16 thru 6-28-16; DMAP 26-2016, f. 6-24-16, cert. ef. 6-28-16; DMAP 35-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16; DMAP 54-2016(Temp), f. & cert. ef. 8-26-16 thru 12-27-16; DMAP 62-2016(Temp), f. & cert. ef. 10-13-16 thru 12-27-16

410-121-0060
How to Get Prior Authorization for Drugs

(1) A prescriber electing to order a drug requiring PA may have any licensed medical personnel in their office request the PA. The PA request may be transmitted to the Oregon Pharmacy Help Desk by any of the following methods:

(a) Call the Oregon Pharmacy Help Desk

(b) FAX the request form shown in the Pharmaceutical Services Supplemental Information on the Oregon Health Authority's website to the Oregon Pharmacy Help Desk

(c) Transmit the request electronically via the secure MMIS web portal.

(2) The status of a PA request received from prescribers or their licensed medical personnel will be reported on the secure MMIS web portal, or by calling the Automated Voice Recognition (AVR) System, within 24 hours of receipt by the Oregon Pharmacy Help Desk

(3) PA approval:

(a) It is the pharmacy personnel's responsibility to check whether the drugs are covered, whether the client is eligible, and to note restrictions such as date ranges and quantities before dispensing any medications that require PA.

(b) The pharmacy personnel must also check whether the client's prescribed medications are covered by a managed care plan because an enrollment may have taken place after PA was received. If the client is enrolled in a managed care plan and the pharmacy receiving the PA is not a participating pharmacy provider in the managed care plan's network, the pharmacy must inform the client that it is not a participating provider in the managed care plan's network and must also recommend that the client contact his or her managed care plan for a list of pharmacies participating in its network.

(c) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy provider, if consistent with all other applicable administrative rules.

(3) If the PA request has been denied, notification to client and prescriber will occur in accordance with OHP General Rules 410-120-1860.

(4) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from the Pharmacy Benefits Manager (PBM) when the client is eligible for covered fee-for-service drug prescriptions.

(a) Clients who do not have a PA pending may receive an emergency dispensing for a 96-hour supply.

(b) Clients who do have a PA pending may receive an emergency dispensing up to a seven-day supply.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0180; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10

410-121-0061
Durable Medical Equipment, Medical Supplies, and Medical Surgical Services (Physician Administered Drugs)

Follow the guidelines in the Durable Medical Equipment and Medical Supplies (OAR 410 Division 122), Home Enteral/Parenteral Nutrition and IV Services (OAR chapter 410, division 148), and Medical Surgical Services (OAR chapter 410, division 130) administrative rules and supplemental information for billing and prior authorization of these medical supplies and services. This information is available on the Oregon Health Authority's web site.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 26-1991, f. & cert. ef. 7-1-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12

410-121-0100
Drug Use Review

(1) Drug Use Review (DUR) in Division of Medical Assistance Programs (Division) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program shall include, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse:

(a) Information collected in a DUR program that identifies an individual is confidential;

(b) Staff of the Drug Use Review (DUR)/Pharmacy & Therapeutics (P&T) Committee and contractors may have access to identifying information to carry out intervention activities approved by the Division. The Division, DUR/P&T Committee or contractors shall adhere to all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and all Division policies relating to confidential client information.

(2) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is performed at the point of sale by the dispensing pharmacist:

(a) Dispensing pharmacists must offer to counsel each Division client receiving benefits who presents a new prescription, unless the client refuses such counsel. Pharmacists must document these refusals;

(A) Dispensing pharmacists may offer to counsel the client's caregiver rather than the client presenting the new prescription if the dispensing pharmacist determines that it is appropriate in the particular instance;

(B) Counseling must be done in person whenever practicable;

(C) If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide access to toll-free services (for example, some mail order pharmacy services) and must provide access to toll-free service for long-distance client calls in relation to prescription counseling;

(b) Prospective DUR is not required for drugs dispensed by Fully Capitated Health Plans (FCHPs);

(c) Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening must be followed.

(3) Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. The Division provides a professional drug therapy review for Medicaid clients through this program:

(a)The criteria used in retrospective DUR are compatible with those used in prospective DUR. Retrospective DUR criteria may include Pharmacy Management (Lock-In), Polypharmacy, and Psychotropic Use in Children. Drug therapy review is carried out by pharmacists with the Oregon State University College of Pharmacy, Drug Use Research and Management Program.

(b) If therapy problems are identified, an educational letter is sent to the prescribing provider, the dispensing provider, or both. Other forms of education are carried out under this program with Division approval.

(4) The DUR/P&T Committee is designed to develop policy recommendations in the following areas in relation to Drug Use Review:

(a) Appropriateness of criteria and standards for prospective DUR and needs for modification of these areas. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medical appropriateness, and appropriateness of health care service may be compared.

(b) The use of different types of education and interventions to be carried out or delegated by the DUR/P&T Committee and the evaluation of the results of this portion of the program; and

(c) The preparation of an annual report on Oregon Medicaid DUR Program which describes:

(A) DUR/P&T Committee Activities;

(i) A description of how pharmacies comply with prospective DUR;

(ii) Detailed information on new criteria and standards in use; and

(iii) Changes in state policy in relation to DUR requirements for residents in nursing homes;

(B) A summary of the education/intervention strategies developed; and

(C) An estimate of the cost savings in the pharmacy budget and indirect savings due to changes in levels of medical visits and hospitalizations.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 38-1992, f. 12-31-92, cert. ef. 1-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 27-2011(Temp), f. & cert. ef. 9-30-11 thru 3-15-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 42-2012(Temp), f. & cert. ef. 9-12-12 thru 3-10-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13

410-121-0111
Pharmacy and Therapeutics Committee

(1) Pursuant to Oregon Laws 2011, chapter 720 (HB 2100), the Drug Use Review Board (DUR Board) is abolished and the tenure of office for the members of the DUR Board expires. The legislature transferred the duties, functions and powers previously vested in the DUR Board to the Pharmacy and Therapeutics (P&T) Committee. This rule is retroactively effective on September 5, 2011, the date the P&T Committee was created and the DUR Board was abolished by HB 2100 and expires whenever the Oregon Health Authority (Authority) suspends the rule.

(2) Unless otherwise inconsistent with these administrative rules or other laws, any administrative rule or agency policy with reference to the DUR Board or a DUR Board volunteer, staff or contractor shall be considered to be a reference to the P&T Committee or a P&T Committee volunteer, staff or contractor. The current preferred drug list (PDL), prior authorization process, and utilization review process developed by the DUR Board remains in effect until such time as the Authority, after recommendations and advice from the P&T Committee, modifies them through the adoption of new administrative rules or policies and procedures.

(3) The P&T Committee shall advise the Oregon Health Authority (Authority) on the:

(a) Implementation of the medical assistance program retrospective and prospective programs, including the type of software programs to be used by the pharmacist for prospective drug use review and the provisions of the contractual agreement between the state and any entity involved in the retrospective program;

(b) Implementation of the Practitioner Managed Prescription Drug Plan (PMPDP);

(c) Adoption of administrative rules pertaining to the P&T Committee;

(d) Development of and application of the criteria and standards to be used in retrospective and prospective drug use review and safety edit programs in a manner that ensures that such criteria and standards are based on compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, data and experience obtained from drug utilization review program operations. The P&T Committee must have an open professional consensus process, establish an explicit ongoing process for soliciting and considering input from interested parties, and make timely revisions to the criteria and standards based on this input and scheduled reviews;

(e) Development, selection and application of and assessment for interventions being educational and not punitive in nature for medical assistance program prescribers, dispensers and patients.

(4) The P&T Committee shall make recommendations to the Authority, subject to approval by the Director or the Director's designee, for drugs to be included on any PDL adopted by the

Authority and on the PMPDP. The P&T Committee shall also recommend all utilization controls, prior authorization requirements or other conditions for the inclusion of a drug on the PDL.

(5) The P&T Committee shall, with the approval of the Director or designee, do the following:

(a) Publish an annual report;

(b) Publish and disseminate educational information to prescribers and pharmacists regarding the P&T Committee and the drug use review programs, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse or inappropriate or medically unnecessary care among prescribers, pharmacists and recipients;

(B) Potential or actual severe or adverse reactions to drugs;

(C) Therapeutic appropriateness;

(D) Overutilization or underutilization;

(E) Appropriate use of generic products;

(F) Therapeutic duplication;

(G) Drug-disease contraindications;

(H) Drug-drug interactions;

(I) Drug allergy interactions;

(J) Clinical abuse and misuse.

(K) Patient safety

(6) Adopt and implement procedures designed to ensure the confidentiality of any information that identifies individual prescribers, pharmacists or recipients and that is collected, stored, retrieved, assessed or analyzed by the P&T Committee, staff of the P&T Committee, contractors to the P&T Committee or the Authority.

Stat. Auth.: ORS 413.042, 414

Stats. Implemented: ORS 414.065, 414.353 & 414.354

Hist.: SPD 12-2012(Temp) , f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; DMAP 42-2012(Temp), f. & cert. ef. 9-12-12 thru 3-10-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 40-2013(Temp), f. & cert. ef. 8-1-13 thru 1-28-14; DMAP 5-2014, f. & cert. ef. 1-28-14

410-121-0135
Pharmacy Management Program

(1) The Pharmacy Management Program promotes the appropriate use of quality pharmaceutical services by identifying and correcting overutilization of services.

(2) The Pharmacy Management Program limits some fee-for-service clients to receiving their prescription drugs through the following sources:

(a) A single retail pharmacy to pick up prescriptions;

(b) The Division of Medical Assistance Program (Division) mail order pharmacy contractor; and

(c) A specialty pharmacy.

(3) The Division will not include the following clients in the Pharmacy Management Program:

(a) Members enrolled in a Coordinated Care Organization;

(b) Clients with Medicare drug coverage in addition to OHP;

(c) Children in the care and custody of the Department of Human Services; or

(d) Inpatients or residents in a hospital, nursing facility, other medical institution or long term care facility.

(4) The Division will consider referrals of potential Pharmacy Management Program clients from the following sources:

(a) Providers;

(b) Division staff; and

(c) Division contractors.

(5) Reasons for referring a client to the Division for potential enrollment in the Pharmacy Management Program shall be limited to factors that indicate possible overutilization or drug misuse, or that raise concern for patient safety. Those factors are:

(a) Use of three or more pharmacies during the prior six months;

(b) Fills prescriptions from more than one prescriber for the same or comparable medications; or

(c) Evidence that the client altered a prescription; or

(d) Exhibits behaviors or patterns of behavior that the Pharmacy and Therapeutics Committee has identified as indicative of intentional overutilization or misuse.

(6) Clients referred to the Division for potential enrollment in the Pharmacy Management Program shall be enrolled in the program only when a licensed pharmacist appointed by the Division conducts a review and concludes the individual utilized pharmaceutical items or services at a frequency or amount that is not medically necessary based on factors including, but not limited to, those described in subsection (5) of this rule.

(7) When the Division concludes enrollment in the Pharmacy Management Program is appropriate as described in subsection (6), the Division shall send the client a notice that provides the following information:

(a) The Division plans to require that the client use a designated pharmacy for a 12-month period;

(b) The specific date when the requirement will begin;

(c) An explanation of the reason for enrollment in the Pharmacy Management Program, and the benefits of enrollment in the Pharmacy Management Program; and

(d) The client's right to request the following, within 45 days of the date of the notice:

(A) A different designated pharmacy; and

(B) An administrative hearing to appeal the Division's decision to enroll the client into the Pharmacy Management Program.

(8) Changing the Pharmacy Management Program client's enrolled pharmacy:

(a) Clients may change their enrolled pharmacy if they:

(A) Move out of area;

(B) Are reapplying for OHP benefits; or

(C) Are denied access to pharmacy services by their selected pharmacy for reasons other than the Pharmacy Management Program factors identified by the Division;

(b) Clients cannot change their choice of pharmacy more than once every 3 months.

(9) Pharmacy Management Program clients may receive drugs from a different pharmacy if the client urgently needs to fill a prescription and the enrolled pharmacy:

(a) Is not available;

(b) Does not have the prescribed drug in stock; or

(c) Is more than 50 miles away from the client's location at the time the prescription needs to be filled. However, DMAP may deny coverage if the client frequently fills prescriptions out of the area of the enrolled pharmacy.

(10) Call the Oregon Pharmacy Help Desk for authorization to fill a prescription in the situations described in (9)(a)–(c) above.

(11) The client's appeal rights and the process for appealing a Division decision to enroll a client in the Pharmacy Management Program are found in OAR 410-120-1860. If the client requests an administrative hearing before the effective date of the client notice and requests that the services be continued, the Authority shall continue the services pursuant to OAR 410-120-1865.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065, OL 2013 Ch. 467 Sec. 2

Hist.: OMAP 26-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 77-2015, f. 12-22-15, cert. ef. 1-1-16

410-121-0143
Client Confidentiality

Pharmacists are responsible for maintaining the confidentiality of client information in compliance with HIPAA standards. Facilities shall provide adequate privacy for patient consultations.

Stat. Auth.: ORS 413.042,

Stats. Implemented: ORS 414.065

Hist.: HR 16-1992, f. & cert. ef. 7-1-92; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0145
Prescription Requirements

(1) Division of Medical Assistance Programs (Division) will make payment for covered drugs supplied on drug order or prescription of a licensed practitioner and dispensed by a pharmacist. Dispensings include new prescriptions, refills of existing prescriptions, and over-the-counter (OTC) medications.

(a) Each drug order or prescription filled for a Division client must be retained in the pharmacy's file at the pharmacy's place of business; and,

(b) All drug orders or prescriptions must comply with the Oregon State Board of Pharmacy rules and regulations as listed in OAR 855 Division 041.

(2) Notwithstanding subsection (1) of this rule, the following rules shall apply to over-the-counter Plan B emergency contraceptive drugs:

(a) Division may reimburse a pharmacy for distributing over-the-counter Plan B emergency contraceptive drug products to women who are 17 years old and older and who are Medicaid eligible; and,

(b) As a condition of reimbursement for over-the-counter Plan B emergency contraceptive drugs, Division may require that the pharmacy show proof that it has complied with Oregon Board of Pharmacy rules pertaining to the distribution of over-the-counter Plan B emergency contraceptive drugs.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented ORS 414.065

Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82; AFS 53-85, f. 9-20-85, ef. 10-1-85 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0020; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0200; HR 25-1994, f. & cert. ef. 7-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 9-2008, f. 3-31-08, cert. ef. 4-1-08; DMAP 2-2010, f. 2-1-10, cert. ef. 2-5-10

410-121-0146
Dispensing Limitations

(1) The Division of Medical Assistance Programs (Division) will reimburse the pharmacy for dispensed medication the lesser of:

(a) The quantity indicated by the prescriber on the prescription;

(b) The quantity indicated by the Division dispensing limitations as outlined in this rule; or

(c) The quantity needed for Prescription Synchronization.

(2) The pharmacy may only dispense less than the prescribed quantity when the prescribed quantity exceeds the Division's dispensing limitations, or when a lesser quantity is needed for Prescription Synchronization.

(3) The pharmacy may, at the client's direction, dispense less than the prescribed quantity of a maintenance medication in order to align the refill dates if the client has received the same dose for two months or more. (4) Unless otherwise specified in this rule, the Division will not reimburse claims for medications exceeding a 34-day supply.

(5) Exceptions to the 34-day supply do not apply to claims for the following Standard Therapeutic Classes of medications. Claims exceeding a 34-day supply for these medications will not be reimbursed under any circumstances:

(a) Ataractics, Tranquilizers — 07;

(b) Muscle Relaxants — 08;

(c) CNS Stimulants — 10;

(d) Psychostimulants, Antidepressants — 11;

(e) Amphetamine Preps — 12;

(f) Narcotic Analgesics — 40;

(g) Sedative Barbiturate — 46;

(h) Sedative Non-Barbiturate — 47.

(6) The Division will allow reimbursement for more than a 34-day supply if the medication's original package size cannot be divided.

(7) Except for medications listed in (5), claims for up to a 100-day supply of the following types of medications may be reimbursed to the Division's mail order pharmacy contractor, Indian Health mail order pharmacy providers, and 340B providers:

(a) A preferred PDL generic; and

(b) A generic drug not on the PDL, costing $10 per month or less.

(8) Any pharmacy provider will be reimbursed for up to a 100-day supply of family planning drugs.

(9) Maintenance Medications — Any pharmacy provider will be reimbursed for up to a 100-day supply of select classes of medications if the client has received the same dose for two months or more. Maintenance medications shall be determined by the Division based on the following criteria:

(a) Have low probability for dosage or therapy changes due to side effects; and

(b) Are used most commonly to treat a chronic disease state and not considered curative or promoting recovery; and

(c) Are administered continuously rather than intermittently.

(10) Selected medications identified by the Division will be limited to a 15-day supply for initial fills. These medications have been identified as having high side effect profiles, high discontinuation rates, or needing frequent dose adjustments.

(11) After stabilization of a diabetic, the pharmacy should provide a minimum of a one-month supply of insulin per dispensing.

(12) For vaccines available in multiple dose packaging, the Division will allow a dispensing fee for each multiple dose. When vaccines are administered at the pharmacy, refer to Oregon Administrative Rule (OAR) 410-121-0185.

(13) Splitting prescriptions:

(a) For compounded prescriptions, bill components of the prescription separately. Third party payments for compounded prescriptions must be split and applied equally to each component;

(b) The Division will consider any other form of prescription splitting as a billing offense and take appropriate action as described in the General Rules (OAR 410 division 120).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 26-1984, f. & ef. 6-19-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 52-1986, f. & ef. 7-2-86; AFS 15-1987, f. 3-31-87, ef. 4-1-87; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0090; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0210; HR 16-1992, f. & cert. ef. 7-1-92; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1996(Temp), f. & cert. ef. 8-1-96; HR 27-1996, f. 12-11-96, cert. ef. 12-15-96; HR 20-1997, f. & cert. ef. 9-12-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 74-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 6-2010(Temp), f. & cert. ef. 4-1-10 thru 6-30-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12, DMAP 76-2015, f. 12-22-15, cert. ef. 1-1-16

410-121-0147
Exclusions and Limitations

(1) The following items are not covered for payment by the Division of Medical Assistance Programs (Division) Pharmaceutical Services Program:

(a) Drug products for diagnoses below the funded line on the Health Services Commission Prioritized List or an excluded service under Oregon Health Plan (OHP) coverage;

(b) Home pregnancy kits;

(c) Fluoride for individuals over 18 years of age;

(d) Expired drug products;

(e) Drug products from non-rebatable manufacturers, with the exception of selected oral nutritionals, vitamins, and vaccines;

(f) Active Pharmaceutical Ingredients (APIs) and Excipients as described by Centers for Medicare and Medicaid (CMS);

(g) Drug products that are not assigned a National Drug Code (NDC) number;

(h) Drug products that are not approved by the Food and Drug Administration (FDA);

(i) Drug products dispensed for Citizen/Alien-Waived Emergency Medical client benefit type;

(j) Drug Efficacy Study Implementation (DESI) drugs (see OAR 410-121-0420);

(k) Medicare Part D covered drugs or classes of drugs for fully dual eligible clients (see OAR 410-121-0149, 410-120-1200 & 410-120-1210).

(2) Effective on or after April 1, 2008, Section 1903(i) of the Social Security Act requires that written (nonelectronic) prescriptions for covered outpatient drugs for Medicaid clients be executed on a tamper-resistant pad in order to be eligible for federal matching funds. To meet this requirement, the Division shall only reimburse for covered Medicaid outpatient drugs only when the written (non-electronic) prescription is executed on a tamper-resistant pad, or the prescription is electronically submitted to the pharmacy.

(3) Drugs requiring a skilled medical professional for safe administration will be billed by the medical professional's office; unless otherwise specified by the Division.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 22-1993(Temp),f. & cert. ef. 9-1-93; HR 34-1993(Temp), f. & cert. ef. 12-1-93; HR 11-1994, f. 2-25-94, cert. ef. 2-27-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 22-1997, f. & cert. ef. 10-1-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 9-2008, f. 3-31-08, cert. ef. 4-1-08; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 14-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12

410-121-0148
Dispensing in a Nursing Facility or Community Based Care Living Facility

A pharmacy serving Division of Medical Assistance Program's (Division) clients in a nursing facility or a Community Based Care Living Facility must dispense medication in a manner consistent with Board of Pharmacy rules as set out in OAR 855-041.

(1) For the purposes of this rule, "Long term care facility" includes skilled nursing facilities and intermediate care facilities consistent with the definitions in ORS 443.400 to 443.455.

(2) An intermediate care facility is a facility providing regular health related care and services to individuals at a level above room and board, but less than hospital or skilled nursing levels ORS 442.015.

Stat. Auth.: 404.110, 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 83-1982 (Temp), f. & ef. 9-2-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 58-1983, f. 11-30-83, ef. 1-1-84; AFS 16-1985, f. 3-26-85, ef. 5-1-85; AFS 52-1986, f. & ef. 7-2-86; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0070; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0230; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08

410-121-0150
Billing Requirements

(1) When billing the Division of Medical Assistance Programs (Division) for drug products, the provider must:

(a) Not bill in excess of the usual and customary charge to the general public:

(A) The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's usual and customary charge for the same or similar service;

(B) When billing the Division for a prescription, the pharmacy shall bill the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program;

(b) Indicate the National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed;

(c) Bill the actual metric decimal quantity dispensed;

(d) When clients have other insurances, bill the other insurances as primary and the Division as secondary;

(e) When clients have Medicare prescription drug coverage, bill Medicare as primary and the Division as secondary.

(2) When submitting a paper claim, the provider must accurately furnish all information required on the 5.1 Universal Claims Form.

(3) The prescribing provider's National Provider Identifier (NPI) is mandatory on all fee-for-service client drug prescription claims. Claims will deny for a missing or invalid prescriber NPI. An exception to this includes, but is not limited to a Prescribing provider who does not have an NPI for billing, but who prescribes fee-for-service prescriptions for clients under prepaid health plans (PHP), long-term care, or other capitated contracts. This provider is to be identified with the:

(a) Non-billing NPI-assigned for prescription writing only;

(b) Clinic or facility NPI until an individual NPI is obtained; or

(c) Supervising physician's NPI when billing for prescriptions written by the physician assistant, physician students, physician interns, or medical professionals who have prescription writing authority;

(4) Billing for Death With Dignity services:

(a) Claims for Death With Dignity services cannot be billed through the Point-of-Sale system;

(b) Services must be billed directly to the Division, even if the client is in a PHP;

(c) Prescriptions must be billed on a 5.1 Universal Claims Form paper claim form using an NDC number. Claims should be submitted to the address indicated at the Division Supplemental Information for Pharmaceutical Services.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 15-1987, f. 3-31-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0093; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0240; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 44-1998(Temp), f. 12-1-98, cert. ef. 12-1-98 thru 5-1-99; OMAP 11-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 25-1999, f. & cert. ef. 6-4-99; OMAP 5-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 23-2011, f. 8-24-11, cert. ef. 9-1-11

410-121-0155
Reimbursement

(1) The Division shall pay the lesser of the provider's usual charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee. The EAC is defined by the Division as the lesser of:

(a) The Average Actual Acquisition Cost (AAAC) of the drug;

(b) In cases where no AAAC is available, the Division shall reimburse at Wholesale Acquisition Cost (WAC);

(c) The Federally Mandated Upper Limit (FUL) for certain multiple source drugs as established and published by CMS;

(d) 340B covered entities and federally qualified health centers or their contracted agents that fill Medicaid patient prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Service Act must bill Medicaid for the actual acquisition cost.

(2) The Division shall revise its EAC file weekly. Pharmacies must make available to the Division, or its contractor, any information necessary to determine the pharmacy's actual acquisition cost of drug products dispensed to the Division's clients.

(3) The AAAC shall serve as the basis for reimbursement. Individual pharmacies are required to participate in an AAC survey conducted by the Division, or its contractor, not more than one time per every 18 to 24-month period. Pharmacies that do not respond to AAC survey requests may be subject to disenrollment as providers for the Oregon Health Plan.

(4) If a provider is unable to purchase a particular drug product at the AAAC the provider shall report this to the Division or its contractor for further review through a dispute resolution pro-

cess. Providers may submit inquiries via telephone, facsimile, via electronic mail, or the contractor's secure web site: http://www.mslc.com/Oregon/AAACRateReview.aspx:

(a) The Division or its contractor shall respond to all inquiries or complaints within 24 hours and resolve the issue within 5 business days;

(b) The pricing dispute resolution process shall include the Division or its contractor verifying the accuracy of pricing to ensure consistency with marketplace pricing and drug availability;

(c) Price adjustments shall be made during the next weekly pricing update.

(5) Payment for covered fee-for-service drug products shall be the lesser of the billed amount or the EAC of the generic form, minus applicable copayments, plus a professional dispensing fee.

(6) Payment for trade name forms of multiple source products:

(a) Shall be the EAC of the trade name form, minus applicable copayments, plus a professional dispensing fee;

(b) The Division shall pay only if the prescribing practitioner has received a prior authorization for the trade name drug, or;

(c) The brand drug is listed on the Division's Preferred Drug List.

(7) No professional dispensing fee is allowed for dispensing pill splitters/cutters or diabetic supplies and glucose monitors which are exempt from co-payments under OHP General Rules.

(8) Payment for pill splitters/cutters with a National Drug Code (NDC) number shall be reimbursed at the lesser of the billed amount or the EAC, and:

(a) A practitioner prescription is required, and;

(b) The Division shall only pay for one pill splitter/cutter per client in a twelve-month period.

(9) A prescription is required for glucose monitors and related diabetic supplies.

(10) Payment for glucose monitors and related diabetic supplies billed with an NDC shall be reimbursed at a percentage of Medicare's rate for the HCPCS procedure code. The Division's reimbursement rates are listed in the DMAP fee schedule located at: http://www.oregon.gov/OHA/healthplan/pages/feeschedule.aspx.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 846(Temp), f. & ef. 7-1-77; PWC 858, f. 10-14-77, ef. 11-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 15-1979(Temp), f. 6-29-79, ef. 7-1-79; AFS 41-1979, f. & ef. 11-1-79; AFS 15-1981, f. 3-5-81, ef. 4-1-81; AFS 35-1981(Temp), f. 6-26-81, ef. 7-1-81; AFS 53-1981(Temp), f. & ef. 8-14-81; AFS 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices. AFS 74-1982 (Temp), f. 7-22-81, ef. 8-1-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 113-1982(Temp), f. 12-28-82, ef. 1-1-83; AFS 13-1983, f. & ef. 3-21-83; AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 18-1984, f. 4-23-84, ef. 5-1-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0100; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0250; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 32-2002, f. & cert. ef. 8-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 5-2009(Temp), f. 3-26-09, cert. ef. 4-1-09 thru 9-25-09; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 14-2011, f. 6-29-11, cert. ef. 7-1-11

410-121-0157

Participation in the Medicaid Drug Rebate Program

(1) The Oregon Medicaid Pharmaceutical Services Program is a participant in the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Patient Protection and Affordable Care Act (PPACA) enacted on March 23,2010 and the Health Care and Education Reconciliation Act of 2010, (HCERA) enacted on March 30, 2010, together called the Affordable Care Act, requires the Division to collect drug rebates for covered outpatient drugs dispensed to enrollees of Medicaid managed care organizations, (MCOs). The Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). Pharmaceutical companies participating in this program have signed agreements with CMS to provide rebates to the Division of Medical Assistance Programs (Division) on all their drug products. The Division will reimburse providers only for outpatient drug products manufactured or labeled by companies participating in this program.

(2) Documents in rule by reference: Names and Labeler Code numbers for participants in the Medicaid Drug Rebate Program are the responsibility of and maintained by CMS. The Division receives this information from CMS in the form of numbered and dated Releases. The Division includes in rule by reference, the CMS Releases online at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/program-releases.html.

(3) Retroactive effective dates: The CMS Medicaid Drug Rebate Program experiences frequent changes in participation and often this information is submitted to the Division after the effective date(s) of some changes. Therefore, certain participant additions and deletions may be effective retroactively. See specific instructions in the CMS Releases for appropriate effective date(s) of changes.

(4) The Division contracts with a Pharmacy Benefit Manager (PBM) to manage the Medicaid Rebate Dispute Resolution program. Pharmacy providers must verify the accuracy of their Medicaid pharmacy claims with the PBM within 30 days of request in instances where drug manufacturers dispute their claim information. Verification can be photocopies of drug invoices showing that the billed products were in stock during the time of the date of service.

(5) The actual National Drug Code (NDC) dispensed and the actual metric decimal quantity dispensed, must be billed.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 16-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 22-1991, f. & cert. ef. 5-16-91; HR 23-1991(Temp), f. 6-14-91, cert. ef. 6-17-91; HR 31-1991, f. & cert. ef. 7-16-91; HR 36-1991(Temp), f. 9-16-91, cert. ef. 10-1-91; HR 45-1992, f. & cert. ef. 10-16-91; HR 50-1991(Temp), f. & cert. ef. 10-29-91; HR 1-1992, f. & cert. ef. 1-2-92; HR 13-1992, f. & cert. ef. 6-1-92; HR 21-1992, f. 7-31-92, cert. ef. 8-1-92; HR 31-1992, f. & cert. ef. 10-1-92; HR 34-1992, f. & cert. ef. 12-1-92; HR 4-1993, f. 3-10-93, cert. ef. 3-11-93; HR 7-1993 (Temp), f. & cert. ef. 4-1-93; HR 14-1993, f. & cert. ef. 7-2-93; HR 24-1993, f. & cert. ef. 10-1-93; HR 17-1994, f. & cert. ef. 4-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2000(Temp), f. 12-29-00, cert. ef. 1-1-01 thru 5-1-01; OMAP 3-2001, f. & cert. ef. 3-16-01; OMAP 24-2001(Temp) f. 5-9-01, cert. ef. 5-10-01 thru 11-1-01; OMAP 25-2001(Temp) f. 6-28-01, cert. ef. 7-1-01 thru 12-1-01; OMAP 27-2001(Temp) f. 7-30-01, cert. ef. 8-1-01 thru 1-26-02; OMAP 48-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 56-2001(Temp), f. & cert. ef. 11-1-01 thru 4-15-02; OMAP 57-2001(Temp), f. 11-28-01, cert. ef. 12-1-01 thru 4-15-02; OMAP 66-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 4-2002(Temp), f. & cert. ef. 3-5-02 thru 8-1-02; OMAP 16-2002(Temp) f. & cert. ef. 4-12-02 thru 9-1-02; OMAP 20-2002(Temp), f. & cert. ef. 5-15-02 thru 10-1-02; OMAP 34-2002(Temp), f. & cert. ef. 8-14-02 thru 1-15-03; OMAP 67-2002(Temp), f. & cert. ef. 11-1-02 thru 3-15-03; OMAP 6-2003(Temp), f. & cert. ef. 2-14-03 thru 7-1-03; OMAP 38-2003, f. & cert. ef. 5-9-03; OMAP 39-2003(Temp), f. & cert. ef. 5-15-03; OMAP 48-2003, f. & cert. ef. 7-7-03; OMAP 74-2003, f. & cert. ef. 10-1-03; OMAP 5-2004(Temp), f. & cert. ef. 2-4-04 thru 6-15-04; OMAP 24-2004, f. & cert. ef. 3-30-04; OMAP 31-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 42-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 53-2004(Temp), f. & cert. ef. 9-10-04 thru 2-15-05; OMAP 82-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 1-2005(Temp), f. & cert. ef. 1-14-05 thru 6-1-05; OMAP 6-2005, f. 3-1-05, cert. ef. 3-31-05; OMAP 7-2005(Temp), f. 3-1-05, cert. ef. 4-1-05 thru 8-1-05; OMAP 30-2005, f. & cert. ef. 6-6-05; OMAP 55-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 5-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 7-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 12-2006, f. 5-26-06, cert. ef. 6-1-06; OMAP 49-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 16-2008, f. 6-13-08, cert.

ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 14-2011, f. 6-29-11, cert. ef. 7-1-11

410-121-0160
Dispensing Fees

(1) Effective August 1, 2011 professional dispensing fees allowable for services shall be reimbursed as follows:

(a) All enrolled chain affiliated pharmacies shall be reimbursed at a rate of $9.68 per claim;

(b) Independently owned pharmacies in communities that are the only enrolled pharmacy within a fifteen (15) mile radius from another pharmacy shall be reimbursed at a dispensing fee of $14.01 per claim;

(c) All other enrolled independently owned pharmacies excluding those in 410-121-0160(b) shall be reimbursed based on an individual pharmacy's annual claims volume as follows:

(A) Less than 30,000 claims a year = $14.01;

(B) Between 30,000 and 49,999 claims per year = $10.14;

(C) 50,000 or more claims per year = $9.68.

(2) All Division enrolled independent pharmacies shall be required to complete an annual survey that collects claim volumes from enrolled pharmacies and other information from the previous 12 month period to determine the appropriate dispensing fee reimbursement:

(a) Claims volume shall be stated by total OHP covered prescriptions and claims from all payer types;

(b) Survey activities shall be conducted by either the Division or its contractor and must be completed and returned by pharmacies within 14 days of receipt;

(c) Completed surveys must be signed with a letter of attestation by the store owner or majority owner;;

(d) Pharmacies that fail to respond to the survey or do not include the letter of attestation shall default to the lowest dispensing tier;

(e) Once a tier is established for a calendar year, the pharmacy's dispensing fee shall remain in that tier until the next annual claims volume survey is conducted;

(f) Newly enrolled independent pharmacies shall be defaulted to the lowest dispensing tier until the next claims volume survey is conducted.

(3) All chain affiliated pharmacies shall be exempt from completing the annual claims volume survey.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 41-1984(Temp), f. 9-24-84, ef. 10-1-84; AFS 1-1985, f. & ef. 1-3-85; AFS 54-1985(Temp), f. 9-23-85, ef. 10-1-85; AFS 66-1985, f. 11-5-85, ef. 12-1-85; AFS 13-1986(Temp), f. 2-5-86, ef. 3-1-86; AFS 36-1986, f. 4-15-86, ef. 6-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 28-1987(Temp), f. & ef. 7-14-87; AFS 50-1987, f. 10-20-87, ef. 11-1-87; AFS 41-1988(Temp), f. 6-13-88, cert. ef. 7-1-88; AFS 64-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0101; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 20-1990, f. & cert. ef. 7-9-90, Renumbered from 461-016-0260; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 21-1993(Temp), f. & cert. ef. 9-1-93; HR 12-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 5-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 22-1998, f. & cert. ef. 7-15-98; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 50-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 60-2001, f. & cert. ef. 12-11-01; OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04; OMAP 21-2004, f. 3-15-04, cert. ef. 4-15-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 14-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12

410-121-0185
Pharmacy Based Immunization Delivery

(1) When administering immunizations for adults (ages 19+) the pharmacy can bill either:

(a) Through Point-of-Sale (POS) using the appropriate National Drug Code (NDC) for the serum and the administration fee shall automatically be applied equivalent to Current Procedural Terminology (CPT) codes 90470-90474 ; or

(b) Bill on a CMS-1500, DMAP 505, or Provider Web Portal professional claim using the appropriate immunization CPT code for the serum; or

(c) Bill as a Provider Web Portal pharmacy claim.

(2) If billing as a professional claim, you must also include:

(a) A primary diagnosis to the highest degree of specificity, and;

(b) The appropriate CPT code for the serum, code ranges 90476-90749; and

(c) The appropriate CPT code for the administration, code ranges 90470-90474.

(3) Pursuant to ORS 689.205 and the Board of Pharmacy administrative rules 855-019-0270 through 855-019-0290; pharmacists may prescribe and administer vaccines to children who are from the age of 11 through 18 years of age only if the pharmacy is enrolled in the Vaccines for Children (VFC) Program. The Division will not reimburse providers the cost of privately purchased vaccination.

(4) If the pharmacy is enrolled in the VFC Program, then only the administration fee shall be reimbursed by the Division and must be billed on a professional claim. For detailed information on billing for the VFC Program, refer to Medical Surgical Services OAR 410-130-0255.

Stat. Auth.: ORS 413.042, & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 14-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-121-0190
Medication Therapy Management Services and Clozapine Therapy Monitoring

(1) Clozapine monitoring protocol requires enhanced record keeping and reporting to the drug manufacturer's registry in order to dispense the medication. Dispensing pharmacy must meet all drug manufacturers requirements including data reporting.

(2) Clozapine monitoring includes documentation of client's diagnosis, dosage, dosage changes, appropriate laboratory reports (e.g. white blood cell counts), evaluation intervals, and submission of appropriate information to drug manufacturer to allow dispensing of medication;

(3) Clozapine monitoring is to be billed using appropriate Medication Therapy Management Services (MTMS) Current Procedural Terminology (CPT) code with the modifier TC appended. This is limited to no more than 5 units in 30 day time period per client, including the 30 day period from the date of discontinuation of clozapine therapy;

(4) Clozapine monitoring must be billed by a pharmacy;

(5) MTMS rendered outside of clozapine management must be performed by a licensed pharmacist and must be billed to appropriately reflect the performing provider. These encounters must be billed using the appropriate MTMS CPT code without the TC modifier.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 17-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 45-2002, f. & cert. ef. 10-1-02; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 59-2012(Temp), f. 12-27-12, cert. ef. 12-28-12 thru 6-25-13; DMAP 26-2013, f. & cert. ef. 6-25-13

410-121-0200
Billing Forms

Guidelines for using the Prescription Drug Invoice 5.1 Universal Claim Form:

(1) When a paper claim form is needed, this form is used to bill for all pharmacy services, home blood glucose monitors, and related diabetic supplies. These services must be billed with a National Drug Code (NDC);

(2) The provider may bill on the form when a valid Medical Care Identification has been presented (Refer to OAR 410-120-1140 Verification of Eligibility);

(3) All completed 5.1 Universal Claim Forms must be mailed to the Division of Medical Assistance Programs (Division);

(4) All other durable medical equipment and certain Enteral/Parenteral nutrition and IV services must be billed on the CMS-1500, using the billing instructions found in the Division's Durable Medical Equipment and Medical Supplies administrative rules (Division 122) and Supplemental Information, and the Division's Home Enteral/Parenteral Nutrition and IV Services Administrative rules (Division 148) and Supplemental Information. These services are billed with HCPCS procedure codes.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 14-2011, f. 6-29-11, cert. ef. 7-1-11

410-121-0220

Instructions for Completion of the Prescription Drug Invoice

(1) The 5.1 Universal Claim Form is the required billing form for pharmacies billing on a paper claim. Use the standard Instructions for completion of the 5.1 Universal Claim Form.

(2) Enter all applicable information for billing of prescription drug claims for clients on the Oregon Health Plan.

Stat. Auth.: ORS 413.042, 414.034 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0280; HR 14-1993, f. & cert. ef. 7-2-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03

410-121-0280

Billing Quantities, Metric Quantities and Package Sizes

(1) Use the actual metric quantity dispensed when billing (up to four decimal places).

(2) Use the following units when billing products:

(a) Solid substances (e.g., powders, creams, ointments, etc.), bill per Gram;

(b) Solid substances that are reconstituted with a liquid (e.g., dry powder ampules and vials) such as antibiotic vials or piggybacks must be billed in metric quantity of one each;

(c) Tablets, capsules, suppositories, lozenges, packets; bill per each unit. Oral contraceptives are to be billed per each tablet;

(d) Injectables that are prepackaged syringe — (e.g., tubex, carpujects), bill per ml.;

(e) Prepackaged medications and unit doses must be billed per unit (tablet or capsule). Unit dose liquids are to be billed by ml.;

(f) Fractional units: Bill exact metric decimal quantities dispensed.

Stat. Auth.: ORS 413.042, 414.034 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0320; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99

410-121-0300

CMS Federal Upper Limits for Drug Payments

(1) The Centers for Medicare and Medicaid Services (CMS) Federal Upper Limits for Drug Payments listing of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and 1927(e) of the Act as amended by OBRA 1993 and the DRA 2005.

(2) Payments for multiple source drugs must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the State and specified in the State Plan), plus an amount based on the limit per unit. CMS has determined the amount based on the limit per unit to be equal to 250 percent of the Average Manufacturer's Price (AMP). CMS will post the AMP to a Website available to the public on a quarterly basis.

(3) The FUL drug listing is published in the State Medicaid Manual, Part 6, Payment for Services, Addendum A. The most current Transmittals and subsequent changes are posted to the CMS website http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Federal-Upper-Limits.html.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 3-1990(Temp), f. & cert. ef. 2-23-90; HR 13-1990, f. & cert. ef. 4-20-90, Renumbered from 461-016-0330; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 45-1990, f. & cert. ef. 12-28-90; HR 10-1991, f. & cert. ef. 2-19-91; HR 37-1991, f. & cert. ef. 9-16-91; HR 13-1992, f. & cert. ef. 6-1-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 35-1992(Temp), f. & cert. ef. 12-1-92; HR 1-1993(Temp), f. & cert. ef. 1-25-93; HR 3-1993, f. & cert. ef. 2-22-93; HR 5-1993(Temp), f. 3-10-93, cert. ef. 3-22-93; HR 8-1993(Temp), f. & cert. ef. 4-1-93; HR 11-1993, f. 4-22-93, cert. ef. 4-26-93; HR 15-1993(Temp), f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 25-1993(Temp), f. & cert. ef. 10-1-93; HR 14-1994, f. & cert. ef. 3-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 43-1998(Temp), f. & cert. ef. 11-20-98 thru 5-1-99; OMAP 5-1999, f. & cert. ef. 2-26-99; OMAP 42-2000(Temp), f. & cert. ef. 12-15-00 thru 5-1-01; OMAP 1-2001(Temp), f. & cert. ef. 2-1-01 thru 6-1-01; OMAP 2-2001(Temp), f. 2-14-01, cert. ef. 2-15-01 thru 7-1-01; OMAP 18-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 23-2001(Temp), f. & cert. ef. 4-16-01 thru 8-1-01; OMAP 26-2001(Temp), f. & cert. ef. 6-6-01 thru 1-2-02; OMAP 51-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-15-01; OMAP 58-2001, f. 11-30-01, cert. ef. 12-1-01; OMAP 67-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 3-2002(Temp), f. & cert. ef. 2-15-02 thru 6-15-02; OMAP 5-2002(Temp) f. & cert. ef. 3-5-02 thru 6-15-02; OMAP 19-2002(Temp), f. & cert. ef. 4-22-02 thru 9-15-02; OMAP 29-2002(Temp), f. 7-15-02, cert. ef. 8-1-02 thru 1-1-03; OMAP 71-2002(Temp), f. & cert. ef. 12-1-02 thru 5-15-03; OMAP 10-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 11-2003(Temp), f. 2-28-03, cert. ef. 3-1-03 thru 8-15-03; OMAP 41-2003, f. & cert. ef. 5-29-03; OMAP 51-2003, f. & cert. ef. 8-5-03; OMAP 54-2003(Temp), f. & cert. ef. 8-15-03 thru 1-15-03; OMAP 75-2003, f. & cert. ef. 10-1-03; OMAP 83-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 4-15-04; OMAP 2-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 32-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 43-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 93-2004(Temp), f. & cert. ef. 12-10-04 thru 5-15-05; OMAP 2-2005, f. 1-31-05, cert. ef. 2-1-05; OMAP 23-2005(Temp), f. & cert. ef. 4-1-05 thru 9-1-05; OMAP 29-2005, f. & cert. ef. 6-6-05; OMAP 56-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 59-2005(Temp), f. 11-8-05, cert. ef. 11-12-05 thru 5-1-06; OMAP 68-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 8-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 13-2006, f. 5-26-06, cert. ef. 6-1-06; OMAP 50-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0420

DESI Less-Than-Effective Drug List

(1) An October 23, 1981 ruling by District of Columbia Federal Court directed the Department of Health and Human Services to stop reimbursement, effective October 30, 1981, under Medicaid and Medicare Part B for all DESI less-than-effective drugs which have reached the Federal Drug Administration Notice-of-Opportunity-for-Hearing stage.

(2) In accordance with Section 1903(i) (5) of the Social Security Act, federal funds participation (FFP) is not available for drugs deemed Less Than Effective (LTE) or Identical, Related of Similar (IRS) drugs for which the Food and Drug Administration (FDA) issued a Notice of Opportunity for a Hearing (NOOH) for all labeled indications. These drugs are also termed Drug Efficacy Study Implementation (DESI) drugs. Division does not reimburse for drugs designated as less than effective or drugs identical, related, or similar to a DESI drug.

(3) A current list of LTE/IRS drugs is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program-Data.html. The list is updated on approximately a quarterly basis by CMS after being reviewed for accuracy by the FDA.

(4) The US Food & Drug Administration (FDA) has the responsibility of determining the DESI status of a drug product.

Stat. Auth.: ORS 413.042 & 414.325

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 64-1989(Temp), f. 10-24-89, cert. ef. 11-15-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 17-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0390; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10

410-121-0580
Oregon Medicaid and Pharmaceutical Manufacturers' Dispute Resolution Procedures

(1) Within 60 days after the end of each calendar quarter, the Division of Medical Assistance Programs (Division) shall report the number of units dispensed for each drug National Drug Code (NDC) for which payment was made to the manufacturer of said product. Utilization reports to manufacturers shall follow this schedule:

(a) The period from January 1 through March 31 will be Quarter 1. Quarter 1 invoices shall be due by May 30 of that same year;

(b) The period from April 1 through June 30 will be Quarter 2. Quarter 2 invoices shall be due by August 29 of that same year;

(c) The period from July 1 through September 30 will be Quarter 3. Quarter 3 invoices shall be due by November 29 of that same year;

(d) The period from October 1 through December 31 will be Quarter 4. Quarter 4 invoices shall be due by February 29 of the following year.

(2) A manufacturer must make payment within 30 days of receipt of utilization reports, i.e., rebate invoice. Using eight days as reasonable time for reports to reach the manufacturer, payment of the invoiced amount is due per the following schedule:

(a) Rebate payment for Quarter 1 shall be due by July 7 of that same year;

(b) Rebate payment for Quarter 2 shall be due by October 7 of that same year;

(c) Rebate payment for Quarter 3 shall be due by January 6 of the following year;

(d) Rebate payment for Quarter 4 shall be due by April 6 of the following year.

(3) Division considers any failure to make timely payment in full of the amount due to be a dispute. Timely is defined by Division as 38 days after the postmarked date of the invoice.

(4) If a manufacturer does not indicate in writing, by specific NDC number(s), the reason(s) for non-payment in full, a letter asking for clarification will be sent and interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution, beginning 38 days after the postmarked date of each invoice.

(5) Utilization/unit disputes shall be handled by a careful examination of paid claims data to determine the reasonableness of the reported units of products provided to Oregon recipients. If it is determined that the manufacturer is in error a letter notifying the manufacturer of the completed review and findings will be mailed to the manufacturer and interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution.

(6) If a manufacturer determines that incorrect information was sent to the Centers for Medicare and Medicaid Services (CMS), the manufacturer must still make payment in full to Oregon Medicaid for the invoiced rebate amount. Oregon Medicaid will credit the manufacturer's account through CMS's prior period adjustment process.

(7) Interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution, on the 31st day after a manufacturer receives information from Division on the number of units paid by NDC number (i.e., rebate invoice).

(8) Manufacturer requests for audit information by product and zip codes will be acknowledged by Division in letter form. Each letter will include a Division Audit Request Form and instructions to the manufacturer on how to complete the form. The letter will also include a standard explanation of the audit process.

(9) Days referred to in this process shall be considered calendar days.

(10) Efforts should be made through an informal rebate resolution process as outlined in this rule before a hearing will be scheduled. Hearings will follow OAR 410-120-0760 through 410-120-1060 and be held in Marion County, OR.

(11) Oregon Medicaid will notify CMS of all disputing manufacturers in writing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 21-1992, f. 7-31-92, cert. ef. 8-1-92; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0625
Items Covered in the All-Inclusive Rate for Nursing Facilities

(1) The all-inclusive rate for nursing facilities includes but is not limited to various drug products and OTC items. Division requires that nursing facilities be billed for these items.

(2) The all-inclusive list is available for downloading in the Division of Medical Assistance Programs Web page on the Oregon Health Authority's website.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0920; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-2000 [Renumbered to **431-121-2000**]

410-121-2005 [Renumbered to **431-121-2005**]

410-121-2010 [Renumbered to **431-121-2010**]

410-121-2020 [Renumbered to **431-121-2020**]

410-121-2030 [Renumbered to **431-121-2030**]

410-121-2050 [Renumbered to **431-121-2050**]

410-121-2065 [Renumbered to **431-121-2065**]

410-121-3000 [Runumbered to **333-022-1000**]

410-121-4000 [Runumbered to **333-023-0800**]

410-121-4005 [Runumbered to **333-023-0805**]

410-121-4010 [Runumbered to **333-023-0810**]

410-121-4015 [Runumbered to **333-023-0815**]

410-121-4020 [Runumbered to **333-023-0820**]

DIVISION 122

DURABLE MEDICAL EQUIPMENT, PROSTHETICS ORTHOTICS AND SUPPLIES (DMEPOS)

410-122-0010
Definitions

(1) Activities of daily living (ADL's) — Activities related to personal care. Personal care services include activities such as bathing, dressing, grooming, hygiene, eating, elimination, etc. that are necessary to maintain or improve the client's health, when possible.

(2) Buy up — "Buy-up" refers to a situation in which a client wants to upgrade to a higher level of service than he or she is eligible for; e.g., a heavy duty walker instead of a regular walker.

(3) Consecutive Months — Any period of continuous use where no more than a 60-day break occurs.

(4) Durable Medical Equipment — Equipment, furnished by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or a home health agency that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a client in the absence of an illness or injury and is appropriate for use in the home. Some

examples include wheelchairs, crutches and hospital beds. Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment.

(5) Home — For purposes of purchase, rental and repair of durable medical equipment (DME) that is used primarily as a supportive measure to support a client's basic daily living activities, home is a place of permanent residence, such as an assisted living facility (includes the common dining area), a 24-hour residential care facility, an adult foster home, a child foster home or a private home. This does not include hospitals or nursing facilities or any other setting that exists primarily for the purpose of providing medical/nursing care. Separate payment will not be made to DME providers for equipment and medical supplies provided to a client in their home when the cost of such items is already included in the capitated (per diem) rate paid to a facility or organization.

(6) Lifetime need — 99 months or more.

(7) Manufacturer Part Number (MPN):

(a) Each manufacturer provides an MPN to identify that manufacturer's part. It is a specification used by the manufacturer to store a part in an illustrated part catalog (graphics and text);

(b) An MPN uniquely identifies a part when used together with manufacturer code (external manufacturer), which is the own name used by the manufacturer and not the manufacturer name provided by other.

(8) Medical Records — Include the physician's office records, hospital records, nursing facility records, home health agency records, records from other healthcare professionals, diagnostic and test reports. This documentation must be made available to the Division of Medical Assistance Programs (Division) on request.

(9) Medical Supplies — Generally non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing. Some medical supplies may also be used on a repeated, limited duration basis.

(10) Mobility-related activities of daily living (MRADL's) — Include toileting, eating, dressing, grooming and bathing.

(11) Morbidity — A diseased state, often used in the context of a "morbidity rate" (i.e. the rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state, including diagnosis and complications is referred to as morbidity.

(12) Morbidity Rate — The rate of illness in a population; the number of people ill during a time period divided by the number of people in the total population.

(13) The Division Maximum Allowable Rate — The maximum amount paid by the Division for a service.

(14) Practitioner — A person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitioner's license and certification.

(15) Prosthetic and Orthotic Devices — Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies. Prosthetic and orthotic devices also include leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the client's physical condition.

(16) Purchase price — Includes:

(a) Delivery;

(b) Assembly;

(c) Adjustments, if needed; and

(d) Training in the use of the equipment or supply.

(17) Rental fees — Include:

(a) Delivery;

(b) Training in the use of the equipment;

(c) Pick-up;

(d) Routine service, maintenance and repair; and

(e) Moving equipment to new residence, if coverage is to continue.

(18) Technician — A DMEPOS provider staff professionally trained through product or vendor-based training, technical school training (e.g., electronics) or through apprenticeship programs with on-the-job training.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 54-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0020
Orders

(1) The purchase, rental or modifications of durable medical equipment, and the purchase of supplies must have an order prior to dispensing items to a client.

(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the prescribing practitioner prior to submitting a claim to the Division of Medical Assistance Programs (Division).

(3) A provider may dispense some items based on a verbal order from the prescribing practitioner, except those items requiring a written order prior to delivery (see below) or as specified in a particular rule:

(a) A provider must maintain documentation of the verbal order and this documentation must be available to the Division upon request;

(b) The verbal order must include all the following elements:

(A) Client's name; and,

(B) Name of the practitioner; and,

(C) Description of the item; and,

(D) Start date of the order; and,

(E) Primary ICD-10 diagnosis code for the equipment/supplies requested.

(c) For items that are dispensed based on a verbal order, the provider must obtain a written order that meets the requirements outlined below for written orders.

(4) For an item requiring a written order prior to delivery, Medicare criteria must be met.

(5) When specified in rule, a nurse practitioner may provide the dispensing order and sign the detailed written order only when the following are met:

(a) They are treating the client for the condition for which the item is needed; and

(b) They are practicing independently of a physician.

(6) The DMEPOS provider must have on file a written order, information from the prescribing practitioner concerning the client's diagnosis and medical condition, and any additional information required in a specific rule.

(7) The Division accepts any of the following forms of orders and Certificates of Medical Necessity (CMN): a photocopy, facsimile image, electronically maintained or original "pen and ink" document:

(a) An electronically maintained document is one which has been created, modified, and stored via electronic means such as commercially available software packages and servers;

(b) It is the provider's responsibility to ensure the authenticity/validity of a facsimile image, electronically maintained or photocopied order;

(c) A provider must also ensure the security and integrity of all electronically maintained orders and/or certificates of medical necessity;

(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed.

(8) A written order must be legible and contain the following elements:

(a) Client's name; and,

(b) Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features; and,

(c) The detailed description of the item may be completed by someone other than the practitioner. However, the prescribing practitioner must review the detailed description and personally

indicate agreement by his signature and the date that the order is signed;

(A) The Division requires practitioners to sign for services they order;

(B) This signature must be handwritten or electronic, and it must be in the client's medical record;

(C) The ordering practitioner is responsible for the authenticity of the signature;

(d) Primary ICD-10 diagnosis code for the equipment/supplies requested.

(9) Use of signature stamps is prohibited on any medical record.

(10) When a DMEPOS provider submits a Centers for Medicare & Medicaid Services (CMS) CMN to the Division as documentation, the following is required:

(a) The corresponding instructions for completing the specific CMN form must be followed; and

(b) Section B on the CMN cannot be completed by the DMEPOS provider;.

(11) A provider is responsible to obtain as much documentation from the client's medical record as necessary for assurance that the Division coverage criteria for an item(s) is met.

(12) Certain items require one or more of the following additional elements in the written order:

(a) For accessories or supplies that will be provided on a periodic basis:

(A) Quantity used;

(B) Specific frequency of change or use — "as needed" or "prn" orders are not acceptable;

(C) Number of units;

(D) Length of need: Example: An order for surgical dressings might specify one 4" x 4" hydrocolloid dressing which is changed one to two times per week for one month or until the ulcer heals;

(b) For orthoses: If a custom-fabricated orthosis is ordered by the practitioner, this must be clearly indicated on the written order;

(c) Length of need:

(A) If the coverage criteria in a rule specifies length of need; or,

(B) If the order is for a rental item;

(d) Any other medical documentation required by rule.

(13) For repairs: Labor for repairs, parts for durable medical equipment (DME) repairs and replacement parts for DME (e.g., batteries) do not require a written order.

(14) A new order is required:

(a) When required by Medicare (for a Medicare covered service) (www.cignamedicare.com); or,

(b) When there is a change in the original order for an item; or,

(c) When an item is permanently replaced; or,

(d) When indicated by the prescribing practitioner;

(A) A new order is required when an item is being replaced because the item is worn or the client's condition has changed; and,

(B) The provider's records should also include client-specific information regarding the need for the replacement item; and,

(C) This information should be maintained in the provider's files and be available to the Division on request; and,

(D) A new order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical appropriateness of the item;

(e) When there is a change of DMEPOS provider: In cases where two or more providers merge, the resultant provider should make all reasonable attempts to secure copies of all active CMN's and written orders from the provider(s) purchased. This document should be kept on file by the resultant provider for future presentation to the Division, if requested;

(f) On a regular or specific basis (even if there is no change in the order) only if it is so specified in a particular rule.

(15) A provider is required to maintain and provide (when required by a particular rule) legible copies of facsimile image and electronic transmissions of orders.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 41-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 in the North Salem, Woodburn, McMinnville, Lebanon, Albany and Corvallis branch offices, ef. 6-30-82 in the balance of the state; AFS 20-1983, f. 5-5-83, ef. 6-1-83; AFS 49-1987, f. 10-16-87, ef. 11-1-87; AFS 48-1989, f. & cert. ef. 8-24-89; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 461-024-0004; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 72-2002(Temp), f. & cert. ef. 12-24-02 thru 5-15-03; OMAP 36-2003, f. & cert. ef. 5-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-122-0040
Prior Authorization

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers shall obtain prior authorization (PA) for Healthcare Common Procedure Coding System (HCPCS) Level II codes as specified in rule, unless otherwise noted.

(2) Providers shall request PA as follows (see the DMEPOS Supplemental Information for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (Department) MFCU;

(b) For clients enrolled in a Coordinated Care Organization (CCO), from the CCO;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (Division).

(3) For DMEPOS provided after normal working hours, providers must submit PA requests within five working days from the initiation of service.

(4) See OAR 410-120-1320 for more information about PA.

Stat. Auth.: ORS 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 14-1984 (Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 461-024-0010; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 6-2004, f. 2-10-04 cert. ef. 3-15-04; OMAP 20-2004(Temp), f. & cert. ef. 3-15-04 thru 4-30-04; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 26-2004, f. 4-15-04 cert. ef. 5-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 61-2015, f. 10-29-15, cert. ef. 11-1-15

410-122-0080
Conditions of Coverage, Limitations, Restrictions and Exclusions

(1) The Division of Medical Assistance Programs (Division) may pay for durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) when the item meets all the criteria in this rule, including all of the following conditions. The item:

(a) Has been approved for marketing and registered or listed as a medical device by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended. In the event of delay in FDA approval and registration, the Division shall review purchase options on a case-by-case basis;

(b) Is reasonable and medically appropriate for the individual client;

(c) Is primarily and customarily used to serve a medical purpose;

(d) Is generally not useful to a person in the absence of illness or injury;

(e) Is appropriate for use in a client's home;

(f) Specifically, for durable medical equipment, can withstand repeated use; i.e., could normally be rented and used by successive clients;

(g) Meets the coverage criteria as specified in this division and subject to service limitations of the Division rules;

(h) Is requested in relation to a diagnosis and treatment pair that is above the funding line and consistent with treatment guidelines on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) found in OAR 410-141-0520, and not otherwise excluded under OAR 410-141-0500;

(i) Is included in the Oregon Health Plan (OHP) client's benefit package of covered services; and

(j) Is the least costly, medically appropriate item that meets the medical needs of the client.

(2) Conditions for Medicare-Medicaid Services:

(a) If Medicare is the primary payer and Medicare denies payment, an appeal to Medicare must be filed timely prior to submitting the claim to the Division for payment. If Medicare denies payment based on failure to submit a timely appeal, the Division may reduce any amount the Division determines could have been paid by Medicare;

(b) If Medicare denies payment on appeal, the Division shall apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the OHP.

(3) The Division may not cover DMEPOS items when the item or the use of the item is:

(a) Not primarily medical in nature;

(b) For personal comfort or convenience of the client or caregiver;

(c) A self-help device;

(d) Not therapeutic or diagnostic in nature;

(e) Used for precautionary reasons (e.g., pressure-reducing support surface for prevention of decubitus ulcers);

(f) Inappropriate for client use in the home (e.g., institutional equipment like an oscillating bed);

(g) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or

(h) Reimbursed as part of the bundled rate in a nursing facility as described in OAR 411-070-0085, or as part of a home and community-based care waiver service, or by any other public, community, or third party resource.

(4) Codes that are identified in these rules or in fee schedules are provided as a mechanism to facilitate payment for covered items and supplies consistent with OAR 410-122-0186, but codes do not determine coverage. If prior authorization is required, the request for reimbursement shall document that prior authorization was obtained in compliance with the rules in this division.

(5) DMEPOS providers shall have documentation on file that supports coverage criteria are met.

(6) Billing records shall demonstrate that the provider has not exceeded any limitations and restrictions in the DMEPOS rules. The Division may require additional claim information from the provider consistent with program integrity review processes.

(7) Documentation described in (4), (5), and (6) above shall be made available to the Division upon request.

(8) To identify non-covered items at a code level, providers can refer to the Division fee schedule, subject to the limitation that fee schedules and codes do not determine coverage and are solely provided as a mechanism to facilitate payment for covered services and supplies consistent with OAR 410-122-0186. If an item or supply is not covered for an OHP client in accordance with these rules, there is no basis for payment regardless of whether there is a code for the item or supply on the fee schedule.

(9) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System).

(10) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitutes a buy-up and is prohibited. Refer to the Division General Rules (chapter 410, division 120) for specific language on buy-ups.

(11) Equipment purchased by the Division for a client is the property of the client.

(12) Rental charges, starting with the initial date of service, regardless of payer, apply to the purchase price.

(13) A provider who supplies rented equipment is to continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances.

(14) Before renting, providers should consider purchase for long-term requirements.

(15) The Division may not pay DMEPOS providers for medical supplies separately while a client is under a home health plan of care and covered home health care services.

(16) The Division may not pay DMEPOS providers for medical supplies separately while a client is under a hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, the Division, or other carrier.

(17) Separate payment may not be made to DMEPOS providers for equipment and medical supplies provided to a client in their home when the cost of such items is already included in the capitated (per diem) rate paid to a facility or organization.

(18) Non-contiguous out-of-state DMEPOS providers may seek Medicaid payment only under the following circumstances:

(a) Medicare/Medicaid clients:

(A) For Medicare covered services and then only Medicaid payment of a client's Medicare cost-sharing expenses for DMEPOS services when all of the following criteria are met:

(i) Client is a qualified Medicare beneficiary (QMB);

(ii) Service is covered by Medicare;

(iii) Medicare has paid on the specific code. Prior authorization is not required;

(B) Services not covered by Medicare:

(i) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing practitioner and maintained in the DMEPOS provider's records;

(ii) Some examples of services not reimbursable to a non-contiguous out-of-state provider are incontinence supplies, grab bars, etc. This list is not all-inclusive;

(iii) Services billed must be covered under the OHP;

(iv) Services provided and billed to the Division shall be in accordance with all applicable Division rules;

(b) Medicaid-only clients:

(A) For a specific Oregon Medicaid client who is temporarily outside Oregon or the contiguous borders of Oregon and only when the prescribing practitioner has documented that a delay in service may cause client harm;

(B) For foster care or subsidized adoption children placed out of state;

(C) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing practitioner and maintained in the DMEPOS provider's records;

(D) Services billed must be covered under the OHP;

(E) Services provided and billed to the Division shall be in accordance with all applicable Division rules.

(19) The items listed in Table 122-0080 generally do not meet the requirements under DMEPOS rules for purchase, rent, or repair of equipment or items.

(20) A request for an individual medical review may be made on DMEPOS services or items that are not already identified as covered by the Division. The request shall be submitted by the prescribing practitioner with supporting medical documentation. In no case shall a requested service or item be approved unless it is medically appropriate as defined in OAR 410-120-0000 and 410-141-0000 and meets the requirements of this rule. Requests under this section shall be directed in accordance with 410-122-0040(2).

(21) See General Rules OAR 410-120-1200, Excluded Services and Limitations for more information on general scope of coverage and limitations.

(22) Table 122-0080, Exclusions.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 413.042 & 414.065

Hist.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 24-1990(Temp), f. & cert. ef. 7-27-90; HR 6-1991, f. & cert. ef. 1-18-91, Renumbered from 461-024-0020; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 26-1994, f. & cert. ef. 7-1-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 46-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 26-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11; DMAP 28-2010(Temp), f. & cert. ef. 10-7-10 thru 3-25-11; DMAP 29-2010(Temp), f. & cert. ef. 10-13-10 thru 3-25-11; DMAP 3-2011, f. 3-23-11, cert. ef. 3-25-11; DMAP 87-2014, f. 12-31-14, cert. ef. 1-1-15

410-122-0180
Healthcare Common Procedure Coding System Level II Coding

(1) The Healthcare Common Procedure Coding System (HCPCS) level II is a comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. The Centers for Medicare and Medicaid Services (CMS) maintain and distribute HCPCS Level II Codes.

(2) HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independently of the process for making coverage and payment determinations for medical items or services. Items billed that do not have a HCPCS code will be reviewed by the Division of Medical Assistance Programs (Division) on a case by case basis to ensure rule 410-122-0080 is appropriately applied to item billed.

(3) The Division uses the HCPCS Level II Code Set to ensure that claims are processed in an orderly and consistent manner.

(4) When requesting authorization and submitting claims, DMEPOS providers must use these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code.

(5) This rule division may not contain all code updates needed to report medical services and supplies.

(6) For the most up-to-date information on code additions, changes, or deletions, refer to the fee schedule posted on the Division Web site.

(7) The Division fee schedule lists all of the current HCPCS codes in an alphanumeric index.

(8) Newly established temporary codes and effective dates for their use are also posted on the Division website at www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(9) CMS updates permanent national codes annually on January 1st.

(10) CMS may add, change, or delete temporary national codes on a quarterly basis.

(11) The Medicare Pricing, Data Analysis and Coding (PDAC) contractor is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code should be used to describe DMEPOS items.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 413.042 & 414.065

Hist.: AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 7-1990, f. 3-30-89, cert. ef. 4-1-89, Renumbered from 461-024-0200; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 410-122-0100; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 12-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 26-1999, f. & cert. ef. 6-4-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 54-2001(Temp), f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02; OMAP 63-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 26-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11; DMAP 3-2011, f. 3-23-11, cert. ef. 3-25-11

410-122-0182
Legend

This rule is retroactive and applies to services rendered on or after Jan. 1, 2009.

(1) The Division uses abbreviations in the tables within this division.

(2) This rule explains the meaning of these abbreviations.

(3) PA — Prior authorization (PA): "PA" indicates that PA is required, even if the client has private insurance. See OAR 410-122-0040 for more information about PA requirements.

(4) PC — Purchase: "PC" indicates that purchase of this item is covered for payment by the Division.

(5) RT — Rent: "RT" indicates that the rental of this item is covered for payment by the Division.

(6) MR — Months Rented:

(a) "13" — Indicates up to 13 consecutive months of continuous rental, when the Division fee schedule purchase price is met for the item, when the usual purchase price is reached or the actual charge is met (whichever is lowest), the equipment is considered paid for and owned by the client. The provider must then transfer title of the equipment to the client;

(b) For any other rental situation, where the Division fee schedule lists a purchase price and this purchase price is met for the item, when the usual purchase price is reached or the actual charge is met (whichever is lowest), the equipment is considered paid for and owned by the client. The provider must then transfer title of the equipment to the client.

(7) RP — Repair: "RP" indicates that repair of this item is covered for payment by the Division.

(8) NF — Nursing Facility: "NF" indicates that this procedure code is covered for payment by the Division when the client is a resident of a nursing facility.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10

410-122-0184
Repairs, Maintenance, Replacement, Delivery and Dispensing

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: The Division may cover reasonable and necessary repairs, servicing, and replacement of medically appropriate, covered durable medical equipment, prosthetics and orthotics, including those items purchased or in use before the client enrolled with the Division:

(a) Repairs:

(A) To repair means to fix or mend and to put the equipment back in good condition after damage or wear to make the equipment serviceable;

(B) If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment will be made for the amount of the excess;

(C) Payment for repairs is not covered when:

(i) The skill of a technician is not required; or

(ii) The equipment has been previously denied; or

(iii) Equipment is being rented, including separately itemized charges for repair; or

(iv) Parts and labor are covered under a manufacturer's or supplier's warranty;

(D) Code K0739 must not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate;

(b) Servicing:

(A) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking of the client's equipment is not covered. However, more extensive servicing which, based on the manufacturers' recommendations, is to be performed by authorized technicians, may be covered for medically appropriate client-owned equipment. For example, this might include, breaking down sealed components and performing tests that require specialized testing equipment not available to the client;

(B) Payment for maintenance/service is not covered for rented equipment. The Division may authorize payment for covered servicing of capped rental items after six months have passed from the end of the final paid rental month. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of servicing at no more than the rental fee schedule allowable amount;

(C) Up to one month's rental will be reimbursed at the level of either the equipment provided; or, the equipment being repaired, whichever is less costly;

(D) Maintenance and servicing that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered;

(c) Replacement - Replacement refers to the provision of an identical or nearly identical item:

(A) Temporary Replacement: One month's rental of temporary replacement for client-owned equipment being repaired, any type (K0462) may be reimbursed when covered client-owned equipment such as a wheelchair is in need of repair. The equipment in need of repair must be unavailable for use for more than one day. For example, the repair takes more than one day or a part has to be ordered and the wheelchair is non-functional;

(B) Permanent Replacement: Situations involving the provision of a different item because of a change in medical condition must meet the specific coverage criteria identified in chapter 410, division 122;

(C) Equipment which the client owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment;

(i) Reasonable useful lifetime of durable medical equipment (DME) is no less than five years;

(ii) Computation of the useful lifetime is based on when the equipment is delivered to the client, not the age of the equipment;

(iii) Replacement due to wear is not covered during the reasonable useful lifetime of the equipment;

(iv) During the reasonable useful lifetime, repair up to the cost of replacement (but not actual replacement for medically appropriate equipment owned by the client) may be covered;

(D) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered;

(d) Delivery:

(A) Providers may deliver directly to the client or the designee (person authorized to sign and accept delivery of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) on behalf of the client);

(B) Providers, their employees, or anyone else having a financial interest in the delivery of an item are prohibited from signing and accepting an item on behalf of a client;

(C) A provider may deliver DMEPOS to a client in a hospital or nursing facility for the purpose of fitting or training the client in its proper use. This may be done up to two days prior to the client's anticipated discharge to home. On the claim bill the date of service as the date of discharge and specify the place of service (POS) as the client's home. The item must be for subsequent use in the client's home;

(D) A provider may deliver DMEPOS to a client's home in anticipation of a discharge from a hospital or nursing facility. The provider may arrange for actual delivery approximately two days prior to the client's anticipated discharge to home. On the claim bill the date of service as the date of discharge and specify the POS as the client's home;

(E) No payment is made on dates of service the client receives training or fitting in the hospital or nursing facility for a particular DMEPOS item;

(e) For Dispensing Refills:

(A) For DMEPOS products that are supplied as refills to the original order, providers must contact the client or designee prior to dispensing the refill to check the quantity on hand and continued need for the product;

(B) Contact with the client or designee regarding refills may only take place no sooner than approximately seven days prior to the delivery/shipping date;

(C) For subsequent deliveries of refills, the provider may deliver the DMEPOS product no sooner than approximately fifteen days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. The Division will allow for the processing of claims for refills delivered/shipped prior to the client exhausting their supply, but the provider must not dispense supplies that exceed a client's expected utilization;

(D) Supplies dispensed are based on the practitioner's order. Regardless of utilization, a provider must not dispense more than a three-month quantity of supplies at a time. This three-month dispensing restriction for supplies may be further limited by rule limitations of coverage;

(E) The provider must not automatically ship, dispense or deliver a quantity of supplies on a predetermined regular basis, even if the client or designee has "authorized" this in advance;

(F) Shipping and handling charges are not covered;

(f) The following services are not covered:

(A) Pick-up, delivery, shipping and handling charges for DMEPOS, whether rented or purchased including travel time:

(i) These costs are included in the calculations for allowable rates;

(ii) These charges are not billable to the client;

(B) Supplies used with DME or a prosthetic device prior to discharge from a hospital or nursing facility;

(C) Surgical dressings, urological supplies, or ostomy supplies applied in the hospital or nursing facility, including items worn home by the client.

(2) Documentation Requirements:

(a) For Repairs, Servicing and Temporary Replacement: A new Certificate of Medical Necessity (CMN) and/or physician's order is not required;

(b) Submit the following documentation with the prior authorization request:

(A) For Repairs/Servicing:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and estimated labor time; and

(iii) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair;

(B) For Temporary Replacement:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Narrative description, manufacturer and brand name/model name and number of the replacement equipment; and

(iii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and estimated labor time; and

(iv) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair; and

(v) Description of why repair takes more than one day to complete;

(C) For Permanent Replacement: See specific coverage criteria in chapter 410, division 122 for more information;

(D) For Proof of Delivery: DMEPOS providers are required to:

(i) Maintain proof of delivery documentation to the client in their records for seven years;

(ii) Maintain documentation that supports that conditions of coverage in this rule are met;

(iii) Make proof of delivery documentation available to the Division upon request;

(c) Proof of delivery requirements are based on the method of delivery;

(d) A signed and dated delivery slip is required for items delivered directly by the provider to the client or designee. The delivery slip must include the following:

(A) When a designee signs the delivery slip, their relationship to the client must be noted and the signature legible;

(B) The client or designee's signature with the date the items were received; and

(C) Client's name, and

(D) Quantity, brand name, serial number and a detailed description of the items being delivered; and

(E) The date of signature on the delivery slip must be the date the DMEPOS item is received by the client or designee; and

(F) The date the client receives the item is the date of service;

(e) If the provider uses a delivery/shipping service or mail order, an example of proof of delivery would include the service's tracking slip and the provider's own shipping invoice:

(A) The provider's shipping invoice must include the:

(i) Client's name, and

(ii) Quantity, brand name, serial number and a detailed description of the items being delivered, and

(iii) Delivery service's package identification number associated with each individual client's package with a unique identification number and delivery address, including the actual date of delivery, if possible; and

(iv) The shipping date must be used as the date of service, unless the actual date of delivery is available then use this date as the date of service;

(B) The delivery service's tracking slip must reference:

(i) Each client's packages; and

(ii) The delivery address and corresponding package identification number given by the delivery service;

(f) Providers may utilize a signed/dated return postage-paid delivery/shipping invoice from the client or designee as a form of proof of delivery that must contain the following information:

(A) Client's name;

(B) Quantity, brand name, serial number and a detailed description of items being delivered;

(C) Required signatures from either the client or the designee;

(g) Delivery to Nursing Facilities or Hospitals:

(A) The date of service is the date the DMEPOS item(s) is received by the nursing facility if delivered by the DMEPOS provider;

(B) The date of service is the shipping date (unless the actual delivery date is known and documented) if the DMEPOS provider uses a delivery/shipping service;

(h) For those clients who are residents of an assisted living facility, a twenty-four hour residential facility, an adult foster home, a child foster home, a private home or other similar living environment, providers must ensure supplies are identified and labeled for use only by the specific client for whom the supplies/items are intended.

(3) Procedure Codes:

(a) Replacement parts for wheelchair repair are billed using the specific HCPCS code, if one exists, or code K0108 (other accessories);

(b) K0739:

(A) Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes;

(B) This code is used for services not covered by other codes or combination of codes in reference to the repairs of DMEPOS;

(c) K0108 — Other wheelchair accessories — PA;

(d) K0462 — Temporary replacement for client-owned equipment being repaired, any type — Prior authorization (PA) required — PA.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0186
Payment Methodology

(1) The Division of Medical Assistance Programs (Division) utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that is generally based on the 2012 Medicare fee schedule:

(a) The Division fee schedule amount is 82.6 percent of 2012 Medicare Fee Schedule for items covered by Medicare and the Division, except for:

(A) Ostomy supplies fee schedule amounts are 93.3 percent of 2012 Medicare Fee Schedule (See Table 122-0186-1 for list of Ostomy codes subject to this pricing); and

(B) Prosthetic and Orthotic fee schedule amounts (L-codes) are 82.6 percent of 2012 Medicare Fee Schedule; and

(C) Complex Rehabilitation items and services other than power wheelchairs, fee schedule amounts are 88 percent of 2012 Medicare Fee Schedule (See Table 122-0186-2 for list of Complex Rehabilitation codes subject to this pricing); and

(D) Group 1 power wheelchairs (K0813-K0816) and Group 2 power wheelchairs with no added power option (K0820-K0829) fee schedule amounts are 55 percent of 2012 Medicare Fee Schedule;

(E) Group 3 power wheelchairs (K0835-K0864) fee schedule amounts are 58.7 percent of 2012 Medicare Fee Schedule;

(b) For items that are not covered by Medicare but covered by the Division, the fee schedule amount shall be 99 percent of the Division's published rate effective 7/31/11;

(c) For new codes added by the Center for Medicare and Medicaid Services (CMS), payment shall be based on the most current Medicare fee schedule and shall follow the same payment methodology as stated in section (1)(a)(A-E) of this rule. New codes that do not appear on the current Medicare fee schedule shall be manually priced as indicated in section (4)(a-c) of this rule.

(2) Payment is calculated using the lesser of the following:

(a) The Division fee schedule amount, using the above methodology in section (1) (a) and (b); or

(b) The manufacturer's suggested retail price (MSRP); or

(c) The actual charge submitted.

(3) The Division shall reimburse for the lowest level of service that meets medical appropriateness. (See OAR 410-120-1280 Billing; and 410-120-1340 Payment).

(4) The Division shall reimburse miscellaneous codes E1399 (durable medical equipment, miscellaneous) and K0108 (wheelchair component or accessory, not otherwise specified), and any code that requires manual pricing, using the lesser of the following:

(a) Seventy-five percent of MSRP verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is MSRP; or

(b) If MSRP is not available then reimbursement shall be acquisition cost plus 20 percent, verifiable with quote, invoice, or bill from the manufacturer that clearly states the amount indicated is acquisition cost; or

(c) Actual charge submitted by the provider.

(5) Reimbursement on miscellaneous codes E1399 and K0108 shall be capped at $3,200.

(6) Prior authorization (PA) is required for miscellaneous codes E1399, K0108, and A4649 (surgical supply; miscellaneous)

when the cost is greater than $150, and the DMEPOS provider must submit the following documentation:

(a) A copy of the items from section (4)(a) and (b) that will be used to bill; and,

(b) Name of the manufacturer, description of the item, including product name or model name and number, serial number when applicable, and technical specifications;

(c) A picture of the item upon request by the Division.

(7) The DMEPOS provider shall submit verification for items billed with miscellaneous codes A4649, E1399, and K0108 when no specific Healthcare Common Procedure Coding System (HCPCS) code is available. Providers may submit verification from an organization such as the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(8) The Division may review items that exceed the maximum allowable or cap on a case-by-case basis and may ask the provider submit the following documentation for reimbursement:

(a) Documentation which supports that the client meets all of the coverage criteria for the less costly alternative; and,

(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) that clearly explains why the less costly alternative is not sufficient to meet the client's medical needs, and;

(c) The expected hours of usage per day, and;

(d) The expected outcome or change in the client's condition.

(9) PA is not required for codes A4649, E1399, and K0108 when the cost is $150.00 or less per each unit:

(a) Only items that have received an official product review coding decision from an organization such as PDAC with codes A4649, E1399, or K0108 shall be billed to the Division. These products may be listed in the PDAC Durable Medical Equipment Coding System Guide (DMECS) DMEPOS Product Classification Lists;

(b) Subject to service limitations of the Division's rules;

(c) The amount billed to the Division may not exceed 75 percent of MSRP. The provider must retain documentation of the quote, invoice, or bill to allow the Division to verify through audit procedures.

(10) For rented equipment, the equipment is considered paid for and owned by the client when the Division fee schedule allowable is met or the actual charge from the provider is met, whichever is lowest. The provider must transfer title of the equipment to the client.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 31-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 12-27-12; DMAP 57-2012, f. & cert. ef 12-27-12; DMAP 2-2014(Temp), f. 1-15-14, cert. ef. 2-1-14 thru 7-31-14; DMAP 44-2014, f. & cert. ef. 7-11-14; DMAP 3-2016, f. & cert. ef. 2-3-16

410-122-0187

Durable Medical Equipment (DME) Repurposing Pilot Program

(1) The DME Repurposing Pilot Program is designed to refurbish gently used durable medical equipment that is no longer needed by other individuals and reassign to OHP clients. The pilot program serves clients residing in Washington, Multnomah, Clackamas, Umatilla, Marion, and Polk Counties and other counties as approved by the Division of Medical Assistance Programs (Division).

(2) DME provided through this program requires a written order signed and dated by the prescribing practitioner prior to dispensing items to a client. Medical need shall be supported within the prescribing practitioner's clinical documentation.

(3) The DME collected for use in this program shall be properly cleaned, sanitized, repaired, refurbished, and reconfigured by qualified and trained staff prior to reassignment.

(4) Certified Assistive Technology Professionals (ATP) or other appropriately licensed or certified providers shall:

(a) Assess each item of equipment to assure that it is safe and functionally appropriate for reuse;

(b) Assess the client's needs for equipment and consult with and advise the client and the prescribing practitioner in the selection of medically appropriate equipment;

(c) Instruct the client or the client's caregiver in the appropriate use of the equipment; and

(d) Be available after delivery of the equipment to provide timely support, repairs, and necessary modifications.

(5) The non-profit organization awarded the grant for this pilot program shall be reimbursed for costs associated with managing inventory, collection, sanitizing, repairing, refurbishing, reconfiguring, fitting, delivery, and follow-up support of the DME reassigned through the program.

Stat. Auth.: ORS 414.065 & HB 4108

Stats. Implemented: ORS 414.065

Hist.: DMAP 1-2015(Temp), f. & cert. ef. 1-29-15 thru 7-27-15; DMAP 22-2015, f. & cert. ef. 4-15-15

410-122-0188

DMEPOS Rebate Agreements

(1) The Division of Medical Assistance Programs (Division) has a, Centers for Medicare and Medicaid Services (CMS) approved DMEPOS Rebate Agreement.

(2) The Division negotiates DMEPOS Rebate Agreements for specific products through the Sovereign States Drug Consortium (SSDC) multi-state pool and DMEPOS manufacturers. Negotiations are confidential, and shall not be disclosed, except in connection with an agreement/contract or as may be required by law. Confidentiality is required of any third party involved in administration of the agreement/contract.

(3) Manufacturers may submit rebate offers for consideration to include their product(s) on the Preferred DME List (PDMEL), after gaining access to the SSDC secure web-based offer entry system.

(4) Manufacturers must abide by requirements of the SSDC.

(5) The PDMEL shall consist of DMEPOS that the Food and Drug Administration (FDA) has determined to be safe and effective

(6) Upon acceptance of the offer:

(a) The SSDC will notify manufacturers of the status of their offer(s);

(b) Supplemental Agreements will be executed after signed by all parties, approved by CMS if required, and products may be added to the PDMEL;

(c) The Division may contract for the functions of tracking utilization, invoicing, and dispute resolution for rebate products.

(7) The division will develop a PDMEL, however specific items may be categorized together to create specific lists such as, but not limited to the Preferred Diabetic Supply List (PDSL).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12

410-122-0200

Pulse Oximeter for Home Use

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division may cover a tamper-proof pulse oximeter for home use when all of the following criteria are met:

(A) The client has frequently fluctuating oxygen saturation levels that are clinically significant;

(B) Measurements are integral in dictating acute therapeutic intervention;

(C) The absence of readily available saturation measurements represents an immediate and demonstrated health risk;

(D) The client has a caregiver trained to provide whatever care is needed to reverse the low oxygen saturation level ordered by the physician;

(b) Some examples of when a home pulse oximeter may be covered include the following:

(A) When weaning a client from home oxygen or a ventilator;

(B) When a change in the client's physical condition requires an adjustment in the liter flow of their home oxygen needs;

(C) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep;

(D) To monitor a client on mechanical ventilation at home;

(E) To periodically re-assess the need for long-term oxygen in the home;

(F) Infants with chronic lung disease (e.g., bronchopulmonary dysplasia);

(G) Premature infants on active therapy for apnea;

(H) When a client exhibits a certain unstable illness and has compromised or potentially compromised respiratory status;

(I) When evidence-based clinical practice guidelines support the need;

(c) Home pulse oximetry for indications other than those listed above may be covered on a case-by-case basis upon medical review by the Division's Policy Unit;

(d) The durable medical equipment prosthetics, orthotics and supplies (DMEPOS) provider is responsible to ensure the following services for home pulse oximetry rental are provided:

(A) For purchase or rental of a pulse oximeter for home use:

(i) Training regarding the use and care of the equipment and care of the client as it relates to the equipment, including progressive intervention and cardiopulmonary resuscitation (CPR) training prior to use of the equipment by the client; and

(ii) A follow-up home visit within the first 30 days of equipment setup to ensure a CPR/emergency area has been designated; and

(B) For rental of a pulse oximeter for home use:

(i) Monthly telephone follow-up and support to ensure caregivers are using the equipment as ordered by the physician; and

(ii) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.;

(iii) The allowable rental fee includes all equipment, supplies, services, including all probes, routine maintenance and necessary training for the effective use of the pulse oximeter;

(e) The Division may cover probes for a client-owned covered oximeter:

(A) The Division will reimburse for the least costly alternative for payment of probes, whether disposable or reusable, which meets the medical need of the client;

(B) A reusable probe must be used when it is the least costly alternative rather than a disposable probe, unless the client's medical records clearly substantiates why a reusable probe is contraindicated;

(C) Disposable probes (oxisensors) may be reused on the same client as long as the adhesive attaches without slippage;

(f) The use of home pulse oximetry for indications considered experimental and investigational, including the following, are not covered:

(A) Asthma management;

(B) When used alone as a screening/testing technique for suspected obstructive sleep apnea;

(C) Routine use (e.g., client with chronic, stable cardiopulmonary condition).

(2) Documentation Requirements:

(a) Submit the following documentation for prior authorization (PA) review:

(A) An order from the treating physician that clearly specifies the medical appropriateness for home pulse oximetry testing;

(B) Documentation of signs/symptoms/medical condition exhibited by the client, that require continuous pulse oximetry monitoring as identified by the need for oxygen titration, frequent suctioning or ventilator adjustments, etc.;

(C) Plan of treatment that identifies a trained caregiver is available to perform the testing, document the frequency and the results and implement the appropriate therapeutic intervention, when necessary;

(D) For probes for a client-owned oximeter, documentation that probes requested are the least costly alternative;

(E) Other medical records that corroborate conditions for coverage are met as specified in this rule;

(b) History and physical exam and progress notes must be available for review by the Division, upon request.

(3) Procedure Codes:

(a) A4606 — Oxygen probe for use with client-owned oximeter device, replacement:

(A) PA required;

(B) The Division will purchase;

(b) E0445 — Oximeter device for measuring blood oxygen levels non-invasively:

(A) PA required;

(B) The Division will purchase or rent on a monthly basis;

(C) The Division will repair a client-owned, covered pulse oximeter when cost effective;

(D) Item considered purchased after seven months of rent;

(E) Quantity (units) is one on a given date of service.

413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994,. f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 32-1999, f. & cert. ef. 10-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0202
Positive Airway Pressure (PAP) Devices for Adult Obstructive Sleep Apnea

(1) The Division of Medical Assistance Programs (Division) may cover a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA) when:

(a) The client has a face-to-face clinical evaluation by the treating physician prior to a sleep test to assess the client for obstructive sleep apnea; and

(b) The client has a polysomnogram performed in a facility-based laboratory or a home sleep test that demonstrates positive diagnosis of OSA with either of the following:

(A) The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour; or

(B) The AHI or RDI is between 5 and 14 events with additional symptoms including one or more of the following:

(i) Excessive daytime sleepiness as documented by a score of greater than 10 on the Epworth Sleepiness Scale or daytime sleepiness interfering with ADLs that is not attributable to another modifiable sedating condition (e.g. narcotic dependence); or

(ii) Documented hypertension; or

(iii) Ischemic heart disease; or

(iv) History of stroke.

(c) The client or their caregiver has received instruction from the supplier of the PAP device and accessories in the proper use of the equipment.

(d) The client meets criteria listed in section (2) of this rule for the particular device to be used.

(2) Continuous Positive Airway Pressure (CPAP) or Auto-titrating Continuous Positive Airway Pressure (APAP) devices:

(a) A CPAP/APAP device (E0601) may be covered for clients with OSA when criteria in (1)(a)–(c) are met;

(b) A three-month trial (rental) period for PAP devices is required to determine benefit and ongoing coverage of the device;

(c) Rental charges apply toward purchase.

(3) Respiratory Assist devices:

(a) A respiratory assist device (RAD) without backup rate (E0470) may be covered for clients with OSA when:

(A) Criteria in (1)(a)–(c) of this rule are met, and

(B) A CPAP/APAP device (E0601) has been tried and proven ineffective;

(b) If a CPAP/APAP device is tried and found ineffective during the initial facility-based titration or three-month home trial,

substitution of a RAD does not require a new face-to-face clinical evaluation or sleep test;

(c) If a CPAP/APAP device has been used for more than three months and the client is switched to a RAD, a clinical re-evaluation must occur, but a new sleep test is not required. A new three-month trial would begin for use of the RAD;

(d) Coverage, coding, and documentation requirements for the use of RADs for diagnoses other than OSA are addressed in 410-122-0205 Respiratory Assist Devices.

(e) A RAD with backup rate (E0471) is not medically indicated for the treatment of obstructive sleep apnea.

(4) For a client using a PAP device prior to Oregon Health Plan (OHP) enrollment, continuing coverage for the device and related accessories may be authorized on a case-by-case basis by the appropriate authorizing unit.

(5) Continued Coverage of PAP device:

(a) Ongoing rental of a PAP device (E0470 or E0601) beyond the three-month trial period is an option in lieu of purchase when medically appropriate, cost effective, and conditions of coverage have been met;

(b) Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating practitioner shall conduct a face-to-face clinical re-evaluation and document that the client is benefiting from PAP therapy;

(c) If the clinical re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the client is benefiting from PAP therapy as defined in criteria, continued coverage of the PAP device will commence with the date of that re-evaluation;

(d) If a CPAP/APAP has been used more than three months and the client is switched to a RAD, then the clinical re-evaluation shall occur between the 31st and 91st day following initiation of the RAD.

(6) Accessories:

(a) Accessories used with a PAP device are covered when the coverage criteria for the device are met;

(b) Accessories are separately reimbursable at the time of initial issue and when replaced;

(c) Either a non-heated (E0561) or heated (E0562) humidifier is covered when ordered by the treating practitioner for use with a covered PAP device (E0470, E0601);

(d) The following represents the usual maximum amount of accessories expected to be medically appropriate:

(A) A4604 — 1 per 3 months;
(B) A7027 — 1 per 3 months;
(C) A7028 — 2 per month;
(D) A7029 — 2 per month;
(E) A7030 — 1 per 3 months;
(F) A7031 — 1 per month;
(G) A7032 — 2 per month;
(H) A7033 — 2 per month;
(I) A7034 — 1 per 3 months;
(J) A7035 — 1 per 6 months;
(K) A7036 — 1 per 6 months;
(L) A7037 — 1 per 3 months;
(M) A7038 — 2 per month;
(N) A7039 — 1 per 6 months;
(O) A7046 — 1 per 6 months.

(7) Payment Authorization:

(a) From the initial date of service through the second date of service, prior authorization (PA) is not required for PAP device rental and related accessories. The provider is responsible to ensure all rule requirements are met;

(b) Payment authorization (i.e., a payment authorization number for billing) is required prior to submitting claims and will be given once all required documentation has been received and any other applicable rule requirements have been met;

(c) Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040;

(d) All subsequent services starting with the third date of service require PA;

(e) An order refill does not have to be approved by the ordering practitioner. However, a client or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance;

(f) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating practitioner. When the equipment is not being used as prescribed, the provider shall stop billing for the equipment and related accessories and supplies.

(8) Guidelines:

(a) Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It shall include sleep staging, which is defined to include a 1–4 lead electroencephalogram (EEG), electro-oculogram (EOG), submental electromyogram (EMG) and an electrocardiogram (ECG). It shall also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment;

(b) Polysomnographic and home studies shall be ordered by the client's treating physician, conducted by an entity that qualifies as a Medicare provider of sleep tests, and in compliance with all applicable state regulatory requirements;

(c) Polysomnographic studies and home sleep tests shall be scored according to the recommended rules as described in the American Academy of Sleep Medicine (AASM) Manual for Scoring of Sleep and Associated Events;

(d) Polysomnographic studies may not be performed by a DMEPOS provider;

(e) Home sleep tests are performed unattended in the client's home using a portable monitoring device that meets the following criteria:

(A) Type II device — Monitors and records a minimum of seven (7) channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory movement/effort, and oxygen saturation; or

(B) Type III device — Monitors and records a minimum of four (4) channels: respiratory movement/effort, airflow, ECG/heart rate, and oxygen saturations; or

(C) Type IV device — Monitors and records a minimum of three (3) channels, one of which is airflow; or

(D) Other — Devices that monitor and record a minimum of three (3) channels that include actigraphy, oximetry, and peripheral arterial tone;

(f) For all PAP devices, clients who undergo a home sleep study shall, prior to having the test, receive instruction on how to properly apply a portable sleep monitoring device. This instruction shall be provided by the entity conducting the home sleep test and may not be performed by a DME supplier.

(g) Apnea is defined as the cessation of airflow for at least 10 seconds and documented on a polysomnogram or home sleep monitoring equipment;

(h) Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline and with at least a 4 percent decrease in oxygen saturation;

(i) The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device;

(j) The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device;

(k) If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded

events used to calculate the AHI or RDI (respectively) shall be at least the number of events that would have been required in a two-hour period (i.e., must reach >30 events without symptoms or >10 events with symptoms);

(l) Adherence to therapy is defined as use of PAP four hours or more per night on 70 percent of nights during a consecutive thirty-day period anytime during the first three months of initial usage.

(9) Documentation Requirements:

(a) Initial coverage:

(A) For CPAP/APAP device, submit the facility-based polysomnogram report or home sleep study report that supports a diagnosis of OSA prior to the third date of service;

(B) For a RAD, submit specific documentation from the treating practitioner that a CPAP was tried and shown to be ineffective;

(b) For extended rental use or purchase of a PAP device beyond the first three months of initial therapy, submit the following documentation no sooner than the 61st day after initiating therapy and prior to the fourth date of service:

(A) Documentation of the face-to-face clinical re-evaluation by the treating practitioner that supports clinical benefit including client tolerance, compliance and efficacy, and demonstrates symptoms of OSA are improved; and

(B) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage date; or

(C) When objective data does not support compliance and efficacy, a face-to-face visit with the treating practitioner clearly specifying a treatment plan with measurable goals to improve adherence to treatment; and

(D) Any other medical documentation that supports indications of coverage;

(E) If a CPAP/APAP device has been used more than three months and the client is switched to a RAD, documentation of adherence to therapy shall be submitted during the three-month trial with the RAD;

(c) For a client using a PAP device prior to OHP enrollment, submit the following:

(A) Documentation of clinical benefit including client tolerance, compliance and efficacy, and that symptoms of OSA are improved from the client's treating practitioner; and

(B) A facility-based polysomnogram report or home sleep test as described in this rule and scored as described in (1)(n) that supports a diagnosis of OSA, if available.

(10) Table 122-0202 — PAP Devices.

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

Stat. Auth.: ORS 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 46-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 44-2008(Temp), f. 12-17-08, cert. ef. 1-1-09 thru 6-15-09; DMAP 11-2009, f. & cert. ef. 6-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 81-2014, f. 12-23-14, cert. ef. 1-1-15

410-122-0203

Oxygen and Oxygen Equipment

Unless stated otherwise within this rule, this rule is retroactive and applies to services rendered on or after January 1, 2009. Prior authorization (PA) requirements referenced in Table 122-0203-2 are effective January 1, 2010.

(1) Indications and limitations of coverage and medical appropriateness: the Division may cover home oxygen therapy services. Refer to Table 122-0203-1 and the following guidelines:

(a) For children under age 19 when the treating practitioner has determined oxygen services to be medically appropriate; or

(b) For adults age 19 years of age and older who are fully dual-eligible clients (Medicare clients who are also eligible for Medicaid/Oregon Health Plan (OHP); See definition in General Rules, OAR 410-120-0000), the Division of Medical Assistance Programs (Division) may cover oxygen services as follows:

(A) If Medicare paid on the claim for the oxygen equipment, the Division may provide reimbursement;

(B) If Medicare denied payment on the claim for the oxygen equipment, the Division will not provide reimbursement in accordance with Medicare rules and regulations;

(C) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplemental Information for additional details on Medicare's reimbursement limitation of 36 monthly rental payments;

(c) For adults 19 years of age and older who are not eligible for Medicare (only eligible for Medicaid/OHP), PA is required effective January 1, 2010 and all of the following conditions must be met:

(A) The treating practitioner has determined that the client has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy;

(B) The client's blood gas study meets the criteria stated below;

(C) The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services;

(D) The qualifying blood gas study was obtained under the following conditions:

(i) If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date; or

(ii) If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the client is in a chronic stable state — i.e., not during a period of acute illness or an exacerbation of their underlying disease;

(E) Alternative treatment measures have been tried or considered and deemed clinically ineffective;

(d) Group I coverage duration and indications:

(A) Initial coverage for clients meeting Group I criteria is limited to 12 months or the practitioner-specified length of need, whichever is shorter. See information on recertification in section 3(g) and (6);

(B) Group I criteria include any of the following:

(i) An arterial partial pressure of oxygen (PO2) at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake);

(ii) An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake;

(iii) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least five minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia;

(iv) An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air;

(e) Group II coverage duration and indications:

(A) Initial coverage for clients meeting Group II criteria is limited to three months or the practitioner-specified length of need, whichever is shorter. See information on recertification in section 3(g) and (6);

(B) Group II criteria include the presence of an arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent

at rest (awake), during sleep for at least five minutes, or during exercise (as described under Group I criteria) and any of the following:

(i) Dependent edema suggesting congestive heart failure;

(ii) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure; gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF);

(iii) Erythrocythemia with a hematocrit greater than 56 percent;

(f) Group III indications include a presumption of non-coverage. Criteria include arterial PO2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent;

(g) For all the sleep oximetry criteria, the five minutes does not have to be continuous;

(h) When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met;

(i) If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result will determine coverage;

(j) Oxygen therapy and related services, equipment or supplies are not covered for any of the following:

(A) Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments;

(B) Dyspnea without cor pulmonale or evidence of hypoxemia;

(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation;

(D) Terminal illnesses that do not affect the respiratory system;

(E) Group III clients;

(F) Emergency or stand-by oxygen systems for clients who are not regularly using oxygen since these services are precautionary and not therapeutic in nature;

(G) Topical hyperbaric oxygen chambers (A4575);

(H) When furnished by an airline (responsibility of the client);

(I) When provided/used outside the United States and its territories.

(2) Testing Specifications:

(a) The term blood gas study in this policy refers to either an ABG test or an oximetry test:

(A) An ABG is the direct measurement of the PO2 on a sample of arterial blood. The PO2 is reported as mm Hg.

(B) An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger. The saturation is reported as a percent;

(b) The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B;

(c) The test must be performed by a qualified provider (a laboratory, a physician, etc.):

(A) A DMEPOS provider is not considered a qualified provider or a qualified laboratory for purposes of this policy;

(B) Division will not accept blood gas studies either performed or paid for by a DMEPOS provider;

(C) This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests;

(d) When oxygen is covered based on an oxygen study obtained during exercise, documentation of three oxygen studies performed within the same testing session in the client's medical record is required:

(A) Testing at rest without oxygen;

(B) Testing during exercise without oxygen; and

(C) Testing during exercise with oxygen applied, to demonstrate the improvement of the hypoxemia;

(e) Only the qualifying test value (i.e., testing during exercise without oxygen) is reported on the Certificate of Medical Necessity (CMN). The other results do not have to be routinely submitted but must be available on request;

(f) The qualifying blood gas study may be performed while the client is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

(3) Certification:

(a) A completed and signed CMN is required to receive payment for oxygen;

(b) The blood gas study must be the most recent study obtained within 30 days prior to the initial date, indicated in Section A of the CMN;

(c) There is an exception to the 30-day test requirement for clients who were started on oxygen while enrolled in a Division health maintenance organization (HMO) and transition to fee-for-service. For those clients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent qualifying test obtained while in the HMO;

(d) The client must be seen and evaluated by the treating practitioner within 30 days prior to the date of Initial Certification;

(e) Initial CMN is required for any of the following situations:

(A) With the first claim to the Division for home oxygen, (even if the client was on oxygen prior to becoming eligible for Division coverage;

(B) When there has been a change in the client's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended;

(C) When an initial CMN does not meet coverage criteria and the client was subsequently retested and meets coverage criteria;

(D) When a Group I client with a length of need less than or equal to 12 months was not retested prior to a revised certification/recertification, but a qualifying study was subsequently performed;

(E) When the client initially qualified in Group II, repeat blood gas studies were not performed between the 61st and 90th day of coverage, but a qualifying study was subsequently performed;

(F) When there was a change of DMEPOS provider due to an acquisition and the previous provider did not file a recertification when it was due and the requirements for the recertification were not met when it was due;

(G) When the equipment is replaced in the following situations:

(i) The reasonable useful lifetime of prior equipment has been reached; or

(ii) Irreparable damage, theft or loss of the originally dispensed equipment:

(I) Irreparable damage refers to a specific accident or a natural disaster (e.g., fire, flood); and

(II) Irreparable damage does not refer to wear and tear over time;

(f) For initial CMN of replacement equipment described in (3)(e)(G):

(A) Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN;

(B) There is no requirement for a practitioner visit that is specifically related to the completion of the CMN for replacement equipment;

(g) Recertification CMN is required in the following situations:

(A) Group I — 12 months after initial certification (i.e., with the thirteenth month's claim);

(B) Group II — 3 months after initial certification (i.e., with the fourth month's claim);

(C) Recertification following initial certification done in section (3)(e)(A & B):

(i) For clients initially meeting Group I criteria, the most recent qualifying blood gas study prior to the thirteenth month of therapy must be reported on the recertification CMN;

(ii) For clients initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following initial certification must be reported on the recertification CMN. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy but the client continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, coverage would resume beginning with the date of that test;

(iii) For clients initially meeting Group I or II criteria, the client must be seen and re-evaluated by the treating practitioner 90 days prior to the date of any recertification. If the practitioner visit is not obtained within the 90-day window but the client continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit;

(h) Recertification following replacement equipment described in (3)(e)(G):

(A) Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN;

(B) There is no requirement for a practitioner visit that is specifically related to the completion of the CMN for replacement equipment;

(i) The DMEPOS provider must submit a revised CMN in the following circumstances. The Division does not require a practitioner visit in these situations. Submission of a revised CMN does not change the recertification schedule specified elsewhere:

(A) When the prescribed maximum flow rate changes from one of the following categories to another. In this situation, the blood gas study must be the most recent study obtained within 30 days prior to the initial date:

(i) Less than 1 liter per minute (LPM);

(ii) 1-4 LPM;

(iii) Greater than 4 LPM;

(B) If the change is from less than 1 LPM or 1-4 LPM to greater than 4 LPM, a repeat blood gas study with the client on 4 LPM must be performed within 30 days prior to the start of the greater than 4 LPM flow. In this situation, the blood gas study must be the most recent study obtained within 30 days prior to the initial date;

(C) When the length of need expires — if the practitioner-specified less than lifetime length of need on the most recent CMN. In this situation, the blood gas study must be the most recent study obtained within 30 days prior to the initial date;

(D) When a portable oxygen system is added subsequent to initial certification of a stationary system. In this situation, the Division does not require a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat study must be performed while the client is awake or during exercise (within 30 days of revised date);

(E) When a stationary system is added subsequent to initial certification of a portable system. In this situation, the Divisiondoes not require a repeat blood gas study. A revised CMN does not need to be submitted with claims but must be kept on file by DMEPOS provider;

(F) When there is a new treating practitioner but the oxygen order is the same. In this situation, the Division does not require a repeat blood gas study. The revised certification does not have to be submitted with the claim;

(G) If there is a new DMEPOS provider and that provider does not have the prior CMN. In this situation, the Division does not a repeat blood gas study. The revised certification does not have to be submitted with the claim;

(H) If the indications for a revised CMN are met at the same time that a recertification CMN is due, file the CMN as a recertification CMN.

(4) Portable Oxygen Systems:

(a) A portable oxygen system may be covered if the client is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;

(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. See exception in (5) below;

(c) If a portable oxygen system is covered, the DMEPOS provider must provide whatever quantity of oxygen the client uses; the reimbursement is the same, regardless of the quantity of oxygen dispensed.

(5) Liter flow greater than 4 LPM:

(a) The Division will pay a higher allowance for a stationary system for a flow rate of greater than 4 LPM only when:

(A) Basic oxygen coverage criteria have been met; and

(B) A blood gas study performed while the client is on 4 LPM meets Group I or II criteria;

(b) Payment is limited to the standard fee schedule allowance if a flow rate greater than 4 LPM is billed and the coverage criteria for the higher allowance are not met;

(c) If a client qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen:

(A) The Division will pay for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both;

(B) In this situation, if both a stationary system and a portable system are requested for the same rental month, the Division will not cover the portable oxygen system.

(6) Documentation Requirements: The DMEPOS provider must submit documentation which supports conditions of coverage as specified in this rule are met:

(a) A CMN which has been completed, signed, and dated by the treating practitioner:

(A) The CMN may act as a substitute for a written order if it is sufficiently detailed;

(B) The CMN for home oxygen is CMS Form 484 (DME form 484.03). Section B (order information), must be completed by the physician or the practitioner, not the DMEPOS provider. The DMEPOS provider may use Section C for a written confirmation of other details of the oxygen order, or the practitioner can enter the other details directly, such as the means of oxygen delivery (cannula, mask, etc.) and the specifics of varying oxygen flow rates and/or non-continuous use of oxygen;

(C) The ABG PO2 must be reported on the CMN if both an arterial blood gas and oximetry test were performed on the same day under the condition reported on the CMN (i.e., at rest/awake, during exercise, or during sleep);

(D) A report of the sleep study documenting the qualifying desaturation for clients who qualify for oxygen based only on a sleep oximetry study. The oxygen saturation value reported in question 1b of the Oxygen CMN must be the lowest value (not related to artifact) during the five minute qualifying period reported on the sleep oximetry study;

(b) The treating practitioner's signed and dated order for each item billed. Items billed before a signed and dated order has been received by the DMEPOS provider must be submitted with an EY modifier added to each affected Healthcare Common Procedure Coding System (HCPCS) code;

(c) The following special instructions apply to replacement equipment for those situations described in (3)(e)(G):

(A) Initial date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment;

(B) The recertification date should be 12 months following the initial date when the value on the initial CMN (for the replacement equipment) meets Group I criteria or 3 months following the initial date when the qualifying blood gas value on the initial CMN meets the Group II criteria (**Note:** The initial date should also be entered on the recertification CMN.);

(C) Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss;

(D) Claims for the initial rental month must include a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the DMEPOS provider's files;

(d) In the following situations, a new order must be obtained and kept on file by the DMEPOS provider, but neither a new CMN nor a repeat blood gas study are required:

(A) Prescribed maximum flow rate changes but remains within one of the following:

(i) Less than 1 LPM;

(ii) 1-4 LPM;

(iii) Greater than 4 LPM;

(B) Change from one type of stationary system to another (i.e., concentrator, liquid, gaseous);

(C) Change from one type of portable system to another (i.e., gaseous or liquid tanks, portable concentrator, transfilling system).

(7) Oxygen contents:

(a) The Division allowance for rented oxygen systems includes oxygen contents;

(b) Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a client-owned stationary gaseous or liquid system respectively;

(c) Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

(A) The client owns a concentrator and rents or owns a portable system; or

(B) The client rents or owns a portable system and has no stationary system (concentrator, gaseous, or liquid);

(C) If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased;

(d) Refer to **Table 122-0203-2** for oxygen contents that may be reimbursable for dual-eligible clients.

(8) Oxygen accessory items:

(a) The allowance for rented systems includes, but is not limited to, the following accessories:

(A) Transtracheal catheters (A4608);

(B) Cannulas (A4615);

(C) Tubing (A4616);

(D) Mouthpieces (A4617);

(E) Face tent (A4619);

(F) Masks (A4620, A7525);

(G) Oxygen tent (E0455);

(H) Humidifiers (E0550, E0555, E0560);

(I) Nebulizer for humidification (E0580);

(J) Regulators (E1353);

(K) Stand/rack (E1355);

(b) The DMEPOS provider must provide any accessory ordered by the practitioner;

(c) Accessories are separately payable only when they are used with a client-owned system that was purchased prior to June 1, 1989. The Division does not cover accessories used with a client-owned system that was purchased on or after June 1, 1989.

(9) Billing for miscellaneous oxygen items:

(a) Only rented oxygen systems (E0424, E0431, E0434, E0439, E1390RR, E1405 RR, E1406RR, E1392RR) are considered for coverage;

(b) For gaseous or liquid oxygen systems or contents, report one unit of service for one month rental. Do not report in cubic feet or pounds;

(c) Use the appropriate modifier if the prescribed flow rate is less than 1 LPM (QE) or greater than 4 LPM (QF or QG). Division only accepts these modifiers with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). Do not use these modifiers with codes for portable systems or oxygen contents;

(d) Use Code E1391 (oxygen concentrator, dual delivery port) in situations in which two clients are both using the same concentrator. In this situation, this code must only be requested for one of the clients;

(e) For E1405 and E1406 (oxygen and water vapor enriching systems), products must be coded as published by the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services;(f) Code E1392 describes a portable oxygen concentrator system. Use E1392 when billing the Division for the portable equipment add-on fee for clients using lightweight oxygen concentrators that can function as both the client's stationary equipment and portable equipment. A portable concentrator:

(A) Weighs less than 10 pounds;

(B) Is capable of delivering 85 percent or greater oxygen concentration; and

(C) Is capable of providing at least two hours of remote portability at a 2 LPM order equivalency;

(g) Contact the PDAC for guidance on the correct coding of these items.

(10) **Table 122-0203-1**, Oxygen and Oxygen Equipment.

(11) **Table 122-0203-2**, Oxygen Contents.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0204
Nebulizer

(1) Indications and limitations of coverage and medical appropriateness:

(a) Equipment:

(A) Small volume nebulizer:

(i) A small volume nebulizer and related compressor may be covered to administer inhalation drugs based on evidence-based clinical practice guidelines;

(ii) The physician shall have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, the MDI was not sufficient for the administration of needed inhalation drugs.

(B) Large volume nebulizer:

(i) A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is medically appropriate to deliver humidity to a client with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;

(ii) Combination code E0585 will be covered for the same indications as in (1)(a)(B)(i);

(C) The Division of Medical Assistance Programs (Division) will consider other uses of compressors/generators individually on a case-by-case basis to determine their medical appropriateness, such as a battery powered compressor (E0571);

(b) Accessories:

(A) A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and may not be separately billed when used for clients with rented home oxygen equipment;

(B) The Division does not cover use of a large volume nebulizer, related compressor/generator, and water or saline when used predominately to provide room humidification;

(C) A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the client or caregiver is an acceptable alternative to the large volume nebulizer when used as indicated in (1)(a)(B)(i) of this rule;

(D) Kits and concentrates for use in cleaning respiratory equipment are not covered;

(E) Accessories are separately payable if the related aerosol compressor and the individual accessories are medically appropriate. The following table lists each covered compressor/generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;

(F) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7017, A7525, E1372); E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0571 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0572 (A7006, A7014); E0585 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7525);

(G) This array of accessories represents all possible combinations, but it may not be appropriate to bill any or all of them for one device;

(H) Table 122-0204-1 lists the usual maximum frequency of replacement for accessories. The Division will not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by the Division before dispensing. The provider shall submit requests for more than the usual maximum replacement amount to the Division for review.

(2) Coding guidelines:

(a) Accessories:

(A) Code A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece, and mouthpiece. In addition, code A7006 includes a filter;

(B) Code A7004 includes only the lid, jar, and baffles;

(C) Code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer;

(D) Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing;

(E) Code A7017 is billed for a durable, bottle type nebulizer when it is used with an E0572 compressor or a separately billed E0565 compressor;

(F) Code A7017 may not be separately billed when an E0585 system is also being billed. Code E0580 (Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as A7017 but shall only be billed when this type of nebulizer is used with a client-owned oxygen system.

(b) Equipment:

(A) In this policy, the actual equipment (i.e., electrical device) will generally be referred to as a compressor (when nebulization of liquid is achieved by means of air flow). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor in order to achieve a functioning delivery system for aerosol therapy;

(B) Code E0565 describes an aerosol compressor, which can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation;

(C) A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered;

(D) A portable compressor (E0571) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It shall have battery or DC power capability and may have an AC power option;

(E) A light duty adjustable pressure compressor (E0572) is a pneumatic aerosol compressor that can be set for pressures above 30 psi at a flow of 6-8 L/m but is capable only of intermittent operation.

(3) Documentation requirements:

(a) When billing for an item in Table 122-0204, medical records shall corroborate that all criteria in this rule are met;

(b) When billing for quantities of supplies greater than those described in Table 122-0204-1 as the usual maximum amounts, there shall be clear documentation in the client's medical records corroborating the medical appropriateness of the current use;

(c) When a battery powered compressor (E0571) is dispensed, supporting documentation that justifies the medical appropriateness shall be on file with the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider;

(d) The DMEPOS provider shall maintain these medical records and make them available to the Division upon request.

(4) **Table 122-0204-1**.

(5) **Table 122-0204-2**.

[ED. NOTE: Table referenced is available from the agency.]

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0205
Respiratory Assist Devices

(1) As referenced in this policy, non-invasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy).

(2) Indications and Coverage — General:

(a) The "treating prescribing practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD);

(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state regulatory requirements;

(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider. For purposes of this policy's coverage and payment guidelines, a DMEPOS provider is not considered a qualified provider or supplier of these tests;

(d) If there is discontinuation of usage of E0470 or E0471 device at any time, the provider is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

(3) Coverage criteria for E0470 and E0471 devices – Table 122-0205-1.

(4) Documentation:

(a) The following documentation must be submitted with the request for prior authorization (PA) and the original kept on file by the provider:

(A) An order for all equipment and accessories including the client's diagnosis, an ICD-10-CM code signed and dated by the treating prescribing practitioner;

(B) Summary of events from the polysomnogram, if required in this rule under the indications and coverage section or Table 122-0205-1;

(C) Arterial blood gas results, if required under the indications and coverage section or Table 122-0205-1;

(D) Sleep oximetry results, if required under the indications and coverage section or Table 122-0205-1;

(E) Treating prescribing practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea;

(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth month review;

(b) A copy of the Evaluation of Respiratory Assist Device (Division 2461) completed and signed by the client, family member or caregiver;

(c) Clients currently using BiPapS and BiPap ST are not subject to the new criteria.

(5) Table **122-0205-1**, Respiratory Assist Devices.

(6) Table **122-0205-2**, Procedure Codes.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-122-0206
Intermittent Positive Pressure Breathing

E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source the Division will rent. Covered if medically appropriate for the following indications:

(1) Clients at risk of respiratory failure because of decreased respiratory function secondary to kyphoscoliosis or neuromuscular disorders.

(2) Clients with severe bronchospasm or exacerbated chronic obstructive pulmonary disease (COPD) who fail to respond to standard therapy.

(3) The management of atelectasis that has not improved with simple therapy.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0207
Respiratory Supplies

Table 122-0207.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0208
Suction Pumps

(1) Indications and Limitations of Coverage:

(a) Use of a home model respiratory suction pump may be covered for a client who has difficulty raising and clearing secretions secondary to:

(A) Cancer or surgery of the throat or mouth; or

(B) Dysfunction of the swallowing muscles; or

(C) Unconsciousness or obtunded state; or

(D) Tracheostomy; or

(E) Neuromuscular conditions;

(b) When a respiratory suction pump (E0600) is covered, tracheal suction catheters are separately payable supplies. In most cases, in the home setting, sterile catheters are medically appropriate only for tracheostomy suctioning. Three suction catheters per day are covered for medically appropriate tracheostomy suctioning, unless additional documentation is provided. When a tracheal suction catheter is used in the oropharynx, which is not sterile, the catheter can be reused if properly cleansed and/or disinfected. In this situation, the medical appropriateness for more than three catheters per week requires additional documentation;

(c) Sterile saline solution (A4216, A4217) may be covered and separately payable when used to clear a suction catheter after tracheostomy suctioning. It is not usually medically appropriate for oropharyngeal suctioning. Saline used for tracheal lavage is not covered;

(d) Supplies (A4628) are covered and are separately payable when they are medically appropriate and used with a medically appropriate suction pump (E0600) in a covered setting;

(e) When a suction pump (E0600) is used for tracheal suctioning, other supplies (e.g., cups, basins, gloves, solutions, etc.) are included in the tracheal care kit code, A4625–(see OAR 410-122-0209 for details). When a suction pump is used for oropharyngeal suctioning, these other supplies are not medically appropriate;

(f) The suction device must be appropriate for home use without technical or professional supervision. Those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.

(2) A client's medical record must reflect the need for the supplies dispensed and billed. The medical record must be kept on file by the durable medical equipment (DME) provider and made available to the Division of Medical Assistance Programs (Division) upon request.

(3) A portable or stationary home model respiratory suction pump (E0600) is an electric aspirator designed for oropharyngeal and tracheal suction.

(4) A portable or stationary home model gastric suction pump (E2000) is an electric aspirator designed to remove gastrointestinal secretions.

(5) A tracheal suction catheter is a long, flexible catheter.

(6) An oropharyngeal catheter is a short, rigid (usually) plastic catheter of durable construction.

(7) Code E0600 must not be used for a suction pump used with gastrointestinal tubes.

(8) Code E2000 must be used for a suction pump used with gastrointestinal tubes.

(9) Providers should contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor for guidance on the correct coding of these items.

(10) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be clear documentation in the client's medical records corroborating the medical appropriateness for the higher utilization. The Division may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities billed.

(11) **Table 122-0208**, Suction Pumps.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0209
Tracheostomy Care Supplies

(1) Indications and Coverage: For a client following an open surgical tracheostomy that has been open or is expected to remain open for at least three months:

(a) Standard tracheostomy supplies, including tracheostomy tubes (A7520, A7521), do not require prior authorization;

(b) Custom/Specialized tracheostomy tubes must be a device that requires the manufacturer to complete substantive customization or modification for a specific individual's medical need;

(c) Custom/Specialized tracheostomy tubes require prior authorization and shall be approved with clinical documentation supporting the medical appropriateness and a statement from the prescribing practitioner explaining why a standard or off-the-shelf tracheostomy tube will not meet the client's medical needs.

(2) Documentation:

(a) A prescription for tracheal equipment that is signed by the prescribing practitioner shall be kept on file by the DMEPOS provider. The prescribing practitioner's records shall contain information that supports the medical appropriateness of the item ordered;

(b) Custom/Specialized tracheostomy tubes require an assessment every six months indicating a standard tracheostomy tube does not currently meet the medical needs of the client. Documentation shall be submitted to the Division at the time of request.

(3) Billing:

(a) Custom/Specialized tracheostomy tubes shall be billed using the correct HCPCS code and modifier 22;

(b) Custom/Specialized tracheostomy tubes shall be reimbursed following the payment methodology outlined in OAR 410-122-0186 for manually priced items.

(4) Procedure Codes – Table 122-0209.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 9-2015, f. 2-26-15, cert. ef. 3-1-15

410-122-0210
Ventilators

(1) Indications and limitations of coverage:

(a) Mechanical ventilatory support may be provided to a client for the purpose of life support during therapeutic support of suboptimal cardiopulmonary function, or therapeutic support of chronic ventilatory failure;

(b) A ventilator may be covered by the Division for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. This includes both positive and negative pressure types;

(c) A ventilator for pediatric home ventilator management may be covered on a case-by-case basis based on medical appropriateness, evidence-based medicine and best health practices.

(2) Primary Ventilators:

(a) A primary ventilator may be covered if supporting documentation indicates:

(A) A client is unable to be weaned from the ventilator or is unable to be weaned from use at night; or

(B) Alternate means of ventilation were used without success; or

(C) A client is ready for discharge and has been on a ventilator more than 10 days;

(b) E0450, E0460, E0461 or E0472 may be covered if:

(A) A client has no respiratory drive either due to paralysis of the diaphragm or a central brain dysfunction; or

(B) A client has a stable, chronic condition with no orders to wean from the ventilator; or

(C) A client has had a trial with blood gases and has no signs or symptoms of shortness of breath or increased work of breathing; or

(D) A client has uncompromised lung disease;

(c) E0463 or E0464 may be covered if supporting documentation indicates:

(A) A client has chronic lung disease where volume ventilation may further damage lung tissue; or

(B) A client has a compromised airway or musculature and has respiratory drive and a desire to breathe; or

(C) A client will eventually be weaned from the ventilator; or

(D) A client has compromised respiratory muscles from muscular dystrophies or increased resistance from airway anomalies or scoliosis conditions.

(3) Secondary Ventilators:

(a) A secondary ventilator, identical or similar to the primary ventilator, may be covered when necessary to serve a different medical need of a client;

(b) For example (not all-inclusive), a secondary ventilator may be covered when:

(A) A client requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure respiratory assist device with a nasal mask) during the rest of the day; or

(B) A client is confined to a wheelchair who requires a ventilator permanently mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed.

(4) Reimbursement Rates:

(a) Reimbursement rates for ventilators are calculated based on consideration that break down or malfunction of a ventilator could result in immediate life-threatening consequences for a client. Therefore ventilators are reimbursed on a monthly rental payment for as long as the equipment is medically appropriate;

(b) Payment includes:

(A) The durable medical equipment (DME) provider ensuring that an appropriate and acceptable contingency plan to address emergency situations or mechanical failures of the primary ventilator is in place. This could mean that the provider furnishes a backup ventilator;

(B) Any equipment, supplies, services, including respiratory therapy (respiratory care) services, routine maintenance and training necessary for the effective use of the ventilator;

(c) Secondary Ventilators: The maximum reimbursement rate is one-half the maximum allowable fee for the primary ventilator.

(5) The client must have a telephone or reasonable access to one.

(6) A backup ventilator provided as a precautionary measure for emergency situations in which the primary ventilator malfunctions is not separately payable by the Division.

(7) Prior authorization (PA):

(a) PA is not required when E0450, E0460, E0461, E0463, E0464 or E0472 is dispensed as the primary ventilator. The provider is responsible to ensure all rule requirements are met;

(b) PA is required for a secondary ventilator:

(A) Payment authorization is required prior to the second date of service and before submitting claims. See Oregon Administrative Rule (OAR) 410-120-0000 (General Rules);

(B) Payment authorization will be given once all required documentation has been received and any other applicable rules and criteria have been met; and

(C) Payment authorization is obtained from the same authorizing authority as specified in OAR 410-122-0040.

(8) Documentation Requirements:

(a) For services requiring payment authorization or PA, submit documentation that supports coverage criteria in this rule are met;

(b) Documentation that coverage criteria have been met must be present in the client's medical records, kept on file with the DME provider and made available to the Division on request.

Table 122-0210

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0211
Cough Stimulating Device

(1) Indications and Limitations of Coverage and Medical Appropriateness: The Division of Medical Assistance Programs (Division) may cover a cough stimulating device, alternating positive and negative airway pressure for a client who meets the following criteria:

(a) The client has been diagnosed with a neuromuscular disease as identified by one of the following diagnosis codes:

(A) Late effects of acute poliomyelitis;

(B) Cystic fibrosis;

(C) Werdnig-Hoffmann disease—anterior horn cell disease unspecified;

(D) Multiple sclerosis — quadriplegia and quadriparesis;

(E) Myoneural disorders;

(F) Disorders of diaphragm;

(G) Fracture of vertebral column, cervical, or dorsal (thoracic);

(H) Late effect of spinal cord injury;

(I) Late effect of injury to a nerve root or roots, spinal plexus or plexuses and other nerves of trunk;

(J) Spinal cord injury without evidence of spinal bone injury, cervical or dorsal (thoracic); and

(b) Standard treatment such as chest physiotherapy (e.g., chest percussion and postural drainage, etc.) has been tried and documentation supports why these modalities were not successful in adequately mobilizing retained secretions; or

(c) Standard treatment such as chest physiotherapy (e.g., chest percussion and postural drainage, etc.) is contraindicated and documentation supports why these modalities were ruled out; and

(d) The condition is causing a significant impairment of chest wall or diaphragmatic movement, such that it results in an inability to clear retained secretions.

(2) Procedure Code:

(a) E0482 (cough stimulating device, alternating positive and negative airway pressure)—prior authorization required;

(b) The Division will purchase or rent on a monthly basis (limited to the lowest cost alternative);

(c) E0482 is considered purchased after no more than ten months of rent;

(d) E0482 may be covered for a client residing in a nursing facility;

(e) The fee includes all equipment, supplies, services, routine maintenance, and necessary training for the effective use of the device.

(3) Documentation Requirements: Submit specific documentation from the treating practitioner that supports coverage criteria in this rule are met and may include, but is not limited to, evidence of any of the following:

(a) Poor, ineffective cough;

(b) Compromised respiratory muscles from muscular dystrophies or scoliosis;

(c) Diaphragmatic paralysis;

(d) Frequent hospitalizations or emergency department/urgent care visits due to pneumonias.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 14-2016, f. 3-22-16, cert. ef. 4-1-16

410-122-0220
Pacemaker Monitor

(1) E0610 — Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems:

(a) The Division will purchase;

(b) Also covered for payment by the Division when client is a resident of a nursing facility.

(2) E0615 — Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems:

(a) The Division will purchase;

(b) Also covered for payment by the Division when client is a resident of a nursing facility.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993 f. & cert. ef. 4-1-93; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0240
Apnea Monitors for Infants

(1) Indications and limitations of coverage and medical appropriateness:

(a) For infants less than 12 months of age with documented apnea, or who have known risk factors for life-threatening apnea, the Division may cover home apnea monitors and related supplies for any of the following indications:

(A) Up to three months for:

(i) Apnea of prematurity: Sudden cessation of breathing that lasts for at least 20 seconds, is accompanied by bradycardia (heart rate less than 80 beats per minute), or is accompanied by oxygen desaturation (O2 saturation less than 90 percent or cyanosis) in an infant younger than 37 weeks gestational age;

(ii) Apparent life-threatening event (ALTE): An episode that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging;

(iii) Documented gastroesophageal reflux disease (GERD) that results in apnea, bradycardia, or oxygen desaturation;

(iv) Documented prolonged apnea of greater than 20 seconds in duration;

(v) Documented apnea accompanied by bradycardia to less than 80 beats per minute;

(vi) Documented apnea accompanied by oxygen desaturation (below 90 percent), cyanosis, or pallor;

(vii) Documented apnea accompanied by marked hypotonia;

(viii) When off medication for bradycardia previously treated with caffeine, theophylline, or similar agents;

(B) Upon discharge from an acute care facility for up to one month post-diagnosis for diagnosis of pertussis with positive cultures;

(C) As the later sibling of an infant who died of Sudden Infant Death Syndrome (SIDS), until the later sibling is one month older than the age at which the earlier sibling died and remains event-free;

(D) On a case-by-case basis for:

(i) Infants with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise;

(ii) Infants with neurologic or metabolic disorders affecting respiratory control;

(iii) Infants with chronic lung disease (bronchopulmonary dysplasia), especially those requiring supplemental oxygen, continuous positive airway pressure, or mechanical ventilation;

(b) Infant apnea monitors are usually considered medically appropriate for no longer than approximately three months except for specific conditions listed above;

(c) The rental fee includes all training, instruction, assistance, 24-hour on-call support, and any other needed services for effective use of the apnea monitor, including cardiopulmonary resuscitation training. The durable medical equipment prosthetics orthotics and supplies (DMEPOS) provider is responsible for ensuring delivery of these services;

(d) The Division may cover related supplies necessary for the effective functioning of the apnea monitor for a three-month period based on the following limitations:

(A) Electrodes, per pair (A4556) — 3 units;

(B) Lead wires, per pair (A4557) — 2 units;

(C) Conductive paste or gel (A4558) — 1 unit;

(D) Belts (A4649) — 2 units;

(e) The cost of apnea monitor rental includes the cost of cables;

(f) The Division does not cover apnea monitors with memory recording (E0619) when the attending physician is monitoring the infant with ongoing sleep studies and pneumograms.

(2) Coding guidelines: For billing purposes, use diagnosis code 798.0, Sudden Infant Death Syndrome (SIDS), for later siblings of infants who died of SIDS.

(3) Documentation requirements: Submit the following information with the prior authorization (PA) request:

(a) Documentation (medical records including hospital records, sleep studies, physician's progress notes, physician-interpreted report from an apnea monitor with memory recording, etc.) of the episode or episodes that led to the diagnosis;

(b) An order from the physician who diagnosed the infant as having clinically significant apnea or known risk factors for life-threatening apnea. The physician's order shall indicate the specific type of apnea monitor (with or without recording feature) and detailed information about the type and quantity of related supplies needed;

(c) For an apnea monitor with recording feature (E0619), submit documentation that supports why an apnea monitor without recording feature (E0618) is not adequate to meet the medical need;

(d) When dispensing and billing for an item in Table 122-0240, the provider shall ensure that documentation corroborates that all criteria in this rule are met;

(e) The DMEPOS provider shall maintain documentation and make it available to the Division upon request.

(4) Table 122-0240.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0250
Breast Pumps

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover electric breast pumps for any of the following conditions:

(A) Medical appropriateness for infant:

(i) Pre-term;

(ii) Term and hospitalized beyond five days;

(iii) Separated from mother for an undetermined length of time;

(iv) Cleft palate or cleft lip;

(v) Cranial-facial abnormalities;

(vi) Inability to suck adequately;

(vii) Re-hospitalized for longer than two days;

(viii) Failure to thrive;

(B) Medical appropriateness for mother:

(i) Breast abscess;

(ii) Mastitis;

(iii) Hospitalized due to illness or surgery (for short-term use to maintain lactation);

(iv) Short-term treatment with medications that may be transmitted to the infant;

(v) A hand pump or manual expression has been tried for one week without success in mothers with established milk supply;

(b) Documentation that transition to breast feeding started as soon as the infant was stable enough to begin breast feeding;

(c) Use E1399 for an electric breast pump starter kit for single or double pumping;

(d) An electric breast pump starter kit will be reimbursed separately from the breast pump rental;

(e) Electric breast pump rental cannot exceed 60 days,

(f) An electric breast pump may only be purchased when cost effective for one of the following conditions:

(i) Cleft palate or cleft lip;

(ii) Cranial-facial abnormalities;

(iii) Inability to suck adequately;

(iv) Infant is separated from mother for an undetermined length of time;

(g) Electric breast pump rental charges apply to the purchase price;

(h) The following services are not covered:

(i) Accessories;

(ii) An electric breast pump for the comfort and convenience of the mother;

(iii) Supplemental Nutrition System (SNS);

(iv) Heavy duty, hospital grade breast pumps;

(v) Replacement parts.

(2) Documentation requirements:

(a) For services that require prior authorization (PA): Submit documentation for review which supports conditions of coverage as specified in this rule are met;

(b) For services that do not require PA: Medical records which support conditions of coverage as specified in this rule are met must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request.

(3) Procedure Codes:

(a) E0602 — Breast pump, manual, any type — the Division will purchase;

(b) E0603 — Breast pump, electric (AC and/or DC), any type:

(A) The Division will purchase or rent on a monthly basis;

(B) PA required; .

(c) E1399 — Electric breast pump starter kit;

(A) The Division will purchase;

(B) PA required.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08

410-122-0260
Home Uterine Monitoring

(1) Home uterine monitoring (S9001) requires prior authorization (PA) and may be approved for the following conditions:

(a) Pre-term labor with one or more of the following complications:

(A) Incompetent cervix;

(B) Cervical cerclage;

(C) Polyhydramnios;

(D) Anomalies of the uterus;

(E) History of cone biopsy;

(F) Cervical dilation or effacement;

(G) Unknown etiology.

(b) History of pre-term labor and delivery;

(c) Multiple gestation.

(2) Uterine monitoring will only be approved for the above conditions between the 24th and through the completion of the 36th week of pregnancy.

(3) The Division will provide coverage for rental only. The allowable rental fee for the uterine monitor includes all equipment, supplies, services, and nursing visits necessary for the effective use of the monitor. This does not include medications or prescribing practitioner's professional services.

(4) The client must have landline telephone or reasonable access to one. The Division will not be responsible for providing the landline telephone or landline access.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; DMAP 61-2014, f. 10-3-14, cert. ef. 10-7-14

410-122-0280
Heating/Cooling Accessories

Procedure Codes for Heating/Cooling Accessories: Table 122-0280.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993 f. & cert. ef. 4-1-93; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0300
Light Therapy

(1) Phototherapy (bilirubin light therapy):

(a) The Division may cover home phototherapy for a term or near-term infant whose elevated bilirubin is not due to a primary hepatic disorder or other hemolytic disorder that requires inpatient care;

(b) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instruction, and 24-hour on-call service necessary for the effective use of the equipment;

(c) Documentation by the treating physician shall indicate home phototherapy is the appropriate treatment modality;

(d) Home phototherapy may be covered for any of the following conditions:

(A) Jaundice in healthy term (>37 weeks) infant ready to be discharged or recently discharged from the hospital; feeding well/appears well with serum bilirubin values as follows:

(i) 25–48 hours old ≥12 mg/dl total serum bilirubin; or

(ii) 49–72 hours old ≥15 mg/dl total serum bilirubin; or

(iii) >72 hours old ≥ 17 mg/dl total serum bilirubin; or

(B) Jaundice in preterm infant <37 weeks when total serum bilirubin level is ≥10mg/dl;

(e) Treatment days will be determined based on lab values.

(2) Documentation Requirements:

(a) For services that require PA: Submit documentation for review that supports conditions of coverage as specified in this rule are met;

(b) For services that do not require PA: Medical records that support conditions of coverage as specified in this rule are met shall be on file with the DMEPOS provider and made available to the Division upon request.

(3) Table 122-0300 Light Therapy.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0320
Manual Wheelchair Base

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The Division may cover a manual wheelchair when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADL); places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010, Definitions, for complete definition of MRADL;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the manual wheelchair that is being requested;

(D) Use of a manual wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

(E) The client is willing to use the requested manual wheelchair in the home, and will use it on a regular basis in the home;

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested manual wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

(b) Division may authorize a manual wheelchair for any of the following situations, only when conditions of coverage as specified in (1) (a) of this rule are met:

(A) When the wheelchair can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a manual wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a manual wheelchair may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of manual wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a manual wheelchair;

(B) For a purchase request, when a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement cost;

(C) When a covered, client-owned wheelchair is in need of repair, Division may pay for one month's rental of a wheelchair. (See OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing).

(c) Division does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

(d) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. Division does not reimburse for adapting living quarters;

(e) Division does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(f) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(g) Division may cover an adult tilt-in-space wheelchair (E1161) when a client meets all of the following conditions:

(A) A standard base with a reclining back option will not meet the client's needs;

(B) Is dependent for transfers;

(C) Spends a minimum of six hours a day in a wheelchair;

(D) The client's plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(E) Has one of the following:

(i) High risk of skin breakdown;
(ii) Poor postural control, especially of the head and trunk;
(iii) Hyper/hypotonia;
(iv) Need for frequent changes in position and has poor upright sitting;
(h) One month's rental for a manual adult tilt-in-space wheelchair (E1161) may be covered for a client residing in a nursing facility when all of the following conditions are met:
(A) The anticipated nursing facility length of stay is 30 days or less;
(B) The conditions of coverage for a manual tilt-in-space wheelchair as described in (1)(g)(A)(E) are met;
(C) The client is expected to have an ongoing need for this same wheelchair after discharge to the home setting;
(D) Coverage is limited to one month's rental;
(i) Division may cover a standard hemi (low seat) wheelchair (K0002) when a client requires a lower seat height (17" to 18") because of short stature or needing assistance to place his/her feet on the ground for propulsion;
(k) Division may cover a lightweight wheelchair (K0003) when a client:
(A) Cannot self-propel in a standard wheelchair using arms and/or legs; and
(B) Can and does self-propel in a lightweight wheelchair.
(j) High-strength lightweight wheelchair (K0004):
(A) Division may cover a high-strength lightweight wheelchair (K0004) when a client:
(i) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or
(ii) Requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.
(B) If the expected duration of need is less than three months (e.g., post-operative recovery), a high-strength lightweight wheelchair is rarely medically appropriate;
(l) Division may cover an ultra-lightweight wheelchair (K0005) when a client has medical needs that require determination on a case-by-case basis;
(m) Division may cover a heavy-duty wheelchair (K0006) when a client weighs more than 250 pounds or has severe spasticity;
(n) Division may cover an extra heavy-duty wheelchair (K0007) when a client weighs more than 300 pounds;
(o) For a client residing in a nursing facility, an extra heavy-duty wheelchair (K0007) may only be covered when a client weighs more than 350 pounds;
(p) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement and Delivery;
(q) A manual wheelchair for use only outside the home is not covered.
(2) Coding Guidelines:
(a) Adult manual wheelchairs (K0001–K0007, K0009, E1161) have a seat width and a seat depth of 15" or greater;
(b) For codes K0001–K0007 and K0009, the wheels must be large enough and positioned so that the user can self-propel the wheelchair;
(c) In addition, specific codes are defined by the following characteristics:
(A) Adult tilt-in-space wheelchair (E1161):
(i) Ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining the same back-to-seat angle; and
(ii) Lifetime warranty on side frames and crossbraces.
(B) Standard wheelchair (K0001):
(i) Weight: Greater than 36 pounds; and
(ii) Seat height: 19" or greater; and
(iii) Weight capacity: 250 pounds or less.
(C) Standard hemi (low seat) wheelchair (K0002):
(i) Weight: Greater than 36 pounds; and
(ii) Seat height: Less than 19"; and
(iii) Weight capacity: 250 pounds or less.
(D) Lightweight wheelchair (K0003):
(i) Weight: 34–36 pounds; and
(ii) Weight capacity: 250 pounds or less.
(E) High strength, lightweight wheelchair (K0004):
(i) Weight: Less than 34 pounds; and
(ii) Lifetime warranty on side frames and crossbraces.
(F) Ultralightweight wheelchair (K0005):
(i) Weight: Less than 30 pounds;
(ii) Adjustable rear axle position; and
(iii) Lifetime warranty on side frames and crossbraces.
(G) Heavy duty wheelchair (K0006) has a weight capacity greater than 250 pounds;
(H) Extra heavy duty wheelchair (K0007) has a weight capacity greater than 300 pounds.
(d) Coverage of all adult manual wheelchairs includes the following features:
(A) Seat width: 15"–19";
(B) Seat depth: 15"–19";
(C) Arm style: Fixed, swingaway, or detachable, fixed height;
(D) Footrests: Fixed, swingaway, or detachable.
(e) Codes K0003–K0007 and E1161 include any seat height;
(f) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);
(g) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);
(h) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings;
(i) A manual wheelchair with a seat width and/or depth of 14" or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229 (see 410-122-0720 Pediatric Wheelchairs) unless determination by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor for the wheelchair is otherwise indicated;
(j) For more information on other features included in the allowance for the wheelchair base, see 410-122-0340 Wheelchair Options/Accessories;
(k) Contact PDAC regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.
(3) Documentation Requirements:
(a) Functional Mobility Evaluation:
(A) Providers must submit medical documentation that supports conditions of coverage in this rule are met for purchase and modifications of all covered, client-owned manual wheelchairs except for K0001, K0002, or K0003 (unless modifications are required).
(B) Information must include, but is not limited to:
(i) Medical justification, needs assessment, order, and specifications for the wheelchair, completed by a physical therapist (PT), occupational therapist (OT), treating physician or nurse practitioner. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; and
(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and
(iii) Signature and date by the treating physician or nurse practitioner and the PT or OT.
(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order;
(b) Additional documentation:

(A) Information from a PT, OT, treating physician or nurse practitioner that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a PT, OT, treating physician or nurse practitioner about the following elements that support coverage criteria are met for a manual wheelchair; only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, power-operated vehicle (POV), or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs, or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Documentation from a PT, OT, treating physician or nurse practitioner that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since Division determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options; and

(E) Detailed information about client-owned equipment (including serial numbers), as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it can't be grown or modified, if applicable; and

(F) For the home assessment, prior to delivery of the wheelchair, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters. This assessment must support that the client's home can accommodate and allow for the effective use of a wheelchair. This assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc.; and

(G) All HCPCS codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that will be separately billed;

(c) A written order by the treating physician or nurse practitioner, identifying the specific type of manual wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority;

(d) For purchase of K0001, K0002 or K0003 (without modifications), send documentation listed in (3)(b)(A)–(E);

(e) For an ultralight wheelchair (K0005), documentation from a PT, OT, treating physician or nurse practitioner that includes a description of the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home. This may include what types of activities the client frequently encounters and whether the client is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base;

(f) When code K0009 is requested, send all information from a PT, OT, treating physician or nurse practitioner that justifies the medical appropriateness for the item;

(g) Any additional documentation that supports indications of coverage are met as specified in this policy;

(h) For a manual wheelchair rental, submit all of the following:

(A) A written order from the treating physician or nurse practitioner, identifying the specific type of manual wheelchair needed:

(i) If the order does not specify the type of wheelchair requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested;

(ii) The DMEPOS provider may enter the items on this order;

(iii) This order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority;

(B) HCPCS codes;

(C) Documentation from the DMEPOS provider which supports that the client's home can accommodate and allow for the effective use of the requested wheelchair;

(i) All documentation listed in section (3) of this rule must be kept on file by the DMEPOS provider;

(j) Documentation that coverage criteria have been met must be present in the client's medical records and this documentation must be made available to Division on request.

(4) Table 122-0320 — Manual Wheelchair Base.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 18-1994(Temp), f. & cert. ef. 4-1-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30- 94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0325
Motorized/Power Wheelchair Base

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover a power wheelchair (PWC) (K0813-K0816, K0820-K0829, K0835-K0843, K0848-K0864, K0898) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs); places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010, Definitions, for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day:

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the PWC that is being requested;

(E) Use of a PWC will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(F) The client is willing to use the requested PWC in the home, and the client will use it on a regular basis in the home;

(G) The client has either:

(i) Strength, postural stability, or other physical or mental capabilities insufficient to safely operate a power-operated vehicle (POV) in the home; or

(ii) Living quarters that do not provide adequate access between rooms, maneuvering space, and surfaces for the operation of a POV with a small turning radius;

(H) The client has either:

(i) Sufficient mental and physical capabilities to safely operate the PWC that is being requested; or

(ii) A caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the PWC that is being requested;

(I) The client's weight is less than or equal to the weight capacity of the PWC that is being requested;

(b) Only when conditions of coverage as specified in (1) (a) of this rule are met, may the Division authorize a PWC for any of the following situations:

(A) When the PWC can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a PWC will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a PWC may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of PWC coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a PWC;

(B) When a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement costs;

(C) When a covered client-owned wheelchair is in need of repair, the Division may pay for one month's rental of a wheelchair (see OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing);

(c) For a PWC to be covered, the treating physician or nurse practitioner must conduct a face-to-face examination of the client before writing the order and the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device:

(A) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(B) The physician or nurse practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination;

(i) If the client was referred to the PT/OT before being seen by the physician or nurse practitioner, then once the physician or nurse practitioner has received and reviewed the written report of this examination, the physician or nurse practitioner must see the client and perform any additional examination that is needed. The physician's or nurse practitioner's report of the visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician or nurse practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the physician or nurse practitioner;

(ii) If the physician or nurse practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician or nurse practitioner visit. However, it is also acceptable for the physician or nurse practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician or nurse practitioner must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician or nurse practitioner signs and dates the PT/OT examination;

(iii) If the PWC is a replacement of a similar item that was previously covered by the Division or when only PWC accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(d) The Division does not reimburse for another chair if a client has a medically appropriate wheelchair, regardless of payer;

(e) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. The Division does not reimburse for adapting the living quarters;

(f) The equipment must be supplied by a DMEPOS provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client;

(g) The provider's ATP must be employed by a provider in a full-time, part-time or contracted capacity as is acceptable by state law. The provider's ATP, if part-time or contracted, must be under the direct control of the provider;

(h) Documentation must be complete and detailed enough so a third party would be able to understand the nature of the provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation;

(i) The provider's ATP may not conduct the provider evaluation at the time of delivery of the power mobility device to the client's residence;

(j) Reimbursement for wheelchair codes include all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the wheelchair;

(k) The delivery of the PWC must be within 120 days following completion of the face-to-face examination;

(l) A PWC may not be ordered by a podiatrist;

(m) The following services are not covered:

(i) A PWC for use only outside the home;

(ii) A PWC with a captain's chair for a client who needs a separate wheelchair seat and/or back cushion;

(iii) Items or upgrades that primarily allow performance of leisure or recreational activities including but not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, head lights, and tail lights;

(iv) Power mobility devices, not coded by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or does not meet criteria (K0899);

(v) Power wheelchairs, group 4 (K0868-K0871, K0877-K0880, K0884-K0886);

(vi) Power wheelchairs, not otherwise classified (K0898);

(vii) Seat elevator PWCs (E2300, K0830, K0831).

(2) Coding Guidelines:

(a) Specific types of PWCs:

(A) A Group 1 PWC (K0813–K0816) or a Group 2 Heavy Duty (HD), Very Heavy Duty (VHD), or Extra Heavy Duty (EHD) wheelchair (K0824-K0829) may be covered when the coverage criteria for a PWC are met;

(B) A Group 2 Standard PWC with a sling/solid seat (K0820, K0822) may be covered when:

(i) The coverage criteria for a PWC are met; and

(ii) The client is using a skin protection and/or positioning seat and/or back cushion that meets the coverage criteria defined in Wheelchair Options/Accessories, 410-122-0340;

(C) A Group 2 Single Power Option PWC (K0835–K0840) may be covered when the coverage criteria for a PWC are met; and

(i) The client either:

(I) Requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or

(II) Meets the coverage criteria for a power tilt or recline seating system (see Wheelchair Options/Accessories, 410-122-0340) and the system is being used on the wheelchair; and

(ii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, nurse practitioner or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, nurse practitioner or physician may have no financial relationship with the DMEPOS provider;

(D) A Group 2 Multiple Power Option PWC (K0841-K0843) may be covered when the coverage criteria for a PWC are met; and

(i) The client either:

(I) Meets the coverage criteria for a power tilt or recline seating system with three or more actuators (see Wheelchair Options/Accessories, 410-122-0340); or

(II) Uses a ventilator which is mounted on the wheelchair; and

(ii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT, OT, nurse practitioner or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, nurse practitioner or physician may have no financial relationship with the DMEPOS provider;

(E) A Group 3 PWC with no power options (K0848-K0855) may be covered when:

(i) The coverage criteria for a PWC are met; and

(ii) The client's mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity; and

(iii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, physician or nurse practitioner may have no financial relationship with the DMEPOS provider;

(F) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) may be covered when:

(i) The Group 3 criteria (2)(a)(E) (i-ii) are met; and

(ii) The Group 2 Single Power Option (2)(a)(C)(i)(I) or (II) and (2)(a)(C)(ii) or Multiple Power Options (2)(a)(D)(i)(I) or (II) and (2)(a)(D)(ii) (respectively) are met;

(b) PWC Basic Equipment Package: Each PWC code is required to include the following items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted):

(A) Lap belt or safety belt (E0978);

(B) Battery charger single mode (E2366);

(C) Complete set of tires and casters any type (K0090, K0091, K0092, K0093, K0094, K0095, K0096, K0097, K0099);

(D) Legrests. There is no separate billing/payment if fixed or swingaway detachable non-elevating legrests with/without calf pad (K0051, K0052, E0995) are provided. Elevating legrests may be billed separately;

(E) Fixed/swingaway detachable footrests with/without angle adjustment footplate/platform (K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0052);

(F) K0040 may be billed separately with K0848 through K0864;(G) Armrests. There is no separate billing/ payment if fixed/swingaway detachable non-adjustable armrests with arm pad (K0015, K0019, K0020) are provided. Adjustable height armrests may be billed separately;

(H) Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair (E0981, E0982);

(I) Weight specific components per patient weight capacity;

(J) Controller and Input Device: There is no separate billing/payment if a non-expandable controller and proportional input device (integrated or remote) is provided. If a code specifies an expandable controller as on option (but not a requirement) at the time of initial issue, it may be separately billed;

(c) If a client needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it may be appropriate to request a captain's chair seat rather than a sling/solid seat/back and a separate general use seat and/or back cushion;

(d) A PWC with a seat width or depth of 14" or less is considered a pediatric PWC base and is coded E1239, PWC, pediatric size, not otherwise specified (see OAR 410-122-0720 Pediatric Wheelchairs);

(e) Contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician or nurse practitioner:

(A) This report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) Why a POV can't meet this client's mobility needs in the home;

(v) This client's physical and mental abilities to operate a PWC safely in the home:

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in activities of daily living (ADLs), how these conditions will be ameliorated or compensated by use of the wheelchair;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility

assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home;

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or PWC and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a PWC may use that device outside the home, because the Division coverage of a wheelchair is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's or nurse practitioner's written order, received by the DMEPOS provider within 45 days (date stamp or equivalent must be used to document receipt date) after the physician's or nurse practitioner's face-to-face examination. The order must include all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "power wheelchair" or "power mobility device"– or may be more specific:

(i) If this order does not identify the specific type of PWC that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific PWC that is being ordered and any options and accessories requested;

(ii) The items on this clarifying order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination;

(C) Date of the face-to-face examination;

(D) Pertinent diagnoses/conditions and diagnosis codes that relate specifically to the need for the PWC;

(E) Length of need;

(F) Physician's or nurse practitioner's signature;

(G) Date of physician's or nurse practitioner's signature;

(c) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it can't be grown or modified, if applicable;

(e) For the home assessment, prior to or at the time of delivery of a PWC, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters. This assessment must support that the client's home can accommodate and allow for the effective use of a PWC. Assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) A written document (termed a detailed product description) prepared by the DMEPOS provider and signed and dated by the physician or nurse practitioner that includes:

(i) The specific base (HCPCS code and manufacturer name/model) and all options and accessories (including HCPCS codes), whether PA is required or not, that will be separately billed;

(ii) The DMEPOS provider's charge and the Division fee schedule allowance for each separately billed item;

(iii) If there is no Division fee schedule allowance, the DMEPOS provider must enter "not applicable";

(iv)The DMEPOS provider must receive the signed and dated detailed product description from the physician or nurse practitioner prior to delivery of the PWC;

(v) A date stamp or equivalent must be used to document receipt date of the detailed product description; and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The DMEPOS provider must keep the above documentation on file;

(i) Documentation that the coverage criteria have been met must be present in the client's medical records and made available to the Division on request.

(4) Prior Authorization:

(a) All codes in this rule required PA and may be purchased, rented and repaired;

(b) Codes specified in this rule are not covered for clients residing in nursing facilities;

(c) Reimbursement on standard Group 1 and 2 wheelchairs without power option (K0813–K0816, K0820–K0829) will only be made on a monthly rental basis.

(d) Rented equipment is considered purchased when the Division fee schedule allowable for purchase is met, or the actual charge from the provider is met, whichever is the lowest;

(5) Table 122-0325.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 12-27-12; DMAP 57-2012, f. & cert. ef 12-27-12

410-122-0330
Power-Operated Vehicle

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover a power-operated vehicle (POV) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs); places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day:

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;

(E) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the POV being requested;

(F) Use of a POV will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(G) The client is willing to use the requested POV in the home, and the client will use it on a regular basis in the home;

(H) The Division does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup POVs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if the POV meets the same need, custom colors, and wheelchair gloves;

(b) For a POV to be covered, the treating physician or nurse practitioner must conduct a face-to-face examination of the client before writing the order:

(A) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device.

(B) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(C) The physician or nurse practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination:

(i) If the client was referred to the PT/OT before being seen by the physician or nurse practitioner, then once the physician or nurse practitioner has received and reviewed the written report of this examination, the physician or nurse practitioner must see the client and perform any additional examination that is needed. The physician's or nurse practitioner's report of the visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician or nurse practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the physician or nurse practitioner;

(ii) If the physician or nurse practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician or nurse practitioner visit. However, it is also acceptable for the physician or nurse practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician or nurse practitioner must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician or nurse practitioner signs and dates the PT/OT examination;

(iii) If the POV is a replacement of a similar item that was previously covered by the Division or when only POV accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(c) The Division may authorize a new POV when a client's existing POV is no longer medically appropriate; or repair and/or modifications to the POV exceed replacement costs;

(d) If a client has a medically appropriate POV regardless of payer, the Division will not reimburse for another POV;

(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.;

(f) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the POV;

(g) If a client-owned POV meets coverage criteria, medically appropriate replacement items, including but not limited to batteries, may be covered;

(h) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically appropriate;

(i) The Division will cover one month's rental of a POV if a client-owned POV is being repaired;

(j) The following services are not covered:

(A) POV for use only outside the home; and

(B) POV for a nursing facility client.

(2) Coding guidelines:

(a) Codes K0800 — K0802 are used only for POVs that can be operated inside the home;

(b) Codes K0800 — K0802 are not used for a manual wheelchair with an add-on tiller control power pack;

(c) A replacement item, including but not limited to replacement batteries, should be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified);

(d) For guidance on correct coding, DMEPOS providers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician or nurse practitioner:

(A) The report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) This client's physical and mental abilities to operate a POV (scooter) safely in the home:

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions will be ameliorated or compensated;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a POV may use that device outside the home, because the Division's coverage of a POV is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's or nurse practitioner's written order, received by the DMEPOS provider within 30 days after the physician's or nurse practitioner's face-to-face examination, which includes all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "POV" or "power mobility device" — or may be more specific:

(i) If this order does not identify the specific type of POV that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific POV that is being ordered and any options and accessories requested;

(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination.

(C) Most significant ICD-10 diagnosis code that relates specifically to the need for the POV;

(D) Length of need;

(E) Physician's or nurse practitioner's signature;

(F) Date of physician's or nurse practitioner's signature;

(c) For all requested equipment and accessories, include the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) All HCPCS to be billed on this claim (both codes that require authorization and those that do not require authorization); and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The above documentation must be kept on file by the DMEPOS provider;

(i) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to the Division on request.

(4) Billing:

(a) Procedure Codes:

(A) K0800 Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds — PA;

(B) K0801 Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds — PA;

(C) K0802 Power operated vehicle, group 1 very heavy duty, patient weight capacity, 451 to 600 pounds — PA;

(b) The Division will purchase, rent and repair;

(c) Item considered purchased after 13 months of rent.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-122-0340
Wheelchair Options/Accessories

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover options and accessories for covered wheelchairs when the following criteria are met:

(A) The client has a wheelchair that meets Division coverage criteria; and

(B) The client requires the options/accessories to accomplish their mobility-related activities of daily living (MRADLs) in the home. See 410-122-0010, Definitions, for definition of MRADLs;

(b) The Division does not cover options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities;

(c) Arm of Chair:

(A) Adjustable arm height option (E0973, K0017, K0018, K0020) may be covered when the client:

(i) Requires an arm height that is different than what is available using nonadjustable arms; and

(ii) Spends at least two hours per day in the wheelchair;

(B) An arm trough (E2209) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements;

(d) Foot rest/Leg rest:

(A) Elevating leg rests (E0990, K0046, K0047, K0053, K0195) may be covered when:

(i) The client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or

(ii) The client has significant edema of the lower extremities that requires having an elevating leg rest; or

(iii) The client meets the criteria for and has a reclining back on the wheelchair;

(B) Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per leg rest;

(C) Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests;

(e) Nonstandard Seat Frame Dimensions:

(A) For all adult wheelchairs, the Division includes payment for seat widths and/or seat depths of 15-19 inches in the payment for the base code. These seat dimensions must not be separately billed;

(B) Codes E2201–E2204 and E2340–E2343 describe seat widths and/or depths of 20 inches or more for manual or power wheelchairs;

(C) A nonstandard seat width and/or depth (E2201–E2204 and E2340–E2343) is covered only if the patient's dimensions justify the need;

(f) Rear Wheels for Manual Wheelchairs: Code K0064 (flat free insert) is used to describe either:

(A) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or

(B) Non-removable foam material in a foam filled rubber tire;

(C) K0064 is not used for a solid self-skinning polyurethane tire;

(g) Batteries/Chargers:

(A) Up to two batteries (E2360–E2365) at any one time are allowed if required for a power wheelchair;

(B) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base;

(h) Seating:

(A) The Division may cover a general use seat cushion and a general-use wheelchair back-cushion for a client whose wheelchair that meets Division coverage criteria;

(B) A skin protection seat cushion may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets Division coverage criteria; and

(ii) The client has either of the following:

(I) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or

(II) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis), post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease;

(C) A positioning seat cushion, positioning back cushion, and positioning accessory (E0955–E0957, E0960) may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets Division coverage criteria; and

(ii) The client has any significant postural asymmetries due to one of the diagnoses listed in criterion (h) (B)(ii)(II) or to one of the following diagnoses: monoplegia of the lower limb; hemiplegia due to stroke, traumatic brain injury, or other etiology; muscular dystrophy; torsion dystonias; spinocerebellar disease;

(D) A combination skin protection and positioning seat cushion may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion;

(E) Separate payment is allowed for a seat cushion solid support base (E2231) with mounting hardware when it is used on an adult manual wheelchair (K0001–K0009, E1161);

(F) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion;

(G) There is no separate payment for mounting hardware for a seat or back cushion;

(H) There is no separate payment for a headrest (E0955, E0966) on a captain's seat on a power wheelchair;

(I) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient:

(i) Basic materials include liquid foam or a block of foam and sheets of fabric or liquid coating material:

(I) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately;

(II) The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface;

(ii) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, computer-aided design and computer-aided manufacturing (CAD-CAM) technology, or detailed measurements of the patient used to create a configured cushion:

(I) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated;

(II) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion;

(iii) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617;

(J) A custom fabricated seat cushion may be covered if criteria (i) and (iii) are met. A custom fabricated back cushion may be covered if criteria (ii) and (iii) are met:

(i) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;

(ii) Client meets all of the criteria for a prefabricated positioning back cushion;

(iii) There is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs;

(K) A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification as published by the Pricing, Data Analysis and Coding (PDAC) contractor by the Centers for Medicare and Medicaid Services; or which does not meet the criteria stated in this rule is not covered;

(L) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest;

(M) The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion;

(N) A solid insert (E0992) is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support and is included in the allowance for a seat cushion;

(O) A solid support base for a seat cushion is a rigid piece of plastic or other material that is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2231 for this solid support base;

(i) The Division will only cover accessories billed under the following codes when PDAC has made written confirmation of use of the code for the specific product(s) being billed: E2601–E2608, E2611-E2616, E2620, E2621; E2609 and E2617 (brand-name products), K0108 (for wheelchair cushions):

(A) Information concerning the documentation that must be submitted to PDAC for a Coding Verification Request can be found on the PDAC Web site or by contacting PDAC;

(B) A Product Classification List with products that have received a coding verification can be found on the PDAC Web site;

(j) Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955–E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(k) Power seating systems:

(A) A power-tilt seating system (E1002):

(i) Includes all the following:

(I) A solid seat platform and a solid back; any frame width and depth;

(II) Detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests;

(IV) Fixed or flip-up footplates;

(V) Motor and related electronics with or without variable speed programmability;

(VI) Switch control that is independent of the power wheelchair drive control interface;

(VII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability for the supplier to adjust the seat to back angle;

(IV) Ability to support patient weight of at least 250 pounds;

(B) A power recline seating system (E1003-E1005):

(i) Includes all the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth;

(III) Detachable or flip-up fixed height or adjustable height arm rests;

(IV) Fixed or swingaway detachable leg rests;

(V) Fixed or flip-up footplates;

(VI) A motor and related electronics with or without variable speed programmability;

(VII) A switch control that is independent of the power wheelchair drive control interface;

(VIII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to recline to greater than or equal to 150 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability to support patient weight of at least 250 pounds;

(C) A power tilt and recline seating system (E1006-E1008):

(i) Includes the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swing-away detachable leg rests; fixed or flip-up footplates;

(IV) Two motors and related electronics with or without variable speed programmability;

(V) Switch control that is independent of the power wheelchair drive control interface;

(VI) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Ability to recline to greater than or equal to 150 degrees from horizontal;

(III) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds;

(D) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises, a mechanical linkage between the two panels allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(E) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises, a separate motor controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(F) A power leg elevation feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s);

(l) Codes E2310 and E2311 (Power Wheelchair Accessory):

(A) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or non-proportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing;

(B) Include a function selection switch that allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected;

(C) When the wheelchair drive function is selected the indicator feature may also show the direction that is selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface;

(D) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present);

(E) When a switch is medically appropriate and a client has adequate hand motor skills, a switch would be considered the least costly alternative;

(F) E2310 or E2311 may be considered for coverage when a client does not have hand motor skills or presents with cognitive deficits, contractures or limitation of movement patterns that prevents operation of a switch;

(G) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick);

(H) If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it is not covered;

(m) Power Wheelchair Drive Control Systems:

(A) The term interface in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc;

(B) A proportional interface is one in which the direction and amount of movement by the client controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick;

(C) A non-proportional interface is one that involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a non-proportional interface is a sip-and-puff mechanism;

(D) The term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface) and convert that input into power output to the motor and gears in the power wheelchair base;

(E) A switch is an electronic device that turns power to a particular function either "on" or "off". The external component of a switch may be either mechanical or non-mechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of non-mechanical switches include, but are not limited to, proximity, infrared, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component;

(F) A stop switch allows for an emergency stop when a wheelchair with a non-proportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch is sometimes referred to as a kill switch;

(G) A direction change switch allows the client to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time;

(H) A function selection switch allows the client to determine what operation is being controlled by the interface at any particular time. Operations may include, but are not limited to, drive forward, drive backward, tilt forward, recline backward, etc.;

(I) An integrated proportional joystick and controller is an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair;

(J) The interfaces described by codes E2320–E2322, E2325, and E2327–E2330 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking;

(K) A remote joystick (E2320, E2321) is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. These codes include remote joysticks that are used for hand control as well as joysticks that are used for chin control. Code E2320 includes any type of proportional remote joystick stick including, but not limited to standard, mini-proportional, compact, and short throw remote joysticks;

(L) When code E2320 or E2321 is used for a chin control interface, the chin cup is billed separately with code E2324;

(M) Code E2320 also describes a touchpad that is an interface similar to the pad-type mouse found on portable computers;

(N) Code E2322 describes a system of 3-5 mechanical switches that are activated by the client touching the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch, if provided, are included in the allowance for the code;

(O) Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick — e.g., U shape or T shape — or that have some other nonstandard feature — e.g., flexible shaft;

(P) A sip and puff interface (E2325) is a non-proportional interface in which the client holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit that is described by code E2326;

(Q) A proportional, mechanical head control interface (E2327) is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the client's head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code;

(R) A proportional, electronic head control interface (E2328) is one in which a client's head movements are sensed by a box placed behind the client's head.

The direction and amount of movement of the client's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the client's arm or leg control the direction and speed of the wheelchair;

(S) A non-proportional, contact switch head control interface (E2329) is one in which a client activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(T) A non-proportional, proximity switch head control interface (E2330) is one in which a client activates one of three switches placed around the back and sides of their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(U) The KC modifier (replacement of special power wheelchair interface):

(i) Is used in the following situations:

(I) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface — e.g., remote joystick, head control, sip and puff, etc.; or

(II) The client has a drive control interface described by codes E2320–E2322, E2325, or E2327–E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage;

(ii) The KC modifier is never used at the time of initial issue of a wheelchair;

(iii) The KC modifier specifically states replacement, therefore, the RP modifier is not required;

(n) Other Power Wheelchair Accessories: An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface may be covered if the client has a covered speech generating device. (See division 129, Speech-Language Pathology, Audiology and Hearing Aid Services.);

(o) Miscellaneous Accessories:

(A) Anti-rollback device (E0974) is covered if the client propels himself/herself and needs the device because of ramps;

(B) A safety belt/pelvic strap (E0978) is covered if the client has weak upper body muscles, upper body instability or muscle spasticity that requires use of this item for proper positioning;

(C) A shoulder harness/straps or chest strap (E0960) and a safety belt/pelvic strap (E0978) are covered only to treat a client's medical symptoms:

(i) A medical symptom is defined as an indication or characteristic of a physical or psychological condition;

(ii) E0960 and E0978 are not covered when intended for use as a physical restraint or for purposes intended for discipline or convenience of others;

(D) One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028) would be to move the component out of the way so that a client could perform a slide transfer to a chair or bed;

(E) A fully reclining back option (E1226) is covered if the client spends at least 2 hours per day in the wheelchair and has one or more of the following conditions/needs:

(i) Quadriplegia;

(ii) Fixed hip angle;

(iii) Trunk or lower extremity casts/braces that require the reclining back feature for positioning;

(iv) Excess extensor tone of the trunk muscles; and/or

(v) The need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(2) Documentation Requirements: Submit documentation that supports coverage criteria in this rule are met and the specified information as follows with the prior authorization (PA) request:

(a) When code K0108 is billed, a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical appropriateness for the item;

(b) Options/accessories for individual consideration might include documentation on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment;

(c) For a custom-fabricated seat cushion:

(A) A comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a DMEPOS provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs, and;

(B) Diagnostic reports that support the medical condition;

(C) Dated and clear photographs;

(D) Body contour measurements;

(d) Documentation that the coverage criteria in this rule have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to the Division on request.

(3) **Table 122-0340** — 1.

(4) **Table 122-0340** — 2.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12

410-122-0360
Canes and Crutches

(1) Indications and Coverage: When prescribed by a practitioner for a client with a condition causing impaired ambulation and there is a potential for ambulation.

(2) A white cane for a visually impaired client is considered to be a self-help item and is not covered by the Division.

(3) Table 122-0360.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0365
Standing and Positioning Aids

(1) Indications and coverage: If a client has one aid that meets medical needs, regardless of who obtained it, the Division may not provide another aid of same or similar function.

(2) Documentation to be submitted for PA and kept on file by the Durable Medical Equipment (DME) provider:

(a) Documentation of medical appropriateness, which has been reviewed and signed by the prescribing practitioner;

(b) The care plan outlining positioning and treatment regime and all DME currently available for use by the client;

(c) The physician's order;

(d) The documentation for a customized positioner shall include objective evidence that commercially available positioners are not appropriate;

(e) Each item requested shall be itemized with description of product, make, model number, and manufacturers' suggested retail price (MSRP);

(f) Submit Positioner Justification form (DMAP 3155) or reasonable facsimile with recommendation for most appropriate equipment. This shall be submitted by a physical therapist, occupational therapist, or prescribing practitioner when requesting a PA;

(3) Gait Belts:

(a) Covered when:

(A) The client weighs 60 lbs. or more; and

(B) The care provider is trained in the proper use; and

(C) The client can walk independently but needs:

(i) A minor correction of ambulation; or

(ii) Minimal or standby assistance to walk alone; or

(iii) Requires assistance with transfer;

(b) Use code E0700.

(4) Standing frame systems, prone standers, supine standers or boards, and accessories for standing frames are covered when:

(a) The client has been sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and,

(b) The client is following a therapy program initially established by a physical or occupational therapist; and

(c) The home is able to accommodate the equipment; and

(d) The weight of the client does not exceed manufacturer's weight capacity; and

(e) The client has demonstrated an ability to utilize the standing aid independently or with caregiver; and

(f) The client has demonstrated compliance with other programs; and

(g) The client has demonstrated a successful trial period in a monitored setting; and

(h) The client does not have access to equipment from another source.

(5) Sidelyers and custom positioners shall meet the following criteria in addition to the criteria in Table 122-0365:

(a) The client shall be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and

(b) The client shall be following a therapy program initially established by a physical or occupational therapist; and,

(c) The home shall be able to accommodate the equipment; and

(d) The caregiver or family are capable of using the equipment appropriately.

(6) Criteria for Specific Accessories:

(a) A back support may be covered when a client:

(A) Needs balance, stability, or positioning assistance; or

(B) Has extensor tone of the trunk muscles; or

(C) Needs support while being raised or while completely standing;

(b) A tall back may be covered when:

(A) The client is over 5'11" tall; and

(B) The client has no trunk control and needs additional support; or

(C) The client has more involved need for assistance with balance, stability, or positioning;

(c) Hip guides may be covered when a client:

(A) Lacks motor control or strength to center hips; or

(B) Has asymmetrical tone that causes hips to pull to one side; or

(C) Has spasticity; or

(D) Has low tone or high tone; or

(E) Needs balance, stability, or positioning assistance;

(d) A shoulder retractor or harness may be covered when:

(A) Erect posture cannot be maintained without support due to lack of motor control or strength; or

(B) Has kyphosis; or

(C) Presents strong flexor tone;

(e) Lateral supports may be covered when a client:

(A) Lacks trunk control to maintain lateral stability; or

(B) Has scoliosis that requires support; or

(C) Needs a guide to find midline;

(f) A headrest may be covered when a client:

(A) Lacks head control and cannot hold head up without support; or

(B) Has strong extensor thrust pattern that requires inhibition;

(g) Independent adjustable knee pads may be covered when a client:

(A) Has severe leg length discrepancy; or

(B) Has contractures in one leg greater than the other;

(h) An actuator handle extension may be covered when a client:

(A) Has no caregiver; and

(B) Is able to transfer independently into standing frame; and

(C) Has limited range of motion in arm or shoulder and cannot reach actuator in some positions;

(i) Arm troughs may be covered when a client:

(A) Has increased tone that pulls arms backward so hands cannot come to midline; or

(B) Has poor tone, strength, or control that causes arms to hang out to side and backward causing pain and risking injury; or

(C) Has needs for posture;

(j) A tray may be covered when proper positioning cannot be accomplished by other accessories;

(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;

(L) Sandals (shoe holders) may be covered when a client:

(A) Has dorsiflexion of the foot or feet; or

(B) Has planar flexion of the foot or feet; or

(C) Has eversion of the foot or feet; or

(D) Has need for safety.

(7) **Table 122-0365**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0375
Walkers

(1) Indications and Limitations of Coverage:

(a) A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if both of the following criteria are met:

(A) When prescribed by a treating practitioner for a client with a medical condition impairing ambulation and there is a potential for increasing ambulation; and

(B) When there is a need for greater stability and security than provided by a cane or crutches;

(b) For an adult gait trainer, use the appropriate walker code. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157), that code may be separately billed;

(c) A heavy duty walker (E0148, E0149) is covered for clients who meet coverage criteria for a standard walker and who weigh more than 300 pounds

(d) A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for clients who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand;

(e) When a walker with an enclosed frame (E0144) is dispensed to a client, documentation must support why a standard folding wheeled walker, E0143, was not provided as the least costly medically appropriate alternative;

(f) Enhancement accessories of walkers are non-covered;

(g) Leg extensions (E0158) are covered only for patients six feet tall or more.

(2) Coding Guidelines:

(a) A wheeled walker (E0141, E0143, E0149) is one with either two, three or four wheels. It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel;

(b) A glide-type brake consists of a spring mechanism (or equivalent) which raises the leg post of the walker off the ground when the patient is not pushing down on the frame;

(c) Code E0144 describes a folding wheeled walker which has a frame that completely surrounds the patient and an attached seat in the back;

(d) A heavy duty walker (E0148, E0149) is one which is labeled as capable of supporting patients who weigh more than 300 pounds. It may be fixed height or adjustable height. It may be rigid or folding;

(e) Code E0147 describes a 4-wheeled, adjustable height, folding-walker that has all of the following characteristics:

(A) Capable of supporting patients who weigh greater than 350 pounds;

(B) Hand operated brakes that cause the wheels to lock when the hand levers are released;

(C) The hand brakes can be set so that either or both can lock both wheels;

(D) The pressure required to operate each hand brake is individually adjustable;

(E) There is an additional braking mechanism on the front crossbar;

(F) At least two wheels have brakes that can be independently set through tension adjustability to give varying resistance;

(f) The only walkers that may be billed using code E0147 are those products listed in the Product Classification List on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor's web site;

(g) An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes

(other than those described in code E0147), or basket (or equivalent);

(h) A4636, A4637, and E0159 are only used to bill for replacement items for covered, patient-owned walkers. Codes E0154, E0156, E0157, and E0158 can be used for accessories provided with the initial issue of a walker or for replacement components. Code E0155 can be used for replacements on covered, patient-owned wheeled walkers or when wheels are subsequently added to a covered, patient-owned non-wheeled walker (E0130, E0135). Code E0155 cannot be used for wheels provided at the time of, or within one month of, the initial issue of a non-wheeled walker;

(i) Hemi-walkers must be billed using code E0130 or E0135, not E1399;

(j) A gait trainer is a term used to describe certain devices that are used to support a client during ambulation;

(k) Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code:

(l) See attached Table 122-0375-1

(l) Providers should contact PDAC for guidance on the correct coding of these items.

(3) Documentation: An order for each item billed must be signed and dated by the treating practitioner, kept on file by the DMEPOS provider, and made available to the Division upon request. The treating practitioner's records must contain information that supports the medical appropriateness of the item ordered, including height and weight.

(4) Table 122-0375-1.

(5) Table 122-0375-2.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0380
Hospital Beds

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover some hospital beds for a covered condition including:

(a) A fixed height hospital bed (E0250, E0251, E0290 and E0291) when the client meets at least one of the following criteria:

(A) Has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed;

(B) Requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain;

(C) Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges shall have been considered and ruled out;

(D) Requires traction equipment that can only be attached to a hospital bed;

(b) A variable height hospital bed (E0255, E0256, E0292 and E0293) when all of the following criteria are met:

(A) Criteria for a fixed height hospital bed are met;

(B) A bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position is required;

(c) A semi-electric hospital bed (E0260, E0261, E0294 and E0295) when all of the following criteria are met:

(A) Criteria for a fixed height hospital bed are met;

(B) Frequent changes or an immediate need for a change in body position are required;

(C) The client is capable of safely and effectively operating the bed controls;

(d) A heavy duty extra wide hospital bed (E0301, E0303) when all of the following criteria are met:

(A) Criteria for a fixed height hospital bed are met;

(B) The client weighs more than 350 pounds but less than 600 pounds;

(C) The client is capable of safely and effectively operating the bed controls;

(e) An extra heavy duty hospital bed (E0302, E0304) when all of the following are met:

(A) Criteria for one of the hospital beds described in (1)(a)-(d) are met;

(B) The client weighs more than 600 pounds;

(C) The client is capable of safely and effectively operating the bed controls;

(D) When provided for a nursing facility client, the bed shall be rated for institutional use;

(f) Total electric hospital beds (E0265, E0266, E0296 and E0297) are not covered since the height adjustment feature is considered a convenience feature;

(g) Payment Authorization: Subject to service limitations of Division rules, a hospital bed rental may be dispensed without PA only from the initial date of service through the second date of service. The durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting any claims to the Division regardless of the date of service, including the initial and second dates of service, and will be given once all required documentation has been received and any other applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040. Required documentation shall be received by the authorizing authority prior to the third date of service.

(2) Documentation requirements: Submit documentation that has been reviewed, signed, and dated by the prescribing practitioner and that supports conditions of coverage as specified in this rule are met including:

(a) For all hospital beds:

(A) Primary diagnosis code for the condition necessitating the need for a hospital bed;

(B) The type of bed currently used by the client and why it doesn't meet the medical needs of the client;

(b) For semi-electric beds: Why a variable height bed cannot meet the medical needs of the client;

(c) For heavy duty and extra heavy duty beds: The client's height and weight.

(3) **Table 122-0380** — Hospital Beds.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0400
Pressure Reducing Support Surfaces

(1) Indications and limitations of coverage and medical appropriateness:

(a) Group 1 (A4640, E0180–E0182, E0184–E0189, and E0196-E0199):

(A) The Division of Medical Assistance Programs (Division) may cover a Group 1 support surface when the client meets:

(i) Criterion (I), or;

(ii) Criteria (II) or (III) and at least one of criteria (IV)–(VII):

(I) Completely immobile — i.e., client cannot make changes in body position without assistance;

(II) Limited mobility — i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(III) Any stage pressure ulcer on the trunk or pelvis;

(IV) Impaired nutritional status;

(V) Fecal or urinary incontinence;

(VI) Altered sensory perception;

(VII) Compromised circulatory status;

(B) The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider must provide a support surface in which the client does not "bottom out";

(C) The Division does not cover foam overlays or mattresses without a waterproof cover, since these are not considered durable;

(D) The Division does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(E) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(b) Group 2 (E0193, E0277, and E0371–E0373):

(A) A Group 2 support surface may be covered for up to an initial three month rental period when the client meets:

(i) Criterion (I) and (II) and (III), or;

(ii) Criterion (IV), or;

(iii) Criterion (V) and (VI);

(I) Multiple stage II pressure ulcers located on the trunk or pelvis;

(II) Client has been on a comprehensive ulcer treatment program for at least the past month which includes the following: use of an appropriate Group 1 support surface; education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer); appropriate turning and positioning; appropriate wound care (for a stage II, III, or IV ulcer); appropriate management of moisture/incontinence; and nutritional assessment and intervention consistent with the overall plan of care;

(III) The ulcers have worsened or remained the same over the past month;

(IV) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis A large wound is generally any wound of eight square centimeters (length x width) or more. Individual client circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the client may be taken into account;

(V) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days)

(VI) The client has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days);

(B) The DMEPOS provider must provide a support surface in which the patient does not "bottom out";

(C) When a Group 2 surface is requested following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery

(D) The Division may cover continued use of a Group 2 support surface if healing continues;

(E) The Division does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(F) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(c) Division may consider coverage for bariatric pressure reducing support surfaces only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of Division rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric pressure reducing support surface has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor;

(d) Group 3: Air-fluidized beds (E0194) are not covered.

(2) Definitions for Group 1 and Group 2:

(a) Bottoming out: Finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side-lying position;

(b) Plan of care: Written guidelines developed to identify specific problems and needs of the client and interventions/regimen necessary to assist the client to achieve optimal health potential. Developing the plan of care includes establishing measurable client and nursing goals with time lines and determining nursing/caregiver/other discipline-assigned interventions to meet care objectives;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers;

(3) Guidelines:

(a) Group 1:

(A) Codes E0185 and E0197–E0199 termed "pressure pad for mattress" describe non-powered pressure reducing mattress overlays and are designed to be placed on top of a standard hospital or home mattress;

(B) A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of two inches or greater;

(C) An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump;

(D) A water mattress overlay (E0198) is characterized by a filled height of three inches or greater;

(E) A foam mattress overlay (E0199) is characterized by all of the following:

(i) Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., egg crate) or an overall height of at least three inches if it is a non-convoluted overlay; and

(ii) Foam with a density and other qualities that provide adequate pressure reduction; and

(iii) Durable, waterproof cover;

(F) Codes E0184, E0186, E0187 and E0196 describe non-powered pressure reducing mattresses;

(G) A foam mattress (E0184) is characterized by all of the following:

(i) Foam height of five inches or greater;

(ii Foam with a density and other qualities that provide adequate pressure reduction;

(iii) Durable, waterproof cover; and

(iv) Can be placed directly on a hospital bed frame;

(H) An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

(i) Height of five inches or greater of the air, water, or gel layer (respectively);

(ii) Durable, waterproof cover; and

(iii) Can be placed directly on a hospital bed frame;

(I) Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss) and are characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 2 inches or greater; and

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out;

(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640;

(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a client-owned E0180 or E0181 mattress overlay system;

(L) A Column II code is included in the allowance for the corresponding Column I code when provided at the same time: Column I (Column II), E0180 (A4640, E0182), E0181 (A4640, E0182);

(b) Group 2:

(A) Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

(a) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(b) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(c) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(d) A surface designed to reduce friction and shear; and

(e) Can be placed directly on a hospital bed frame;

(B) Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above;

(C) Code E0371 describes an advanced non-powered pressure-reducing mattress overlay which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;

(ii) Total height of three inches or greater;

(iii) A surface designed to reduce friction and shear; and

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces;

(D) Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 3 ? inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear;

(E) Code E0373 describes an advanced non-powered pressure reducing mattress which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;

(ii) Total height of five inches or greater;

(iii) A surface designed to reduce friction and shear;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces; and

(v) Can be placed directly on a hospital bed frame;

(F) The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by PDAC;

(G) Alternating pressure mattresses and low air loss mattresses are coded using code E0277;

(H) Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with three powered air cells on top of a three foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

(4) Documentation requirements: Submit the following information with the prior authorization request:

(a) Initial Requests:

(A) For all pressure reducing support surfaces, other than a Group I for a completely immobile client or a Group 2 surface following a myocutaneous flap or skin graft:

(i) An order for each item requested, signed and dated by the attending physician;

(ii) Documentation that supports conditions of coverage are met as specified in this rule;

(iii) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following: Education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;

(II) Regular assessment by a nurse, physician, or other licensed healthcare practitioner;

(III) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(IV) Appropriate wound care (for a stage II, III, or IV ulcer);

(V) Appropriate management of moisture/incontinence;

(VI) Nutritional assessment and intervention consistent with the overall plan of care by a licensed healthcare practitioner (by a registered dietitian for a client in a nursing facility) within the last 90 days;

(VII) Client's weight and height (approximation is acceptable, if unable to obtain);

(VIII) Description of all pressure ulcers, which includes number, locations, stages, sizes and dated photographs;

(iv) Lab reports, if relevant;

(v) Other treatments and products that have been tried and why they were ineffective; Interventions and goals for stepping down the intensity of support surface therapy;

(vi) For pressure ulcers on extremities, why pressure cannot be relieved by other methods;

(B) For a Group I surface for a completely immobile client:

(a) An order for each item requested, signed and dated by the attending physician;

(b) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following:

(I) Education of the client, if appropriate, and caregiver on the prevention of pressure ulcers;

(ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner

(iii) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(iv) Appropriate management of moisture/incontinence, if appropriate;

(C) For a Group 2 surface following a myocutaneous flap or skin graft:

(i) An order for each item requested, signed and dated by the treating physician;

(ii) Operative report;

(iii) Hospital discharge summary;

(iv) Plan of care;

(F) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or anyone in a financial relationship of any kind with the DMEPOS provider;

(G) Medical records must corroborate that all criteria in this rule are met when dispensing and billing for an item in Table 122-0400-1 and Table-122-400-2;

(H) Medical records must be kept on file by the DMEPOS provider and made available to the Division upon request;

(b) Subsequent Requests: May be authorized contingent on progress towards healing:

(A) For all pressure reducing support surfaces, other than a Group I surface for a completely immobile client or a Group 2 surface following a myocutaneous flap or skin graft:

(i) Progress notes from the attending physician;

(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare practitioner (by the RN resident care manager for a client in a nursing facility) which includes number, locations, stages, sizes and dated photographs;

(iii) Current plan of care;

(iv) Any other relevant documentation;

(B) For a Group I surface for a completely immobile client:

(i) Progress notes from the attending physician;

(ii) Current plan of care;

(iii) Any other relevant documentation;

(C) For a Group 2 surface following a myocutaneous flap or skin graft:

(i) Progress notes from the attending physician;

(ii) Current plan of care;

(iii) Any other relevant documentation.

(4) **Table 122-0400-1** — Group 1.

(5) **Table 122-0400-2** — Group 2.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-122-0420
Hospital Bed Accessories

(1) Table 122-0420, Hospital Bed Accessories Procedure codes — Trapeze Bars:

(a) Indications and coverage: Trapeze bars are indicated when a client needs this device to sit up because of respiratory condition, to change body position for other medical reasons, or to get in or out of bed;

(b) The Division may consider coverage for bariatric trapeze bars only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility), subject to service limitations of Division rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric trapeze bar has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor;

(C) Supporting documentation has been submitted to the appropriate authorizing authority for prior authorization;

(c) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(2) See **Table 122-0420** for procedure codes.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0475
Therapeutic Shoes for Diabetics

(1) Indications and Coverage:

(a) For each client, coverage of the footwear and inserts is limited to one of the following within one calendar year:

(A) One pair of custom-molded shoes (including inserts provided with such shoes) and two additional pair of inserts; or

(B) One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts.

(b) An individual may substitute modification of custom molded or extra-depth shoes instead of obtaining one pair of inserts, other than the initial pair of inserts. The most common shoe modifications are:

(A) Rigid rocker bottoms;

(B) Roller bottoms;

(C) Metatarsal bars;

(D) Wedges;

(E) Offset heels.

(c) Payment for any expenses for the fitting of such footwear is included in the fee;

(d) Payment for the certification of the need for therapeutic shoes and for the prescription of the shoes (by a different practitioner from the one who certifies the need for the shoes) is considered to be included in the visit or consultation in which these services are provided;

(e) Following certification by the physician managing the client's systemic diabetic condition, a podiatrist or other qualified practitioner knowledgeable in the fitting of the therapeutic shoes and inserts may prescribe the particular type of footwear necessary.

(2) Documentation:

(a) The practitioner who is managing the individual's systemic diabetic condition documents that the client has diabetes and one or more of the following conditions:

(A) Previous amputation of the other foot or part of either foot;

(B) History of previous foot ulceration of either foot;

(C) History of pre-ulcerative calluses of either foot;

(D) Peripheral neuropathy with evidence of callus formation of either foot;

(E) Foot deformity of either foot; or

(F) Poor circulation in either foot; and

(G) Certifies that the client is being treated under a comprehensive plan of care for his or her diabetes and that he or she needs therapeutic shoes;

(b) Documentation of the above criteria may be completed by the prescribing practitioner or supplier but shall be reviewed for accuracy and signed and dated by the certifying physician to indicate agreement and shall be kept on file by the DME supplier.

(3) **Table 122-0475**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. &

cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0480
Pneumatic Compression Devices (Used for Lymphedema)

(1) A pneumatic compression device (lymphedema pump) is medically appropriate only for the treatment of refractory lymphedema involving one or more limbs.

(2) Causes of lymphedema include, but are not limited to, the following conditions with a diagnosis on the currently funded lines of the Prioritized List of Health Services:

(a) Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;

(b) Radical surgical procedures with removal of regional groups of lymph nodes;

(c) Post-radiation fibrosis;

(d) Scarring of lymphatic channels (e.g., those with generalized refractory edema from venous insufficiency that is complicated by recurrent cellulitis) when all of the following criteria have been met:

(A) There is significant ulceration of the lower extremity;

(B) The client has received repeated, standard treatment from a practitioner using such methods as a compression bandage system or its equivalent;

(C) The ulcer has failed to heal after six months of continuous treatment;

(e) Congenital anomalies.

(3) Pneumatic compression devices may be covered only when prescribed by a practitioner and when they are used with appropriate practitioner oversight, i.e., practitioner evaluation for the client's condition to determine medical appropriateness of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment. Used as treatment of last resort.

(4) All pressure devices require a one-month trial period prior to purchase. The rental period is applied toward purchase.

(5) All necessary training to utilize a pressure device is included in the rental or purchase fee.

(6) Documentation:

(a) The practitioner shall document the client's condition, medical appropriateness and instruction as to the pressure to be used, the frequency and duration of use, and that the device is achieving the purpose of reduction and control of lymphedema;

(b) The determination by the practitioner of the medical appropriateness of pneumatic compression device shall include:

(A) The client's diagnosis and prognosis;

(B) Symptoms and objective findings, including measurements that establish the severity of the condition;

(C) The reason the device is required, including the treatments that have been tried and failed; and

(D) The clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the client (or caregiver) to apply the device for continued use in the home;

(c) Documentation of medical appropriateness that has been reviewed and signed by the prescribing practitioner (for example, CMN) shall be kept on file by the DME provider;

(d) If the client has venous stasis ulcers, documentation supporting the medical appropriateness for the device shall include a signed and dated statement from the prescribing practitioner indicating:

(A) The location and size of venous stasis ulcer;

(B) How long each ulcer has been continuously present;

(C) Whether the client has been treated with regular compression bandaging for the past six months;

(D) Whether the client has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results of the treatment;

(E) Other treatment for the venous stasis ulcer during the past six months;

(F) Whether the client has been seen regularly by a practitioner for treatment of venous stasis ulcers during the past six months.

(7) Procedure Codes — **Table 122-0480**.

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

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0500
Transcutaneous Electrical Nerve Stimulator (TENS)

(1) Indications and limitations of coverage and/or medical appropriateness: transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) is a device which utilizes electrical current delivered through electrodes placed on the surface of the skin. A TENS unit decreases the client's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves.

(2) A TENS unit may be covered for the treatment of:

(a) Acute post-operative pain:

(A) Coverage is usually limited to 30 days from the day of surgery; and,

(B) Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the attending physician; and,

(C) Payment is made only as a rental; and,

(D) Acute pain (less than three months duration) other than post-operative pain is not covered; or,

(b) Chronic, intractable pain:

(A) The pain has been present for at least three months; and,

(B) Other appropriate treatment modalities have been tried and failed; and,

(C) The presumed etiology of the pain is a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be medically appropriate are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain; and,

(D) The TENS unit must be used by the client on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period is paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain;

(E) For coverage of a purchase, the physician must determine that the client is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the client at the end of the trial period, must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.

(3) Documentation Requirements: Submit the following documentation from the attending or consulting physician with the prior authorization (PA) request:

(a) For both acute post-operative pain and chronic, intractable pain:

(A) A signed and dated order by the treating physician. The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit; and,

(B) Documentation of multiple medications and/or therapies that have been tried and failed; and,

(C) A new order, when purchase is requested (after the required trial period). The initial date on this order must not overlap the dates of the trial period.

(b) In addition, for a client with acute post-operative pain: date of surgery resulting in acute post-operative pain;

(c) In addition, for a client with chronic, intractable pain: location of the pain, the duration of time the client has had the pain, and the presumed etiology of the pain;

(d) For authorization of quantities of supplies greater than those described in this policy as the usual maximum amounts:

(A) Each request must include documentation supporting the medical appropriateness for the higher utilization; and,

(B) There must be clear documentation in the client's medical records corroborating the medical appropriateness of this amount.

(e) When ordering a 4 lead TENS unit, the client's medical record must document why 2 leads are insufficient to meet the client's needs;

(f) The Division of Medical Assistance Programs (Division) may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities requested.

(4) Rental Guidelines: During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc.

(5) Purchase Guidelines: If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.

(6) Coding guidelines:

(a) Separate allowance may be made for replacement supplies when they are medically appropriate and are used with a TENS unit that has been purchased and/or approved by the Division;

(b) If 2 TENS leads are medically appropriate, then a maximum of one unit of Code A4595 would be allowed per month; if 4 TENS leads are necessary, a maximum of two units per month would be allowed;

(c) If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally;

(d) There is no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit;

(e) Codes A4556 (Electrodes, [e.g., apnea monitor], per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically appropriate TENS owned by the client) are not valid for prior authorization. A4595 should be used instead;

(f) For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service;

(g) Replacement of lead wires (A4557) will be covered when they are inoperative due to damage and the TENS unit is still medically appropriate. Replacement more often than every 12 months is rarely medically appropriate;

(h) A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used);

(i) Other supplies, including but not limited to the following, are not separately payable: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

(j) Providers should contact the Medicare Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

(7) **Table 122-0500**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0510

Osteogenesis Stimulator

(1) Definitions:

(a) An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair;

(b) A noninvasive electrical stimulator is characterized by an external power source that is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site;

(c) An ultrasonic osteogenesis stimulator is a noninvasive device that emits low intensity, pulsed ultrasound signals to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via conductive coupling gel to stimulate fracture healing;

(2) Indications of coverage and medical appropriateness:

(a) Non-spinal Electrical Osteogenesis Stimulator:

(A) The Division may cover a non-spinal electrical osteogenesis stimulator (E0747) when any of the following criteria are met:

(i) Non-union of a long bone fracture (defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator);

(ii) Failed fusion of a joint other than in the spine, where a minimum of nine months has elapsed since the last surgery;

(iii) Congenital pseudarthrosis;

(B) Non-union of a long bone fracture shall be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site and with a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;

(C) A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal or metatarsal.

(b) Spinal Electrical Osteogenesis Stimulator:

(A) The Division may cover a spinal electrical osteogenesis stimulator (E0748) when any of the following criteria are met:

(i) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery;

(ii) Following a multilevel spinal fusion surgery;

(iii) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site;

(B) A multilevel spinal fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.);

(c) Ultrasonic Osteogenesis Stimulator:

(A) The Division may cover an ultrasonic osteogenesis stimulator (E0760) only when all of the following criteria are met:

(i) Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph shall include multiple views of the fracture site accompanied by a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and

(ii) The stimulator is intended for use prior to surgical intervention and with cast immobilization;

(B) Use of an ultrasonic osteogenic stimulator is not covered:

(i) For non-union fractures of the skull or vertebrae;

(ii) For tumor-related fractures;

(iii) For the treatment of a fresh fracture or delayed union; or

(iv) When used concurrently with other noninvasive osteogenic devices;

(C) The Division may cover ultrasonic conductive coupling gel as a separate service when an ultrasonic osteogenesis stimulator is covered.

(3) Coding guidelines: Use E1399 for ultrasonic conductive coupling gel.

(4) Documentation requirements:

(a) Submit the following with the PA request:

(A) Documentation that supports the coverage criteria specified in this rule for the stimulator requested are met;

(B) Copies of x-ray and operative reports;

(b) For an electrical osteogenic stimulator, a Certificate of Medical Necessity (CMN) that has been completed, signed, and dated by the treating physician may substitute for a written order if it contains all the required elements of an order;

(c) Additional medical records may be requested by the Division;

(d) The client's medical records shall reflect the need for the stimulator requested. The client's medical records include, but are not limited to, the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, and test/diagnostic reports.

(5) **Table 122-0510**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0515

Neuromuscular Electrical Stimulator (NMES)

Indications and limitations of coverage and medical appropriateness:

(1) A neuromuscular electrical stimulator (NMES) uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two broad categories of NMES.

(2) NMES for treatment of muscle atrophy.

(3) NMES devices in this category stimulate the muscle when the client is in a resting state to treat muscle atrophy.

(4) The Division of Medical Assistance Programs (Division) will cover NMES to treat muscle atrophy specific to disuse atrophy where nerve supply to the muscle is intact (including brain, spinal cord and peripheral nerves) and to treat other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).

(5) NMES to enhance functional activity of neurologically impaired clients: Specifically, the Division will cover NMES used to improve the ability to walk in clients with Spinal Cord Injury (SCI).

(6) This type of NMES is commonly referred to as functional electrical stimulation (FES). FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

(7) The Division will only cover NMES/FES for SCI clients for walking, who meet the following criteria:

(a) Client has completed at least 32 physical therapy sessions, directly performed one-on-one with the physical therapist with the NMES/FES device over a trial period of three months, with the specific goal of using the NMES/FES device to achieve walking, not to reverse or retard muscle atrophy;

(b) Therapists with the sufficient skills to provide these services are only employed at inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities;

(c) The physician treating the client for SCI will use this trial period to properly evaluate the person's ability to use the NMES/FES frequently and for the long term; and

(d) The client meets all of the following characteristics:

(e) Intact lower motor units (L1 and below) (both muscle and peripheral nerve);

(f) Muscle and joint stability for weight bearing at upper and lower extremities that demonstrates balance and control to maintain an upright support posture independently;

(g) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction;

(h) High motivation, commitment and cognitive ability to use NMES/FES devices for walking;

(i) Can transfer independently and demonstrates independent standing tolerance for at least three minutes;

(j) Demonstrated hand and finger function to manipulate controls;

(k) At least six-month post recovery spinal cord injury and restorative surgery;

(l) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

(m) Demonstrated willingness to use the device long-term;

(n) NMES/FES for walking is not covered in an SCI client with any of the following:

(A) Cardiac pacemaker;

(B) Severe scoliosis or severe osteoporosis;

(C) Skin disease or cancer at area of stimulation;

(D) Irreversible contracture;

(E) Autonomic dysflexia; or

(F) Treatment of muscle weakness due to the following conditions (not all-inclusive):

(i) Stroke; spinal cord injury; peripheral nerve injury; other central nervous system, spinal or peripheral nerve disease/condition affecting motor and/or sensory pathways to/from the muscles being stimulated;

(ii) Documentation requirements: Submit documentation that supports coverage criteria as specified in this rule are met.

(8) Procedure codes:

(a) A4595, Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES) — Includes all supplies necessary for the effective use of the device — Division will purchase — Prior authorization (PA) required;

(b) E0745, Neuromuscular stimulator, electronic shock unit — Division will rent — Purchased after no more than 13 months of rental — PA required.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0520

Glucose Monitors and Diabetic Supplies

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover home blood glucose monitors and related diabetic supplies for clients with diabetes who can self-monitor blood glucose (SMBG) or be monitored with assistance;

(b) Coverage of home blood glucose monitors is limited to clients meeting all of the following conditions:

(A) The client has diabetes that is being treated by a practitioner; and

(B) The glucose monitor and related accessories and supplies have been ordered by a practitioner who is treating the client's diabetes; and

(C) The client or caregiver has successfully completed a structured education and feedback program for self-monitoring of blood glucose and is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and

(D) The client or caregiver is capable of using the test results to assure the client's appropriate glycemic control; and

(E) The device is designed for home use;

(c) Home blood glucose monitors with special features (E2100 or E2101) may be covered for clients who meet the basic coverage criteria (1)(b)(A)–(E) of this rule and the following:

(A) For code E2100, the treating practitioner certifies that the client has a severe visual impairment (i.e., best corrected visual acuity of 20/200 or worse) requiring use of this special monitoring system; or

(B) For code E2101, the treating practitioner certifies that the client has an impairment of manual dexterity severe enough to require the use of this special monitoring system;

(d) If a glucose monitor is covered, lancets, blood glucose test reagent strips, glucose control solutions, insulin syringes, and spring powered devices for lancets may also be covered. Coverage limitations for these supplies are as follows:

(A) For A4258, only one spring powered device every six months;

(B) For A4253 and A4259, the provider of the test strips and lancets shall maintain in their records the order from the treating practitioner. The provider shall verify that the client has nearly exhausted their supply, before dispensing more test strips and lancets. The amount of test strips and lancets covered is based on the needs of the client according to the following limitations:

(i) For clients with type 2 diabetes not requiring multiple daily insulin injections, up to 50 test strips (1 unit) and 100 lancets (1 unit) at the time of diagnosis;

(ii) For clients with type 2 diabetes who require diabetic medication that may result in hypoglycemia, up to 50 test strips and 100 lancets per 90 days. An additional 50 test strips may be covered with clinical documentation of an acute change in glycemic control or active diabetic medication adjustment;

(iii) For clients with Type 1 diabetes and those with type 2 diabetes requiring multiple daily insulin injections, up to 100 test strips and 100 lancets per month;

(iv) For clients with gestational diabetes, up to 150 test strips and 200 lancets per month no longer than 60 days beyond the duration of the pregnancy;

(v) Quantities exceeding these utilization guidelines require prior authorization and may be covered when:

(I) Basic coverage criteria in (1)(b)(A)-(E) for home glucose monitors and related accessories and supplies are met; and

(II) The treating practitioner has seen the client and evaluated their diabetes control within six months prior to ordering quantities of test strips and lancets that exceed the utilization guidelines and has documented in the client's medical record the specific reason for the additional supplies for that particular client; and

(III) If refills of quantities of supplies that exceed utilization guidelines are dispensed, there shall be documentation in the physician's records (e.g., a specific narrative statement that adequately specifies the frequency at which the client is actually testing or a copy of the client's log) that the client is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the client is regularly using quantities of supplies that exceed the utilization guidelines, new documentation shall be present at least every six months;

(C) Home blood glucose monitors are subject to a limit of one monitor per two calendar years;

(e) Diabetic supply providers may not dispense a quantity of supplies exceeding a client's expected utilization. Providers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering practitioner that the atypical utilization is, in fact, warranted. Regardless of utilization, a provider may not dispense more than a three-month quantity of glucose testing supplies (i.e., up to 300 test strips, 300 lancets, and 500 insulin syringes) at a time. Prior authorization (PA) shall be obtained prior to dispensing amounts in excess of these utilization limits;

(f) Providers may contact the treating practitioner to renew an order; however, the request for renewal may only be made with the client's continued monthly use of testing supplies and only with the client's or caregiver's request to the provider for order renewal;

(g) An order refill does not have to be approved by the ordering practitioner; however, a client or their caregiver shall specifically request refills of glucose monitor supplies before they are dispensed. The provider may not automatically dispense a quantity of supplies on a predetermined regular basis, even if the client has "authorized" this in advance;

(h) Purchase fee for a glucose monitor includes normal, low and high-calibrator solution/chips (A4256), a battery (A4233, A4234, A4235 or A4236), and a spring-powered lancet device (A4258);

(i) The following services are not covered:

(A) Peroxide (A4244), betadine, or phisoHex (A4246, A4247);

(B) Alternate site blood glucose monitors;

(C) Blood glucose monitors and related supplies prescribed on an "as needed" basis;

(D) Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor;

(E) Disposable gloves;

(F) Home blood glucose disposable monitors;

(G) Jet injectors;

(H) Insulin delivery devices and related supplies other than those identified in this rule and OAR 410-122-0525;

(I) Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings;

(J) Urine test or reagent strips or tablets.

(2) Guidelines:

(a) Insulin-treated means that the client is receiving insulin injections to treat their diabetes. Insulin does not exist in an oral form and therefore clients taking oral medication to treat their diabetes are not insulin-treated;

(b) A severe visual impairment is defined as a best corrected visual acuity of 20/200 or worse in both eyes;

(c) An order renewal is the act of obtaining an order for an additional period of time beyond that previously ordered by the treating practitioner;

(d) An order refill is the act of replenishing quantities of previously ordered items during the time period in which the current order is valid;

(e) A4256 describes control solutions containing high, normal, and low concentrations of glucose that can be applied to test strips to check the integrity of the test strips. This code does not describe the strip or chip which is included in a vial of test strips and which calibrates the glucose monitor to that particular vial of test strips;

(f) For glucose test strips (A4253), 1 unit of service = 50 strips. For lancets (A4259), 1 unit of service = 100 lancets.

(3) Documentation requirements:

(a) For supplies requiring prior authorization (PA), submit documentation that supports coverage criteria as specified in this rule are met;

(b) The order for home blood glucose monitors and/or diabetic testing supplies shall include all of the following:

(A) All item(s) to be dispensed;

(B) The specific frequency of testing;

(C) The treating practitioner's signature;

(D) The date of the treating practitioner's signature;

(E) A start date of the order is only required if the start date is different than the signature date;

(c) A new order shall be obtained when there is a change in the testing frequency;

(d) For E2100 or E2101 in a client with impaired visual acuity, submit documentation that includes a narrative statement from the practitioner which indicates the client's specific numerical visual acuity (e.g., 20/400) and that this result represents "best corrected" vision;

(e) For E2101 clients with impaired manual dexterity, submit documentation that includes a narrative statement from the practitioner which indicates an explanation of the client's medical condition necessitating the monitor with special features;

(f) When requesting quantities of supplies that exceed utilization guidelines as specified in (1)(d)(B)(i)–(iv) (e.g., more than 100 blood glucose test strips per month for insulin-dependent diabetes mellitus), submit documentation supporting the medical appropriateness for the higher utilization as specified in (1)(d)(B)(v)(I)–(III) to the appropriate authorization authority for PA;

(g) Documentation that supports condition of coverage requirements for codes billed in this rule shall be kept on file by the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider and made available to the Division on request;

(h) The appropriate diagnosis code describing the condition that necessitates glucose testing shall be included on each claim for the monitor, accessories, and supplies;

(i) Diabetic supply providers are not prohibited from creating data collection forms in order to gather medically appropriate information; however, the Division will not rely solely on those forms to prove the medical appropriateness of services provided;

(j) A client's medical records shall support the justification for supplies dispensed and billed to the Division.

(4) Billing and Payment Guidelines:

(a) Diabetic supplies shall be billed using a National Drug Code (NDC). DMEPOS provider types shall submit claims with appropriate NDC and HCPCS codes to the Division via the Web Portal or Point of Sale Systems via professional claim format. Pharmacy provider types shall submit claims with appropriate NDC to the Division via the Web Portal or Point of Sale Systems via pharmacy claim format. Claims submitted on these systems without NDC's will not be processed. This NDC requirement applies to:

(A) Home glucose monitors; and

(B) Blood glucose test reagent strips;

(C) Lancets;

(D) Insulin syringes;

(E) Spring powered lancet devices;

(F) Calibrating solutions and chips;

(b) For specialized glucose monitors and the respective testing supplies, such as those with special features for the visually impaired and those with manual dexterity problems, the provider shall obtain PA. After PA the provider can submit a professional claim to the Division;

(c) Orders received from prescribing clinicians for blood glucose test reagent strips that exceed utilization guidelines outlined in section (1)(d)(B)(i)–(iv) will require PA from the Division. Diabetic supply providers may initially dispense up to utilization limits (i.e., 300 test strips, 300 lancets, and 500 insulin syringes) prior to obtaining PA for orders that exceed utilization guidelines. After PA is issued the remaining amount may be dispensed for a three-month time period.

(3) Procedure Codes: Table 122-0520 — Diabetic Supplies.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 12-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 82-2014, f. 12-23-14, cert. ef. 1-1-15

410-122-0525
External Insulin Infusion Pump

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division may cover an external insulin infusion pump for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus when criterion (A) or (B) is met and criterion (C) or (D) is met:

(A) C-peptide testing requirement:

(i) The C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method; or

(ii) For a client with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method; and

(iii) A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl.

(B) Beta cell autoantibody test is positive;

(C) The client has:

(i) Completed a comprehensive diabetes education program; and

(ii) Been on a program of multiple daily injections of insulin (i.e., at least three injections per day) with frequent self-adjustments of insulin dose for at least six months prior to initiation of the insulin pump; and

(iii) Documented frequency of glucose self-testing an average of at least four times per day during the two months prior to initiation of the insulin pump and meets one or more of the following criteria while on the multiple injection regimen:

(I) Glycosylated hemoglobin level (HbA1C) greater than 7 percent;

(II) History of recurring hypoglycemia;

(III) Wide fluctuations in blood glucose before mealtime;

(IV) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL;

(V) History of severe glycemic excursions;

(D) The client has:

(i) Been on an external insulin infusion pump prior to enrollment in the medical assistance program, and;

(ii) Documented frequency of glucose self-testing an average of at least four times per day during the month prior to medical assistance program enrollment;

(b) For continued coverage of an external insulin pump and supplies, the client shall be seen and evaluated by the treating physician at least every three months;

(c) The external insulin infusion pump shall be ordered and follow-up care rendered by a physician who manages multiple clients on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy;

(d) The Division may cover supplies (including dressings) used with an external insulin infusion pump during the period of covered use of an infusion pump. These supplies are billed with codes A4221 and K0552;

(e) Code A4221 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable;

(f) A4221 is limited to one unit of service per week.

(2) Coding guidelines:

(a) Code A4221 includes all cannulas, needles, dressings, and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784);

(b) Code K0552 describes a syringe-type reservoir that is used with the external insulin infusion pump (E0784).

(3) Documentation requirements:

(a) With the request for PA, the DMEPOS provider shall submit medical justification that supports the criteria in this rule are met;

(b) When billing and dispensing for an item in Table 122-0525, the DMEPOS provider shall ensure that medical records corroborate all criteria in this rule are met;

(c) The DMEPOS provider shall keep medical records on file and make them available to the Division upon request.

(4) Table 122-0525.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0540
Ostomy Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness: The Division of Medical Assistance Programs (Division) may cover ostomy supplies for a client with a surgically

created opening (stoma) to divert urine or fecal contents outside the body:

(a) Only one liquid barrier may be dispensed at a time:

(A) A liquid or spray (A4369); or

(B) Individual wipes or swabs (A5120);

(b) For a client with a continent stoma, only one of the following means to prevent/manage drainage may be covered on a given day:

(A) Stoma cap (A5055);

(B) Stoma plug (A5081); or

(C) Gauze pads (A6216);

(c) For a client with a urinary ostomy, only one of the following may be covered for drainage at night:

(A) Bag (A4357); or

(B) Bottle (A5102);

(d) Provision of ostomy supplies for a client is limited to a three month supply;

(e) The following services are not covered:

(A) Ostomy clamps;

(B) Ostomy supplies when a client is in a covered home health episode;

(C) Pouch covers.

(2) Documentation Requirements:

(a) For miscellaneous ostomy supplies (A4421) ,submit documentation which supports coverage criteria as specified in this rule are met to the responsible unit for prior authorization;

(b) Medical records which support conditions of coverage as specified in this rule are met must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request;

(c) A client's medical records must support the justification for supplies billed to the Division including when a greater quantity of supplies than the amounts listed in this rule are dispensed (e.g., client has more than one ostomy).

(3) **Table 122-0540-1**, Maximum Quantity of Supplies — Monthly Basis.

(4) **Table 122-0540-2**, Maximum Quantity of Supplies — 6-Month Basis.

(5) **Table 122-0540-3**, Faceplate Systems.

(6) **Table 122-0540-4**, Procedure Codes.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12

410-122-0560
Urological Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover the following urinary catheters, external urinary collection devices, and medically appropriate related supplies when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention;

(b) Indwelling Catheters (A4311–A4316, A4338–A4346):

(A) No more than one catheter per month for routine catheter maintenance;

(B) Non-routine catheter changes when documentation substantiates medical appropriateness, such as for the following indications:

(i) Catheter is accidentally removed (e.g., pulled out by client);

(ii) Catheter malfunctions (e.g., balloon does not stay inflated, hole in catheter);

(iii) Catheter is obstructed by encrustation, mucous plug, or blood clot;

(iv) History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once per month;

(C) A specialty indwelling catheter (A4340) or an all silicone catheter (A4344, A4312, or A4315) when documentation in the client's medical record supports the medical appropriateness for that catheter rather than a straight Foley type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex);

(D) A three way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) only if continuous catheter irrigation is medically appropriate;

(c) Catheter Insertion Tray (A4310-A4316, A4353, and A4354):

(A) Only one insertion tray per episode of indwelling catheter insertion;

(B) One intermittent catheter with insertion supplies (A4353) per episode of medically appropriate sterile intermittent catheterization;

(d) Urinary Drainage Collection System (A4314-A4316, A4354, A4357, A4358, A5102, and A5112):

(A) For routine changes of the urinary drainage collection system as noted in Table 122-0560-1;

(B) Additional charges for medically appropriate non-routine changes when the documentation substantiates the medical appropriateness (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection);

(C) A vinyl leg bag (A4358) or a latex leg bag (A5112) only for clients who are ambulatory or are chair or wheelchair bound;

(e) Intermittent Irrigation of Indwelling Catheters:

(A) Supplies for the intermittent irrigation of an indwelling catheter when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter;

(B) Routine intermittent irrigations of a catheter are not covered;

(C) Routine irrigations are defined as those performed at predetermined intervals;

(D) Covered supplies for medically appropriate non-routine irrigation of a catheter include either an irrigation tray (A4320) or an irrigation syringe (A4322), and sterile water/saline (A4217);

(f) Continuous Irrigation of Indwelling Catheters:

(A) Supplies for continuous irrigation of a catheter when there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically appropriate catheter changes;

(B) Continuous irrigation as a primary preventative measure (i.e., no history of obstruction) is not covered;

(C) Documentation must substantiate the medical appropriateness of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation;

(D) The records must also indicate the rate of solution administration and the duration of need;

(E) Covered supplies for medically appropriate continuous bladder irrigation include a three-way Foley catheter (A4313, A4316, and A4346), irrigation tubing set (A4355), and sterile water/saline (A4217):

(i) The Division may cover one irrigation tubing set per day for continuous catheter irrigation;

(ii) Continuous irrigation is considered a temporary measure and may only be covered for up to 14 days;

(g) Intermittent Catheterization: Intermittent catheter supplies when basic coverage criteria are met and the client or caregiver can perform the procedure:

(A) For each episode of covered catheterization, one catheter (A4351, A4352) and an individual packet of lubricant (A4332); or

(B) One sterile intermittent catheter kit (A4353) when the client requires catheterization and meets one of the following criteria (i-iv):

(i) The client is immunosuppressed. Examples of immunosuppressed clients include (but are not limited) clients who are:

(I) On a regimen of immunosuppressive drugs post-transplant;

(II) On cancer chemotherapy;

(III) Have AIDS;

(IV) Have a drug-induced state such as chronic oral corticosteroid use;

(ii) The client has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization;

(iii) The client is a pregnant, spinal cord-injured female with neurogenic bladder (for duration of pregnancy only);

(iv) The client has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant (A4332), twice within the 12 month period prior to the initiation of sterile intermittent catheter kits. A urinary tract infection means a urine culture with greater than 10,000 colony forming units of a urinary pathogen; and documentation in the client's medical records of concurrent presence of one or more of the following signs, symptoms or laboratory findings:

(I) Fever (oral temperature greater than 38º C [100.4º F]);

(II) Systemic leukocytosis;

(III) Change in urinary urgency, frequency, or incontinence;

(IV) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation);

(V) Physical signs of prostatitis, epididymitis, orchitis;

(VI) Increased muscle spasms;

(VII) Pyuria (greater than five white blood cells [WBCs] per high-powered field);

(B) The kit code (A4353) must be used for billing even if the components are packaged separately rather than together as a kit;

(h) Coude (Curved) Tip Catheters:

(A) Use of a Coude (curved) tip catheter (A4352) in female clients is rarely medically appropriate;

(B) For any client, when a Coude tip catheter is dispensed and billed, there must be specific documentation in the client's medical record why a Coude tip catheter is required rather than a straight tip catheter;

(i) External Catheters/Urinary Collection Devices:

(A) Male external catheters (condom-type) or female external urinary collection devices for clients who have permanent urinary incontinence when used as an alternative to an indwelling catheter;

(B) Coverage for male external catheters (A4349) is limited to 35 per month;

(C) Greater utilization of these devices must be accompanied by documentation of medical appropriateness;

(D) Male external catheters (condom-type) or female external urinary collection devices are not covered for clients who also use an indwelling catheter;

(E) The Division may cover specialty type male external catheters such as those that inflate or that include a faceplate (A4326) or extended wear catheter systems (A4348) only when documentation substantiates the medical appropriateness for such a catheter;

(F) Coverage of female external urinary collection devices is limited to one metal cup (A4327) per week or one pouch (A4328) per day;

(j) Miscellaneous Supplies:

(A) Appliance cleaner (A5131): One unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5112);

(B) One external urethral clamp or compression device (A4356) every three months or sooner if the rubber/foam casing deteriorates;

(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one per month) for indwelling urethral catheters;

(D) A catheter/tube anchoring device (A5200) separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube;

(E) Non-Sterile Gloves — The Division will not pay for more than 200 pairs of non-sterile gloves (A4927) per month;

(k) The following services are not covered:

(A) Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250);

(B) Catheter care kits (A9270);

(C) Adhesive remover (A4456, A4455);

(D) Catheter clamp or plug (A9270);

(E) Disposable underpads, all sizes, diapers or incontinence garments, any type, disposable or reusable unless authorized under 410-122-0630 Incontinent Supplies;

(F) Drainage bag holder or stand (A9270);

(G) Urinary suspensory without leg bag (A4359);

(H) Measuring container (A9270);

(I) Urinary drainage tray (A9270);

(J) Gauze pads (A6216–A6218) and other dressings;

(K) Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270);

(L) Irrigation supplies that are used for care of the skin or perineum of incontinent clients;

(M) Syringes, trays, sterile saline, or water used for routine irrigation;

(N) Disposable external urethral clamp or compression device, with pad and/or pouch, each.

(2) Guidelines:

(a) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical records, including the judgment of the attending treating practitioner, indicate the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met;

(b) A urinary intermittent catheter with insertion supplies (A4353) is a kit, which includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use;

(c) Adhesive strips or tape used with male external catheters are included in the allowance for the code and are not separately payable;

(d) Catheter insertion trays (A4310–A4316, A4353, and A4354) that contain component parts of the urinary collection system, (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts may be allowed only per the stated criteria in each section of the policy;

(e) Extension tubing (A4331) may be covered for use with a latex urinary leg bag (A5112) and is included in the allowance for codes A4314, A4315, A4316, A4354, A4357, A4358, and A5105 and A4331 cannot be separately billed with these codes;

(f) Use A4333 when used to anchor an indwelling urethral catheter;

(g) Use code A5105 when billing for a urinary suspensory with leg bag;

(h) Replacement leg straps (A5113, A5114) are used with a urinary leg bag (A4358, A5105, or A5112). These codes are not used for a leg strap for an indwelling catheter;

(i) A4326 is a male external catheter with an integrated collection chamber that does not require the use of an additional leg bag.

(3) Documentation Requirements:

(a) For services requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;

(b) Intermittent Catheterization:

(A) The practitioner's order must indicate the actual number of times intermittent catheterization is performed per day;

(B) The client's medical records must support the number of times per day intermittent catheterization is performed;

(c) When requesting quantities of supplies greater than the maximum units specified in this rule, submit documentation supporting the medical appropriateness for the higher utilization to the appropriate authorization authority for PA;

(d) Documentation, which supports condition of coverage requirements for codes billed in this rule, must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request;

(e) A client's medical records must support the justification for supplies billed to the Division.

(4) **Table 122-0560-1**, Maximum Quantity of Supplies.

(5) **Table 122-0560-2.**

(6) **Table 122-0560-3**, Procedure Codes.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0580
Bath Supplies

(1) Indications and limitations of coverage and medical appropriateness

(a) The Division may cover bath supplies when medically appropriate and cost-effective including a rehab shower/commode chair when all of the following criteria are met:

(A) Client is unable to use a standard shower chair/bench due to a musculoskeletal condition;

(B) Client has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide;

(C) The home (shower) can accommodate a rehab/shower chair;

(D) Less costly alternatives have been considered or tried and ruled out;

(E) The rehab shower/commode chair meets the following specifications and standard features as a minimum:

(i) Constructed specifically for use as a rehab shower/commode chair (corrosive resistant);

(ii) Swing-away or detachable arms;

(iii) Removable commode pan holder and pan;

(iv) Adjustable removable footrests;

(v) Wheel lock system;

(F) The rehab shower/commode chair must be supplied by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the rehab shower/commode chair selection for the client;

(b) Verification of the healthcare common procedure coding system (HCPCS) code assignment by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor is not required for a rehab shower/commode chair;

(c) Use E1399 for a rehab shower/commode chair.

(2) Documentation requirements:

(a) The practitioner's order and medical justification for the equipment must be kept on file by the DMEPOS provider. The client's medical records must contain information which supports the medical appropriateness of the item ordered;

(b) For a rehab shower/commode chair, submit documentation which supports conditions of coverage in this rule are met.

(3) **Table 122-0580** Bath Supplies.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 15-2009 f. 6-12-09, cert. e f . 7-1-09

410-122-0590
Patient Lifts

(1) Indications and coverage — A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the client would be bed confined.

(2) The areas within the client's residence where the lift will be utilized must be able to accommodate and allow for the effective use of the lift. The Division of Medical Assistance Programs (Division) does not reimburse for adapting the living quarters.

(3) A sling or seat for a client lift may be covered as an accessory when ordered as a replacement for the original equipment item.

(4) E0621 is included in the allowance for E0630 when provided at the same time.

(5) E0635 may be covered only when a client weighs 450 pounds or more;

(6) Procedure codes:

(a) E0621 — Sling or seat, client lift, canvas or nylon — Purchase — Prior authorization (PA) required;

(b) E0630 — Client lift, hydraulic with seat or sling (considered purchased after 13 months of rental) — Purchase, rent or repair — PA required;

(c) E0635 — Client lift, electric, with seat or sling — Rent only. This item is a capped rental and becomes the property of the client after 13 months of continuous rental or when the usual purchase price is reached, whichever is lesser. May be covered for a nursing facility client — PA required.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0600
Toilet Supplies

(1) The Division may consider coverage for commodes when:

(a) The client is physically incapable of utilizing regular toilet facilities. This would occur when the client is confined to:

(A) A single room; or

(B) One level of the home environment and there is no toilet on that level; or

(C) The home and there are no toilet facilities in the home.

(b) Extra-wide/heavy-duty commodes may be covered when a client weighs 300 pounds or more and meets the conditions of coverage for commodes;

(c) Only bariatric commodes coded as E1399 (durable medical equipment, miscellaneous) may be covered for a client residing in a nursing facility, subject to service limitations of Division rules, when all of the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric commode has been assigned code E1399 by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(2) Documentation requirements:

(a) Documentation must include the practitioner's order, the client's height and weight and information supporting the medical appropriateness for the commode dispensed;

(b) For codes requiring prior authorization (PA), submit documentation which supports conditions of coverage are met as specified in this rule.

(3) Procedure Codes: Table 122-0600 Toilet Supplies.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0620
Miscellaneous Supplies

Procedure Codes — **Table 122-0620**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 32-1999, f. & cert. ef. 10-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0625
Surgical Dressing

Procedure Codes: **Table 122-0625** Surgical Dressing.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0630
Incontinent Supplies

(1) The Division of Medical Assistance Programs (Division) may cover incontinent supplies for urinary or fecal incontinence as follows:

(a) Category I Incontinent Supplies: For up to 200 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity. For quantities over this limit a prior authorization shall be required. When requesting multiple Category I product types (i.e., diapers and liners) that exceed the allowable, prior authorization and documentation as described in (4)(a)(D) of this rule are required;

(b) Category II Underpads:

(A) Disposable underpads: For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month;

(B) Reusable/washable underpads: For up to eight units (any combination of T4537 and T4540) in a 12 month period;

(C) Category II Underpads may be separately payable with Category I Incontinent Supplies with documentation that supports medical appropriateness for the use of this product;

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months;

(c) Category III Washable Protective Underwear:

(A) For up to 12 units in a 12 month period;

(B) Category III Washable Protective Underwear is not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months;

(d) The following services require PA:

(A) A4335 (Incontinence supply; miscellaneous);

(B) T4543 (Disposable incontinence product, brief/diaper, bariatric);

(C) T4544 (Disposable incontinence product, protective underwear/pull-on);

(D) Quantity of supplies greater than the amounts listed in this rule as the maximum monthly utilization (e.g., more than 200 units per month of Category I Incontinent Supplies, or 100 gloves per month).

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description.

(4) Documentation requirements:

(a) The client's medical records shall support the medical appropriateness for the services provided or being requested by the medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider, including, but not limited to:

(A) For all categories, the medical reason and condition causing the incontinence; and

(B) When a client is using urological or ostomy supplies at the same time as incontinent products specified in this rule, information that clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate;

(C) For all clients not residing in their home subsequent PA requests for incontinence product(s), the provider shall submit a log with the PA request. This log shall be the most recent log for the client documenting the number and frequency of incontinent product changes;

(D) PA requests for multiple Category I incontinence product types for the same client (i.e. doubling up) shall be accompanied by adequate explanation from the client's ordering practitioner to explain why a single, more appropriate, incontinence product cannot be used;

(E) Although PA is not required for Category II incontinence products, the DMEPOS provider shall have documentation on file from the prescribing practitioner supporting medical appropriateness;

(F) When requesting PA for T4543 (Bariatric Brief/Diaper) or T4544 (Protective underwear/pull-on), submit product information showing that the item is size XXL or larger. The request shall also include client weight and measurements that support the use of the bariatric incontinence product (e.g., client weight, waist and hip size). These items are manually priced following payment methodology outlined in OAR 410-122-0186.

(b) For services requiring PA, submit documentation as specified in (4)(a)(A)–(E) and (F);

(c) The DMEPOS provider is required to keep supporting documentation on file and make available to the Division on request.

(5) Quantity specification:

(a) For PA and reimbursement purposes, a unit count for Category I–III codes is considered as a single or individual piece of an item and not as a multiple quantity;

(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) shall be

specified in the unit column on the PA request. See table 122-0630-2;

(c) For gloves (Category IV Miscellaneous), 100 gloves equal one unit.

(6) Table 122-0630-1, Incontinent Supplies

(7) Table 122-0630-2, Incontinent Supplies — Counting Units and Pieces

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

Stat. Auth.: ORS 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 64-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 42-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12; DMAP 62-2015, f. 10-29-15, cert. ef. 11-1-15

410-122-0640
Eye Prostheses

(1) Indications and coverage:

(a) An eye prosthesis is indicated for a client (adult or child) with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal;

(b) For clients under age 21, the prescribing practitioner shall determine and document medical appropriateness of the eye prosthesis and related services;

(c) For clients age 21 and older, coverage is limited as follows:

(A) Polishing and resurfacing will be allowed on a twice per year basis;

(B) Replacement is covered every five years if documentation supports medical appropriateness. An exception to this limitation is allowed when clinical documentation supports medical appropriateness for more frequent replacement;

(C) One enlargement (V2625) or reduction (V2626) of the prosthesis is covered. Additional enlargements or reductions are rarely medically indicated and are therefore covered only when clinical documentation supports medical appropriateness.

(2) Documentation requirements:

(a) An order for each item shall be signed and dated by the treating physician, kept on file by the supplier, and made available upon request;

(b) Documentation of medical appropriateness that has been reviewed and signed by the prescribing practitioner (for example, CMN) shall be kept on file by the supplier and made available upon request;

(c) When billing for an item or service at a greater frequency than allowed, there shall be documentation in the patient's medical records that corroborates the order and supports the medical appropriateness of the items. This documentation shall be kept on file by the supplier and available upon request.

(3) Procedure Codes – **Table 122-0640**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; DMAP 60-2014, f. 10-3-14, cert. ef. 10-7-14; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0655
External Breast Prostheses

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division may cover an external breast prosthesis for a client who has had a mastectomy;

(b) An external breast prosthesis garment, with mastectomy form (L8015) may be covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(c) An external breast prosthesis of a different type may be covered if there is a change in the client's medical condition necessitating a different type of item;

(d) The Division will pay for only one breast prosthesis per side for the useful lifetime of the prosthesis;

(e) The Division will pay for a breast prosthesis for a client residing in a nursing facility;

(f) Two prostheses, one per side, are allowed for a client who has had bilateral mastectomies;

(g) More than one external breast prosthesis per side is not covered;

(h) An external breast prosthesis of the same type may be replaced if it is lost or is irreparably damaged (this does not include ordinary wear and tear);

(i) Replacement sooner than the useful lifetime because of ordinary wear and tear is not covered.

(2) Guidelines:

(a) Use code A4280 when billing for an adhesive skin support that attaches an external breast prosthesis directly to the chest wall;

(b) L8000 is limited to a maximum of four units every 12 months;

(c) Code L8015 describes a camisole type undergarment with polyester fill used post mastectomy;

(d) The right (RT) and left (LT) modifiers must be used with these codes. When the same code for two breast prostheses are billed for both breasts on the same date, the items (RT and LT) must be entered on the same line of the claim form using the RTLT modifier and two units of service;

(e) The useful lifetime expectancy for silicone breast prostheses is two years;

(f) For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is six months.

(3) Requirements:

(a) For services that do not require prior authorization (PA), the durable medical equipment, prosthetic, orthotic and supplies (DMEPOS) provider must have documentation on file which supports conditions of coverage as specified in this rule are met;

(b) For services that require PA, the DMEPOS provider must submit documentation for review which supports conditions of coverage as specified in this rule are met;

(c) Medical records must be made available to the Division on request.

(4) **Table 122-0655** (Procedure Codes): The procedure codes in this table may be covered for purchase.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; Renumbered from 410-122-0255, DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0658
Gradient Compression Stockings/Sleeves

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover gradient compression stockings/sleeves for the following indications:

(A) Ulceration due to chronic venous insufficiency;

(B) Varicose veins with ulcer or inflammation;

(C) Phlebitis/thrombophlebitis;

(D) Deep vein thrombosis (DVT) prophylaxis during pregnancy and postpartum or immobilization due to surgery, trauma, or debilitation;

(E) Funded lymphedema conditions; and

(F) Edema following a covered surgery, fracture, burns, or other trauma;

(b) A gradient compression stocking may be covered when it is used to secure a primary dressing over an open venous stasis ulcer that is currently being treated by a practitioner and requires medically necessary debridement and when the gradient stocking delivers compression less than 50 mmHg;

(c) Two gradient compression stockings/sleeves per affected limb may be provided at dispensing (the second one is for use while the first one is being laundered);

(d) Replacement stockings/sleeves are limited to two per affected limb every six months. Requests for quantities that exceed this amount require detailed medical documentation (e.g., change in size, unusual drainage, wear that renders them ineffective);

(e) Custom-made gradient compression stockings/sleeves require prior authorization with documentation that supports that the treating practitioner has considered ready-made gradient compression stockings/sleeves and the reason why they will not meet the medical needs of the client.

(f) The following services are not covered:

(A) Antiembolism stockings (A4490-A4510);

(B) Garter belts (A6544);

(C) Stockings/sleeves for the following conditions:

(i) Solely for the purpose of air travel;

(ii) Treatment of non-funded lymphedema conditions;

(iii) Venous insufficiency without stasis ulcers;

(D) Support hose (pantyhose).

(2) Documentation Requirements: Medical records that support the conditions of coverage are met, as specified in this rule, shall be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request.

(3) Table 122-0658

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 59-2015, f. 10-28-15, cert. ef. 11-1-15

410-122-0660
Orthotics and Prosthetics

(1) Indications and limitations of coverage and medical appropriateness:

(a) The Division of Medical Assistance Programs (Division) may cover some orthotics and prosthetics for covered conditions;

(b) Use the current Healthcare Common Procedure Coding System (HCPCS) Level II Guide for current codes and descriptions;

(c) For adults, follow Medicare current guidelines for determining coverage;

(d) For clients under age 19, the prescribing practitioner shall determine and document medical appropriateness;

(e) The hospital is responsible for reimbursing the provider for orthotics and prosthetics provided on an inpatient basis;

(f) Evaluations, office visits, fittings, and materials are included in the service provided;

(g) Evaluations will only be reimbursed as a separate service when the provider travels to a client's residence to evaluate the client's need;

(h) See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services for coverage criteria for speech and audiology prosthetic devices and accessories.

(i) See OAR 410-122-0658 for coverage criteria for mastectomy sleeves (L8010).

(2) Documentation requirements:

(a) For services that require prior authorization (PA): Submit documentation for review that supports conditions of coverage as specified in this rule are met;

(b) For services that do not require PA: Medical records that support conditions of coverage as specified in this rule are met shall be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request.

(3) Table 122-0660-1: Codes requiring PA.

(4) Table 122-0660-2: Exclusions of Coverage.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2012, f. 3-30-12, cert. ef. 4-1-12; DMAP 60-2015, f. 10-29-15, cert. ef. 11-1-15

410-122-0662
Ankle-Foot Orthoses and Knee-Ankle-Foot Orthoses

(1) Indications and limitations of coverage and medical appropriateness: The Division of Medical Assistance Programs (Division) may cover some ankle-foot orthotics (AFOs) and knee-ankle-foot Orthotics (KAFOs) and related services for a covered condition, for this episode, when the covered device has not been billed to the Division with a Current Procedure Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code or diagnosis code by any other healthcare provider, and in addition specifically for:

(a) AFOs not used during ambulation: A static AFO (L4396) may be covered when (A)-(E) are met:

(A) The client has a plantar flexion contracture of the ankle (Internal Classification of Diseases (ICD)-10 diagnosis code M24.571, M24.572) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture);

(B) There is a reasonable expectation of the ability to correct the contracture;

(C) The contracture is interfering or expected to interfere significantly with the client's functional abilities;

(D) The static AFO is used as a component of a therapy program that includes active stretching of the involved muscles and/or tendons;

(E) The pre-treatment passive range of motion is measured with a goniometer and an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home) is documented in the client's treatment plan;

(b) AFOs and KAFOs used during ambulation:

(A) AFOs described by codes L1900, L1902-L1990, L2106-L2116, L4350, L4360 and L4386 with weakness or deformity of the foot and ankle requiring stabilization fro medical reasons and with potential to benefit functionally;

(B) KAFOs described by codes L2000-L2038, L2126-L2136 and L4370 when conditions of coverage are met for an AFO and additional knee stability is required:

(C) AFOs and KAFOs that are molded-to-patient model, or custom-fabricated when basic coverage criteria for an AFO or KAFO are met and one of the following criteria is met:

(i) The client could not be fit with a prefabricated AFO;

(ii) The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months);

(iii) There is a need to control the knee, ankle or foot in more than one plane;

(iv) The client has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury;

(v) The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions;

(c) No more than one replacement interface (L4392) may be covered every six months for a covered static AFO;

(d) Evaluation of the client, measurement and/or casting and fitting of the orthotic are included in the allowance for the orthotic;

(e) Repairs/Replacement:

(A) Repairs to a covered orthotic due to wear or to accidental damage when necessary to make the orthotic functional. If the expense for repairs exceeds the estimated expense of providing another entire orthot, no payment will be made for the amount in excess;

(B) Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the client's condition or

irreparable accidental damage if the device is still medically appropriate and conditions of coverage are met;

(C) L4205 (Repair of orthotic device, labor component, per 15 minutes):

(i) May only bill for the actual time involved in the repair of an orthotic;

(ii) May not use this code for any labor involved in the evaluation, fabrication or fitting of a new or full replacement orthotic;

(iii) Use for the labor component of repair of a previously provided orthotic;

(D) Labor Allowance:

(i) Included in the replacement of an orthotic component coded with a specific L code;

(ii) Not included in the replacement of an orthotic component coded with L4210;

(E) Replacement items with specific HCPCS codes:

(i) Use L4392 and L4394 for replacement soft interfaces used with ankle contracture orthotics or foot drop splints;

(ii) Use L2999 (Lower extremity orthotics, not otherwise specified) for replacement components that do not have a specific HCPCS code;

(iii) Addition codes L4002 — L4130, L4392 for replacement components are not payable at initial issue of a base orthotic;

(f) The codes specified in this rule may be covered for a client residing in a nursing facility;

(g) Quantities of supplies greater than those described in the policy as the usual maximum amounts only when supported by documentation clearly and maximum amounts only when supported by documentation clearly and specifically explaining the medical appropriateness of the excess quantities.

(2) Exclusions: The following services are not covered;

(a) A static AFO and replacement interface for:

(A) A fixed contracture; or

(B) A foot drop without an ankle flexion contracture;

(C) When used solely for the prevention or treatment of a heel pressure ulcer;

(b) A component of a static AFO that is used to address positioning of the knee or hip;

(c) A foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394) for a non-ambulatory client when used solely for the prevention or treatment of a pressure ulcer;

(d) An AFO or KAFO and any related addition for an ambulatory client when used solely for treatment of edema and/or prevention or treatment of a pressure ulcer;

(e) Walking boots used primarily to relieve pressure, especially on the sole of the foot or used solely for the prevention or treatment of a pressure ulcer;

(f) Elastic support garments (L1901);

(g) Socks (L2840, L2850) used in conjunction with orthotics;

(h) Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out;

(i) A foot pressure off-loading/supportive device (A9283);

(j) L coded additions to AFOs and KAFOs (L2180-L2550, L2750-L2768, L2780-L2830) if either the coverage criteria for the base orthotic is not met or the specific addition is not medically appropriate.

(3) Coding Guidelines:

(a) A prefabricated orthotic is one that is manufactured in quantity without a specific client in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific client (i.e., custom fitted). An orthotic that is assembled from prefabricated components is considered prefabricated. Any orthotic that does not meet the definition of a custom-fabricated orthotic is considered prefabricated;

(b) A custom-fabricated orthotic is individually made for a specific client starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item;

(c) A molded-to-patient model orthotic is a particular type of custom-fabricated orthotic in that an impression of the specific body part is made (by means of a plaster cast, computer-aided design and computer-aided manufacturing (CAD-CAM) technology, etc.). This impression is used to make a positive model (of plaster or other material) of the body part. The orthotic is then molded on this positive model;

(d) Ankle-foot orthotics extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics that are shoe inserts that do not extend above the ankle. A nonambulatory ankle-foot orthotic may be either an ankle contracture splint, night splint or a foot drop splint;

(e) A static AFO (L4396) is a prefabricated ankle-foot orthotic that has all of the following characteristics:

(A) Designed to accommodate an ankle with a plantar flexion contracture up to 45°;

(B) Applies a dorsiflexion force to the ankle;

(C) Used by a client who is minimally ambulatory or nonambulatory;

(D) Has a soft interface;

(f) A foot drop splint/recumbent positioning device (L4398) is a prefabricated ankle-foot orthotic that has all of the following characteristics:

(A) Designed to maintain the foot at a fixed position of 0° (i.e., perpendicular to the lower leg);

(B) Not designed to accommodate an ankle with a plantar flexion contracture;

(C) Used by a client who is nonambulatory;

(D) Has a soft interface.

(4) HCPCS Modifiers:

(a) EY — No physician or other licensed health care provider order for this item or service;

(b) GY — Item or service statutorily excluded or does not meet the definition of any Medicare benefit:

(A) If an AFO or a KAFO is used solely for the treatment of edema and/or for the prevention or treatment of a pressure ulcer, the GY modifier must be added to the base code and any related additional code;

(B) If a walking boot (L4360, L4386), static AFO (L4396) or foot drop splint/recumbent positioning device (L4398) is used solely for the prevention or treatment of a pressure ulcer, the GY modifier must be added to the base code and to the code for the replacement liner (L4392, L4394);

(C) When the GY modifier is added to a code there must be a short narrative statement indicating why the GY modifier was used — e.g., "used to prevent pressure ulcer" or "used to treat pressure ulcer" or "used to treat edema". This statement must be entered in the narrative field of an electronic claim or attached to a hard copy claim;

(c) KX — Requirements specified in the medical policy have been met. The provider must add a KX modifier to the AFO/KAFO base and additional codes only if all the coverage criteria of this policy have been met and evidence of such is retained in the provider's files;

(d) LT — Left Side; RT — Right Side:

(A) The right (RT) and left (LT) modifiers must be used with orthotic base codes, additions and replacement parts;

(B) When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using the LTRT modifiers and 2 units of service.

(5) Documentation Requirements:

(a) L2999 is the only code in this rule that requires prior authorization (PA): For a PA request, submit documentation for review that supports conditions of coverage as specified in this rule are met, including the plan of care, if applicable;

(b) For services that do not require PA: Documentation from the medical record that supports conditions of coverage as specified

in this rule are met must be kept on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(c) Prior to billing for each new or full replacement item, the DMEPOS provider must first have received a completed written, signed and dated physician's order that includes:

(A) The treating diagnosis code that justifies the need for the orthotic device;

(B) Detailed description of the item including all options or additional features;

(C) The unique features of the base code plus every addition that will be billed on a separate claim line;

(d) For custom-fabricated orthotics, documentation must support the medical appropriateness of that type device rather than a prefabricated orthotic;

(e) For L2999:

(A) The request for PA must include the following information:

(i) A narrative description of the item (for custom fabricated items); or

(ii) The manufacturer's name and model name/number (for pre-fabricated items); and

(iii) Justification of medical appropriateness for the item;

(iv) For replacement components, a HCPCS code or the manufacturer's name and model name/number of the base orthotic;

(v) The manufacturer's name and model name/number must be entered in the narrative field of an electronic claim;

(f) Repair of orthotic devices:

(A) A physician's order is not required;

(B) A detailed description of the reason for the repair, part that is being repaired or replaced must be on file with the DMEPOS provider;

(C) The following information must be entered in the narrative field of an electronic claim:

(i) L4210 must include a description of each item that is billed;

(ii) L4205 must include an explanation of what is being repaired;

(D) All codes for repairs of orthotics billed with the same date of service must be submitted on the same claim;

(g) The provider must include the ICD-10 diagnosis code for the underlying condition on the claim for a static AFO (L4396) or replacement interface material (L4392);

(h) All codes for orthotics billed with the same date of service must be submitted on the same claim;

(i) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be documentation in the client's medical record supporting the medical appropriateness for the higher utilization;

(j) The client's medical record must support the medical appropriateness for items and all additions billed to the Division and this documentation must be made available to the Division on request.

(5) **Table 122-0662**

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 40-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-122-0678
Dynamic Adjustable Extension/Flexion Device

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover some dynamic adjustable extension/flexion devices for a covered condition when all of the following conditions are met:

(a) As an adjunct to physical therapy for clients with signs and symptoms of persistent joint stiffness in the sub-acute injury or post-operative period (> 3 weeks but < 4 months after injury or surgical procedure) when the device is applied and managed under the direct supervision of a physical therapist;

(b) As an adjunct to physical therapy in the acute post-operative period for clients who are undergoing additional surgery to improve the range of motion of a previously affected joint when the device is managed under the direct supervision of a physical therapist;

(c) For this episode, the device has not been billed to the Division with a current procedure terminology (CPT) code, healthcare common procedure coding system (HCPCS) code, or diagnosis code by any other healthcare provider;

(d) Reimbursement is limited to a maximum of four months per episode;

(e) Reimbursement is on a month-to-month rental basis only.

(2) Documentation requirements:

(a) Submit medical records that support the conditions of coverage, as specified in this rule, have been met, including the treatment plan from the physical therapist;

(b) The treatment plan shall include:

(A) Baseline measurements (pre-intervention measurements) of range of motion (ROM) limitations;

(B) Weekly ROM measurements with documented 10 degree improvement.

(3) **Table 0678** — Dynamic Adjustable Extension/Flexion Devices.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 11-2016, f. 2-24-16, cert. ef. 3-1-16

410-122-0680
Facial Prostheses

(1) Indications and Coverage:

(a) Covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect;

(b) Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis are covered. Other skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are not covered;

(c) The following services and items are included in the allowance for a facial prosthesis:

(A) Evaluation of the client;

(B) Pre-operative planning;

(C) Cost of materials;

(D) Labor involved in the fabrication and fitting of the prosthesis;

(E) Modifications to the prosthesis made at the time of delivery of the prosthesis or within 90 days thereafter;

(F) Repair due to normal wear or tear within 90 days of delivery;

(G) Follow-up visits within 90 days of delivery of the prosthesis;

(d) Modifications to a prosthesis that occur more than 90 days after delivery of the prosthesis and that are required because of a change in the client's condition are covered;

(e) Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess;

(f) Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are non-covered services;

(g) Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or wear or when required because of a change in the client's condition that cannot be accommodated by modification of the existing prosthesis;

(h) When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item, whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and not separate codes for the orbit and nose. This would apply even if the prosthesis is fabricated in two separate parts.

(2) Documentation: The following must be submitted for prior authorization (PA):

(a) An order for the initial prosthesis and/or related supplies which is signed and dated by the ordering prescribing practitioner must be kept on file by the prosthetist/supplier and submitted with request for PA;

(b) A separate prescribing practitioner order is not required for subsequent modifications, repairs or replacement of a facial prosthesis;

(c) A new prescribing practitioner order is required when different supplies are ordered;

(d) A photograph of the prosthesis and a photograph of the client without the prosthesis must be retained in the supplier's record and must be submitted with the PA request;

(e) When code L8048 is used for a miscellaneous prosthesis or prosthetic component, the authorization request must be accompanied by a clear description and a drawing/copy of photograph of the item provided and the medical appropriateness;

(f) Requests for replacement, repair or modification of a facial prosthesis must include an explanation of the reason for the service;

(g) When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be clearly documented in the authorization request.

(3) Procedure Codes — **Table 122-0680**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

410-122-0700

Negative Pressure Wound Therapy Pumps

(1) Indications and limitations of coverage and medical appropriateness — Initial Coverage: The Division may cover a negative pressure wound therapy (NPWT) pump and supplies on a monthly basis for up to four months on the most recent covered wound when either criterion (a) or (b) is met:

(a) Ulcers and wounds in the home setting or nursing facility:

(A) The client has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology;

(B) A complete wound therapy program described by criterion (i) and criteria (ii), (iii), or (iv), as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT:

(i) For all ulcers or wounds, the wound therapy program must include a minimum of all of the following general measures, which have either been addressed, applied, or considered and ruled out prior to application of NPWT:

(I) Documentation in the client's medical record of evaluation, care, and wound measurements by a licensed medical professional;

(II) Application of dressings to maintain a moist wound environment;

(III) Debridement of necrotic tissue if present;

(IV) Evaluation of and provision for adequate nutritional status;

(ii) For Stage III or IV pressure ulcers:

(I) Appropriate turning and positioning of the client;

(II) Use of a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see 410-122-0400 Pressure Reducing Support Surfaces). If the ulcer is not on the trunk or pelvis, a Group 2 or 3 support surface is not required; and

(III) Appropriate management of the client's moisture and incontinence;

(iii) For neuropathic (for example, diabetic) ulcers:

(I) The client has been on a comprehensive diabetic management program, and;

(II) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities;

(iv) For venous insufficiency ulcers:

(I) Compression bandages and/or garments have been consistently applied, and;

(II) Leg elevation and ambulation have been encouraged;

(b) Ulcers and wounds encountered in an inpatient setting:

(A) An ulcer or wound as described in subsection (1)(a) is encountered in the inpatient setting and, after wound treatments described in subsection (1)(a) have been tried or considered and ruled out, NPWT is initiated because the treating physician considers it the best available treatment option;

(B) The client has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical appropriateness for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the client that will not allow for healing times achievable with other topical wound treatments);

(c) In either situation described in subsection (1)(b), NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting;

(d) If criterion in subsection (1)(a) or (1)(b) above is not met, the NPWT pump and supplies are not covered;

(e) NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a client. A request for more than one NPWT pump per client for the same time period is not covered;

(f) For the purposes of this rule, a licensed health care professional may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner must be licensed to assess wounds and/or administer wound care.

(2) Indications and limitations of coverage and medical appropriateness — Continued Coverage: For wounds and ulcers described in subsection (1)(a) or (1)(b), for clients placed on an NPWT pump and supplies, the Division will only approve continued coverage when the licensed medical professional does all the following duties:

(a) On a regular basis:

(A) Directly assesses the wound(s) being treated with the NPWT pump; and

(B) Supervises or directly performs the NPWT dressing changes;

(b) On at least a monthly basis, documents changes in the ulcer's dimensions and characteristics.

(3) Coverage for a NPWT pump and supplies ends when any of the following occur:

(a) Criteria in section (2) are not met;

(b) The treating physician determines that adequate wound healing has occurred for NPWT to be discontinued;

(c) Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound;

(d) Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound. Coverage beyond four months will be given individual consideration based upon required additional documentation;

(e) Equipment or supplies are no longer being used for the client, whether or not by the physician's order.

(4) The Division will not cover NPWT pump and supplies if one or more of the following are present:

(a) Necrotic tissue with eschar in the wound, if debridement is not attempted;

(b) Untreated osteomyelitis within the vicinity of the wound;

(c) Cancer present in the wound;

(d) The presence of a fistula to an organ or body cavity within the vicinity of the wound.

(5) The Division will only cover NPWT pumps and their supplies that have been specifically designated as being qualified for use of HCPCS codes E2402, A6550 and A7000 via written instructions from the Medicare Pricing, Data Analysis and Coding (PDAC) contractor.

(6) The Division covers a maximum of 15 dressing kits (A6550) per wound per month, unless there is documentation that the wound size requires more than one dressing kit for each dressing change.

(7) The Division covers a maximum of 10 canister sets (A7000) per month, unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high-volume exudative wounds, a stationary pump with the largest capacity canister must be used. The Division does not cover excess use of canisters related to equipment failure (as opposed to excessive volume drainage).

(8) Guidelines:

(a) Equipment:

(A) Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound. Specifically, an electrical pump (described in the definition of code E2402) intermittently or continuously conveys subatmospheric pressure through connecting tubing to a specialized wound dressing (described in the descriptor of HCPCS code A6550). The dressing includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote wound healing. Drainage from the wound is collected in a canister (described in the definition of HCPCS code A7000);

(B) Code E2402 describes a stationary or portable NPWT electrical pump which provides controlled subatmospheric pressure that is designed for use with NPWT dressings, (A6550) to promote wound healing. Such an NPWT pump is capable of being selectively switched between continuous and intermittent modes of operation and is controllable to adjust the degree of subatmospheric pressure conveyed to the wound in a range from 25 to greater than or equal to 200 mm Hg subatmospheric pressure. The pump can sound an audible alarm when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) and when its wound drainage canister (A7000) is full. The pump is designed to fill the canister to full capacity;

(b) Supplies:

(A) Code A6550 describes a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402), and contains all necessary components, including but not limited to a resilient, open-cell foam surface dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound;

(B) Code A7000 describes a canister set which is used in conjunction with a stationary or portable NPWT pump (E2402) and contains all necessary components, including but not limited to a container, to collect wound exudate. Canisters may be various sizes to accommodate stationary or portable NPWT pumps;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

(9) Documentation Requirements: Submit the following information with the prior authorization request:

(a) For initial coverage:

(A) A statement from the attending physician which describes the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care as specified in subsection (1)(a);

(B) From the treating clinician, history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being requested to include the following:

(i) Changes in wound conditions, including precise, quantitative measurements of wound characteristics (wound length and width (surface area), and depth), quantity of exudates (drainage), presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.);

(ii) Dated photographs of ulcers or wounds with specific location(s) identified within the last 30 days;

(iii) Length of sessions of use;

(iv) Dressing types and frequency of change;

(v) Wound healing progress;

(b) For Continued Coverage:

(A) Progress notes from the attending physician within the last 30 days;

(B) Updated wound measurements and what changes are being applied to effect wound healing including information specified in paragraph (9) (a) (B);

(c) For both initial and continued coverage of an NPWT pump and supplies, any other medical records that corroborate that all criteria in this rule are met;

(d) When requesting quantities of supplies greater than those specified in this rule as the usual maximum amounts, include documentation supporting the medical appropriateness for the higher utilization.

(10) **Table 122-0700**.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09

410-122-0720
Pediatric Wheelchairs

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division may cover a pediatric wheelchair when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs); places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADL;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the pediatric wheelchair that is being requested;

(D) Use of a pediatric wheelchair will significantly improve the client's ability to move within the home to the areas customarily

used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

(E) The client is willing to use the requested pediatric wheelchair in the home, and will use it on a regular basis in the home;

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested pediatric wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

(b) Only when conditions of coverage as specified in (1)(a) of this rule are met, may the Division authorize a pediatric wheelchair for any of the following situations:

(A) When the wheelchair can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a pediatric wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a pediatric wheelchair may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of pediatric wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a pediatric wheelchair;

(B) For a purchase request, when a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement cost;

(C) When a covered, client-owned wheelchair is in need of repair (for one month's rental of a wheelchair). See OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing;

(c) A pediatric tilt-in-space wheelchair (E1231–E1234) may be covered when a client meets all of the following conditions:

(A) A standard base with a reclining back option will not meet the client's needs;

(B) Is dependent for transfers;

(C) Spends a minimum of six hours a day in a wheelchair;

(D) The plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(E) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting;

(d) One month's rental for a manual pediatric tilt-in-space wheelchair (E1231–E1234) may be covered for a client residing in a nursing facility when all of the following conditions are met:

(A) The anticipated nursing facility length of stay is 30 days or less;

(B) The conditions of coverage for a manual tilt-in-space wheelchair as described in (1)(c)(A)(E) are met;

(C) The client is expected to have an ongoing need for this same wheelchair after discharge to the home setting;

(D) Coverage is limited to one month's rental;

(e) The Division does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

(f) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. The Division does not reimburse for adapting living quarters;

(g) The Division does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(h) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(i) Power mobility devices and related options and accessories must be supplied by a DMEPOS provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the client;

(j) The provider's ATP must be employed by a provider in a full-time, part-time or contracted capacity as is acceptable by state law. The provider's ATP, if part-time or contracted, must be under the direct control of the provider;

(k) Documentation must be complete and detailed enough so a third party would be able to understand the nature of the provider's ATP involvement, if any, in the licensed/certified medical professional (LCMP) specialty evaluation;

(l) The provider's ATP may not conduct the provider evaluation at the time of delivery of the power mobility device to the client's residence;

(m) A Group 5 (Pediatric) power wheelchair (PWC) with Single Power Option (K0890) or with Multiple Power Options (K0891) may be covered when:

(i) The coverage criteria for a PWC (see 410-122-0325, Motorized/Power Wheelchair Base) are met; and

(ii) The client is expected to grow in height; and

(iii) Either of the following criteria is met:

(I) The Group 2 Single Power Option in 410-122-0325, Motorized/Power Wheelchair Base, (2)(a)(C)(i)(I)–(II); or

(II) Multiple Power Options in 410-122-0325, Motorized/Power Wheelchair Base, (2)(a)(D)(i)(I)–(II);

(iv) The delivery of a PWC must be within 120 days following completion of the face-to-face examination with the physician;

(v) A PWC may not be ordered by a podiatrist;

(n) A pediatric wheelchair for use only outside the home is not covered;

(o) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.

(2) Coding Guidelines:

(a) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(b) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(c) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings;

(d) A manual wheelchair with a seat width and/or depth of 14" or less is considered a pediatric size wheelchair and is billed with codes E1231–E1238 or E1229 unless determination by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor for the wheelchair is otherwise indicated;

(e) A PWC with a seat width or depth of 14" or less is considered a pediatric PWC base and is coded E1239, PWC, pediatric size, not otherwise specified;

(f) Pediatric seating system codes E2291–E2294 may only be billed with pediatric wheelchair base codes;

(g) Contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation requirements:

(a) Functional Mobility Evaluation:

(A) Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers must submit medical documentation which supports conditions of coverage in this rule are met for purchase and modifications of all covered, client-owned pediatric wheelchairs;

(B) Information must include, but is not limited to:

(i) Medical justification, needs assessment, order, and specifications for the wheelchair, completed by a physical therapist (PT), occupational therapist (OT) or treating physician. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the DMEPOS provider requesting authorization; and

(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and PT or OT;

(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order;

(b) Additional Documentation:

(A) Information from a PT, OT or treating physician that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a PT, OT or treating physician about the following elements that support coverage criteria are met for a pediatric wheelchair; only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, pediatric wheelchair, power-operated vehicle (POV), or PWC and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs, or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a wheelchair or power mobility device;

(II) Walking around their home, to bathroom, kitchen, living room, etc., provide information on distance walked, speed, and balance;

(C) Documentation from a PT, OT or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since the Division determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a pediatric wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options, including growth capabilities; and

(E) Detailed information about client-owned equipment (including serial numbers), as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it can't be grown or modified, if applicable; and

(F) For the home assessment, prior to delivery of the wheelchair, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters. This assessment must support that the client's home can accommodate and allow for the effective use of a wheelchair. This assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc.; and

(G) All HCPCS codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that will be separately billed;

(c) A written order by the treating physician, identifying the specific type of pediatric wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific pediatric wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority; and

(d) For a PWC request: See 410-122-0325, Motorized/Power Wheelchair Base for documentation requirements; and

(e) Any additional documentation that supports indications of coverage are met as specified in this policy; and

(f) For a manual wheelchair rental, submit all of the following:

(A) A written order from the treating physician, identifying the specific type of manual wheelchair needed:

(i) If the order does not specify the type of wheelchair requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested;

(ii) The DMEPOS provider may enter the items on this order;

(iii) This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority;

(B) HCPCS codes;

(C) Documentation from the DMEPOS provider which supports that the client's home can accommodate and allow for the effective use of the requested wheelchair;

(g) The above documentation must be kept on file by the DMEPOS provider; and

(h) Documentation that the coverage criteria have been met must be present in the client's medical records and this documentation must be made available to the Division on request; and

(i) For PWC's furnished on a rental basis with dates of services prior to October 1, 2006, use code E1239 as appropriate.

(4) **Table 122-0720** — Pediatric Wheelchairs.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 15-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2010, f. 6-10-10, cert. ef. 7-1-10

DIVISION 123

DENTAL/DENTURIST SERVICES

410-123-1000
Eligibility, Providing Services and Billing

(1) Eligibility:

(a) Providers are responsible to verify client eligibility and must do so before providing any service or billing the Division of Medical Assistance Programs (Division) or any Oregon Health Plan (OHP) Prepaid Health Plan (PHP);

(b) The Division may not pay for services provided to an ineligible client even if services were authorized. Refer to General Rules OAR 410-120-1140 (Verification of Eligibility) for details.

(2) Co-payments for OHP clients may be required for certain services. See General Rules OAR 410-120-1230 for specific information on co-pays.

(3) Billing:

(a) Providers must follow the Division rules in effect on the date of service. All Division rules are intended to be used in conjunction with the Division's General Rules Program (chapter 410, division 120), the OHP Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant Division OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a signed provider enrollment agreement;

(b) Third Party Resources: A third party resource (TPR) is an alternate insurance resource, other than the Division, available to pay for medical/dental services and items on behalf of OHP clients. Any alternate insurance resource must be billed before the Division or any OHP PHP can be billed. Indian Health Services or Tribal facilities are not considered to be a TPR pursuant to the Division's General Rules Program rule 410-120-1280;

(c) Fabricated Prosthetics:

(A) If a dentist or denturist provides an eligible client with fabricated prosthetics that require the use of a dental laboratory, the date of the final impressions must have occurred:

(i) Prior to the client's loss of eligibility; and

(ii) For dentures for adults age 21 and older, no later than six months from the date of the last extraction from the jaw for which the denture is being provided;

(B) The dentist/denturist should use the date of final impression as the date of service only when criteria in (A) is met and the fabrication extends beyond:

(i) The client's OHP eligibility; or

(ii) Six months after the extractions (for dentures for adults);

(C) The date of delivery must be within 45 days of the date of the final impression and the date of delivery must also be indicated on the claim. These are the only exceptions to the Division's General Rules Program rule 410-120-1280. All other services must be billed using the date the service was provided;

(d) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA). Refer to 410-123-1100 for information regarding dental services that require providers to submit reports for review ("by report" — BR) prior to reimbursement;

(e) The client's records must include documentation to support the appropriateness of the service and level of care rendered;

(f) The Division shall only reimburse for dental services that are dentally appropriate as defined in OAR 410-123-1060;

(g) Refer to OAR chapter 410, division 147 for information about reimbursement for dental services provided through a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC);

(4) Treatment Plans: Being consistent with established dental office protocol and the standard of care within the community, scheduling of appointments is at the discretion of the dentist. The agreed upon treatment plan established by the dentist and patient shall establish appointment sequencing. Eligibility for medical assistance programs does not entitle a client to any services or consideration not provided to all clients.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; DMAP 25-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 45-2011, f. 12-21-11, cert. ef. 12-23-11; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12

410-123-1060
Definition of Terms

(1) "Anesthesia" The following depicts the Health System Division, Medical Assistance Programs' (Division) usage of certain anesthesia terms; however, for further details refer also to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026):

(a) "Conscious Sedation" means the following:

(A) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance maintaining a patient airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained;

(B) "Minimal Sedation" means a minimally depressed level of consciousness produced by non-intravenous pharmacological methods that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation;

(C) "Moderate Sedation" means a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(b) "General Anesthesia" means a drug-induced loss of consciousness during which the patient is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patient airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;

(c) "Local Anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug;

(d) "Nitrous Oxide Sedation" means an induced controlled state of minimal sedation produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(2) Citizen/Alien-Waived Emergency Medical (CAWEM). Refer to OAR 410-120-0000 for definition of clients who are eligible for limited emergency services under the CAWEM benefit package. The definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package.

(3) "Covered Services" means services on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) that have been funded by the legislature and identified in specific program rules. Services are limited as directed by General Rules Excluded Services and Limitations (OAR 410-120-

1200), the Division's Dental Services Program rules (chapter 410, division 123), and the Prioritized List. Services that are not considered emergency dental services as defined by section (12) of this rule are considered routine services.

(4) "Dental Hygienist" means an individual licensed to practice dental hygiene pursuant to state law.

(5) "Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)" means an individual licensed to practice dental hygiene with an EPDH permit issued by the Board of Dentistry and within the scope of an EPDH permit pursuant to state law.

(6) "Dental Practitioner" means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and certification.

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

(8) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes; administrative rules for client records and requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, and any other documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).

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

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

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

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

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

(10) "Dentist" means an individual licensed to practice dentistry pursuant to state law.

(11) "Denturist" means an individual licensed to practice denture technology pursuant to state law.

(12) "Direct Pulp Cap" means the procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

(13) Emergency Services means:

(a) Covered services for an emergency dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. This includes services to treat the following conditions:

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

(D) Unusual swelling of the face or gums; or

(E) A tooth that has been avulsed (knocked out).

(b) The treatment of an emergency dental condition is limited only to covered services. The Division recognizes that some non-covered services may meet the criteria of treatment for the emergency condition; however, this rule does not extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care (See also OAR 410-120-0000).

(14) "Hospital Dentistry" means dental services normally done in a dental office setting but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate.

(15) "Medical Practitioner" means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.

(16) "Medicament" means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.

(17) "Procedure Codes" means the procedure codes set forth in OAR chapter 410, division 123 that refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.

(18) "Standard of Care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14; DMAP 34-2016, f. 6-30-16, cert. ef. 7-1-16

410-123-1100
Services Reviewed by the Division of Medical Assistance Programs (Division)

(1) Services requiring prior authorization (PA): See OAR 410-123-1160 for information about services that require PA and how to request PA.

(2) By Report Procedures:

(a) Request for payment for dental services listed as "by report" (BR), or services not included in the procedure code listing must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division of Medical Assistance Program (Division) dental consultant;

(b) Refer to the "Covered and Non-Covered Dental Services" document for a list of procedures noted as BR. See OAR 410-123-1220.

(3) Treatment Justification: the Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:

(a) Before issuing PA;

(b) In the process of utilization/post payment review; or

(c) In determining responsibility for payment of dental services.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09

410-123-1160
Prior Authorization

(1) Division of Medical Assistance Programs (Division) prior authorization (PA) requirements:

(a) For fee-for-service (FFS) dental clients, the following services require PA:

(A) Crowns (porcelain fused to metal);

(B) Crown repair;

(C) Retreatment of previous root canal therapy — anterior;

(D) Complete dentures;

(E) Immediate dentures;

(F) Partial dentures;

(G) Prefabricated post and core in addition to fixed partial denture retainer;

(H) Fixed partial denture repairs;

(I) Skin graft; and

(J) Orthodontics (when covered pursuant to OAR 410-123-1260);

(b) Hospital dentistry always requires PA, regardless of the client's enrollment status. Refer to OAR 410-123-1490 for more information;

(c) Oral surgical services require PA when performed in an ambulatory surgical center (ASC) or an outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-123-1260 (Oral Surgery Services), and the current Medical Surgical Services administrative rule 410-130-0200 for information;

(d) Maxillofacial surgeries may require PA in some instances. Refer to the current Medical Surgical Services administrative rule 410-130-0200, for information.

(2) The Division does not require PA for outpatient or inpatient services related to life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(3) How to request PA:

(a) Submit the request to the Division in writing. Refer to the Dental Services Provider Guide for specific instructions and forms to use. Telephone calls requesting PA will not be accepted;

(b) Treatment justification: The Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:

(A) When radiographs are required they must be:

(i) Readable copies;

(ii) Mounted or loose;

(iii) In an envelope, stapled to the PA form;

(iv) Clearly labeled with the dentist's name and address and the client's name; and

(v) If digital x-ray, they must be of photo quality;

(B) Do not submit radiographs unless it is required by the Dental Services administrative rules or they are requested during the PA process.

(4) The Division will issue a decision on PA requests within 30 days of receipt of the request. The Division will provide PA for services when:

(a) The prognosis is favorable;

(b) The treatment is practical;

(c) The services are dentally appropriate; and

(d) A lesser-cost procedure would not achieve the same ultimate results.

(5) PA does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service.

(6) For certain services and billings, the Division will seek a general practice consultant or an oral surgery consultant for professional review to determine if a PA will be approved. The Division will deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.

(7) For managed care PA requirements:

(a) For services other than hospital dentistry, contact the client's Dental Care Organization (DCO) for PA requirements for individual services and/or supplies listed in the Dental Services administrative rules. DCOs may not have the same PA requirements for dental services as listed in this administrative rule;

(b) For hospital dentistry, refer to OAR 410-123-1490 for details regarding PA requirements.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 25-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13; Administrative correction, 2-5-14

410-123-1200
Services Not To Be Billed Separately

(1) Services that are not to be billed separately may be included in the Current Dental Terminology (CDT) codebook and may not be listed as combined with another procedure; however, they are considered to be either minimal, included in the examination, part of another service, or included in routine post-op or follow-up care.

(2) The following services do not warrant an additional fee:

(a) Alveolectomy/Alveoloplasty in conjunction with extractions;

(b) Cardiac and other monitoring;

(c) Caries risk assessment and documentation;

(d) Curettage and root planing — per tooth;

(e) Diagnostic casts;

(f) Dietary counseling;

(g) Direct pulp cap;

(h) Discing;

(i) Dressing change;

(j) Electrosurgery;

(k) Equilibration;

(l) Gingival curettage — per tooth;

(m) Gingival irrigation;

(n) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth;

(o) Indirect pulp cap;

(p) Local anesthesia;

(q) Medicated pulp chambers;

(r) Occlusal adjustments;

(s) Occlusal analysis;

(t) Odontoplasty;

(u) Oral hygiene instruction;

(v) Periodontal charting, probing;

(w) Post removal;

(x) Polishing fillings;

(y) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;

(z) Pulp vitality tests;

(aa) Smooth broken tooth;

(bb) Special infection control procedures;

(cc) Surgical procedure for isolation of tooth with rubber dam;

(dd) Surgical splint;

(ee) Surgical stent; and

(ff) Suture removal.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 19-2014(Temp), f. 3-28-14, cert. ef. 4-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14

410-123-1220
Coverage According to the Prioritized List of Health Services

(1) This rule incorporates by reference the "Covered and Non-Covered Dental Services" document dated July 1, 2016, and located on the Health System Division, Medical Assistance Programs (Division) website at: http://www.oregon.gov/oha/healthplan/Pages/dental.aspx.

(a) The "Covered and Non-Covered Dental Services" document lists coverage of Current Dental Terminology (CDT) procedure codes according to the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) and the client's specific Oregon Health Plan benefit package;

(b) This document is subject to change if there are funding changes to the Prioritized List.

(2) Changes to services funded on the Prioritized List are effective on the date of the Prioritized List change:

(a) The Division administrative rules (chapter 410, division 123) will not reflect the most current Prioritized List changes until they have gone through the Division rule filing process;

(b) For the most current Prioritized List, refer to the HERC website at www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(c) In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service.

(3) Refer to OAR 410-123-1260 for information about limitations on procedures funded according to the Prioritized List. Examples of limitations include frequency and client's age.

(4) The Prioritized List does not include or fund the following general categories of dental services, and the Division does not cover them for any client. Several of these services are considered

elective or "cosmetic" in nature (i.e., done for the sake of appearance):

(a) Desensitization;

(b) Implant and implant services;

(c) Mastique or veneer procedure;

(d) Orthodontia (except when it is treatment for cleft palate);

(e) Overhang removal;

(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;

(g) Temporomandibular joint dysfunction treatment; and

(h) Tooth bleaching.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 21-1994(Temp), f. 4-29-94, cert. ef. 5-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; HR 9-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 7-2015(Temp), f. & cert. ef. 2-17-15 thru 8-15-15; DMAP 28-2015, f. & cert. ef. 5-1-15; DMAP 46-2015(Temp), f. 8-26-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 65-2015, f. 11-3-15, cert. ef. 12-1-15; DMAP 20-2016(Temp), f. 5-6-16, cert. ef. 5-10-16 thru 11-5-16; DMAP 48-2016(Temp), f. & cert. ef. 7-22-16 thru 11-5-16; DMAP 61-2016, f. & cert. ef. 10-13-16

410-123-1230
Buying-Up

(1) Buying-up as defined in OAR 410-120-0000 is prohibited.

(2) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (Division) or a managed care plan for a covered service when:

(a) A non-covered service has been provided; and

(b) Additional payment is sought or accepted from the client.

(3) If a client wants to purchase a non-covered service or item, the client must be responsible for full payment. A payment from the Division or the managed care plan for a covered service cannot be credited toward the non-covered service and then an additional client payment sought to obtain, for example, a gold crown (not covered) instead of the stainless steel crown (covered).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 14-1999(T), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 29-1999, f. 6-9-99, cert. ef. 6-10-99; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1240
The Dental Claim Invoice

(1) Providers: Refer to the Dental Services Provider Guide for information regarding claims submissions and billing information.

(2) Providers billing dental services on paper must use the 2012 version of the American Dental Association (ADA) claim form.

(3) Submission of electronic claims directly or through an agent must comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq.

(4) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the Division Web site.

(5) Providers will not include any client co-payments on the claim when billing for dental services.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 76-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 36-2005, f. & cert. ef. 8-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 47-2015(Temp), f. 8-26-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 69-2015, f. 11-25-15, cert. ef. 12-1-15

410-123-1260
OHP Dental Benefits

This administrative rule aligns with and reflects changes to the Prioritized List of Health Services and the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT Codes), as well as a restoration of benefits resulting from legislative action in 2015. Effective January 1, 2016, the Health Evidence Review Commission (HERC) added and deleted oral health procedure codes. This rule provides information on how the Oregon Health Plan will cover newly opened CDT codes and restored benefits as of July 1, 2016.

(1) GENERAL:

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(B) Providers shall provide EPSDT services for eligible Division clients according to the following documents:

(i) The Dental Services Program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at www.oregon.gov/oha/healthplan/Pages/dental.aspx.

(b) Restorative, periodontal, and prosthetic treatments:

(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care and may be limited as follows:

(i) When prognosis is unfavorable;

(ii) When treatment is impractical;

(iii) A lesser-cost procedure would achieve the same ultimate result; or

(iv) The treatment has specific limitations outlined in this rule.

(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.

(2) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:

(a) Topical fluoride treatment:

(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with either the appropriate Current Dental Terminology (CDT) code (D1206-Topical Fluoride Varnish) or the appropriate Current Procedural Terminology (CPT) code (99188 – Application of topical fluoride varnish by a physician or other qualified health care professional).

(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule.

(b) Assessment of a patient:

(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;

(B) For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:

(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;

(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;

(iii) Referral to a dentist in order to establish a dental home;

(iv) Documentation in medical chart of risk assessment findings and service components provided.

(C) For reimbursement, the performing provider must meet all of the following criteria:

(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and

(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:

(I) Smiles for Life; or

(II) First Tooth through the Oregon Oral Health Coalition.

(D) For reimbursement, the medical practitioners must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient).

(E) D0191 Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;

(F) D0191 Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in subsection three (3) of this rule.

(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190.

(3) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children under 19 years of age:

(i) The Division shall reimburse exams (billed as CDT codes D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:

(I) D0150: once every 12 months when performed by the same practitioner;

(II) D0150: twice every 12 months only when performed by different practitioners;

(III) D0180: once every 12 months.

(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner.

(B) For adults 19 years of age and older, the Division shall reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once every 12 months;

(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem-focused follow-up exams. Providers must not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams performed by medical practitioners when the medical practitioner is an oral surgeon;

(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the dentist. The Division may not reimburse dental exams when performed by a dental hygienist (with or without an expanded practice permit).

(b) Assessment of a patient (D0191):

(A) When performed by a dental practitioner, the Division shall reimburse:

(i) If performed by a dentist outside of a dental office;

(ii) If performed by a dental hygienist with an expanded practice dental hygiene permit;

(iii) Only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a patient (D0191) is included as part of an exam (D0120-D0180);

(iv) For children under 19 years of age, a maximum of twice every 12 months; and

(v) For adults age 19 and older, a maximum of once every 12 months.

(B) An assessment does not take the place of the need for oral evaluations/exams.

(c) Radiographs:

(A) The Division shall reimburse for routine radiographs once every 12 months;

(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;

(C) The Division shall reimburse a maximum of six radiographs for any one emergency;

(D) For clients under age six, radiographs may be billed separately every 12 months as follows:

(i) D0220 — once;

(ii) D0230 — a maximum of five times;

(iii) D0270 — a maximum of twice, or D0272 once.

(E) The Division shall reimburse for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period;

(F) Clients shall be a minimum of six years old for billing intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:

(i) For clients age six through 11 — a minimum of ten periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older — a minimum of ten periapicals and four bitewings for a total of 14 films.

(G) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Division shall reimburse for the complete series;

(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;

(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records shall be included in the client's records;

(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.

(4) PREVENTIVE SERVICES:

(a) Prophylaxis:

(A) For children under 19 years of age — Limited to twice per 12 months;

(B) For adults 19 years of age and older — Limited to once per 12 months;

(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily oral health care;

(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:

(i) D1110 (Prophylaxis — Adult) — Use for clients 14 years of age and older; and

(ii) D1120 (Prophylaxis — Child) — Use for clients under 14 years of age.

(b) Topical fluoride treatment:

(A) For adults 19 years of age and older — Limited to once every 12 months;

(B) For children under 19 years of age — Limited to twice every 12 months;

(C) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for clients who:

(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(ii) Are pregnant;

(iii) Have physical disabilities and cannot perform adequate, daily oral health care;

(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or

(v) Are under seven years old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.

(D) Fluoride limits include any combination of fluoride varnish (D1206) or other topical fluoride (D1208).

(c) Sealants (D1351):

(A) Are covered only for children under 16 years of age;

(B) The Division limits coverage to:

(i) Permanent molars; and

(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure.

(d) Tobacco cessation:

(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following brief counseling is provided:

(i) Ask patients about their tobacco-use status at each visit and record information in the chart;

(ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and

(iii) Refer patients who are ready to quit, utilizing internal and external resources, to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco.

(B) The Division allows a maximum of ten services within a three-month period.

(e) Space management:

(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;

(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.

(f) Interim caries arresting medicament application (D1354):

(A) Is limited to silver diamine fluoride (SDF) application as the medicament. It does not include coverage of any other medicaments;

(B) May be billed for two applications per year;

(C) Requires that the tooth or teeth numbers be included on the claim;

(D) Shall be covered with topical application of fluoride (D1206 or D1208) when they are performed on the same date of service if D1354 is being used to treat a carious lesion and D1206 or D1208 to prevent caries;

(E) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354) on the same tooth, when dentally appropriate.

(5) RESTORATIVE SERVICES:

(a) Amalgam and resin-based composite restorations, direct:

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(C) The Division limits payment for replacement of posterior composite restorations to once every five years;

(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;

(E) Providers shall combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);

(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;

(G) Interim therapeutic restoration on primary dentition (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;

(H) Reattachment of tooth fragment (D2921) is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;

(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.

(b) Indirect crowns and related services:

(A) General payment policies:

(i) The fee for the crown includes payment for preparation of the gingival tissue;

(ii) The Division shall cover crowns only when:

(I) There is significant loss of clinical crown and no other restoration will restore function; and

(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures.

(iii) The Division shall cover core buildup (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure must be remaining for coverage of the core buildup.

(iv) Reimbursement of retention pins (D2951) is per tooth, not per pin.

(B) The Division shall not cover the following services:

(i) Endodontic therapy alone (with or without a post);

(ii) Aesthetics (cosmetics);

(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.

(C) Stainless steel crowns (D2930/D2931) are allowed only for anterior primary teeth and posterior permanent or primary teeth;

(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:

(i) Prefabricated plastic crowns (D2932) are allowed only for anterior teeth, permanent or primary;

(ii) Prefabricated stainless steel crowns with resin window (D2933) are allowed only for anterior teeth, permanent or primary;

(iii) Prefabricated post and core in addition to crowns (D2954/D2957);

(iv) Permanent crowns (resin-based composite — D2710 and D2712 and porcelain fused to metal (PFM) — D2751 and D2752) as follows:

(I) Limited to teeth numbers 6–11, 22, and 27 only, if dentally appropriate;

(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed according to (E)(i) of this rule;

(III) Only for clients at least 16 years of age; and

(IV) Rampant caries are arrested, and the client demonstrates a period of oral hygiene before prosthetics are proposed.

(v) PFM crowns (D2751 and D2752) shall also meet the following additional criteria:

(I) The dental practitioner has attempted all other dentally appropriate restoration options and documented failure of those options;

(II) Written documentation in the client's chart indicates that PFM is the only restoration option that will restore function;

(III) The dental practitioner submits radiographs to the Division for review; history, diagnosis, and treatment plan may be requested. (See OAR 410-123-1100 Services Reviewed by the Division);

(IV) The client has documented stable periodontal status with pocket depths within 1–3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation shall be maintained in the client's chart of the dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long-term prognosis;

(V) The crown has a favorable long-term prognosis; and

(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis.

(E) Crown replacement:

(i) Permanent crown replacement limited to once every seven years;

(ii) All other crown replacement limited to once every five years; and

(iii) The Division may make exceptions to crown replacement limitations due to acute trauma, based on the following factors:

(I) Extent of crown damage;

(II) Extent of damage to other teeth or crowns;

(III) Extent of impaired mastication;

(IV) Tooth is restorable without other surgical procedures; and

(V) If loss of tooth would result in coverage of removable prosthetic.

(F) Crown repair (D2980) is limited to only anterior teeth.

(6) ENDODONTIC SERVICES:

(a) Endodontic therapy:

(A) Pulpal therapy on primary teeth (D3230 and D3240) is covered only for clients under 21 years of age;

(B) For permanent teeth:

(i) Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all OHP Plus clients; and

(ii) Molar endodontic therapy (D3330):

(I) For clients through age 20, is covered only for first and second molars; and

(II) For clients age 21 and older who are pregnant, is covered only for first molars.

(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.

(b) Endodontic retreatment and apicoectomy:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy for bicuspid or molars;

(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics.

(C) Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.

(c) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or dental practitioner in the same group practice completed the procedure;

(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(e) Apexification/recalcification procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.

(7) PERIODONTIC SERVICES:

(a) Surgical periodontal services:

(A) Gingivectomy/Gingivoplasty (D4210 and D4211) — limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and

(B) Includes six months routine postoperative care;

(C) The Division shall consider gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure.

(b) Non-surgical periodontal services:

(A) Periodontal scaling and root planing (D4341 and D4342):

(i) Allowed once every two years;

(ii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:

(I) D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;

(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater.

(iv) Prior authorization for more frequent scaling and root planing may be requested when:

(I) Medically/dentally necessary due to periodontal disease as defined above is found during pregnancy; and

(II) Client's medical record is submitted that supports the need for increased scaling and root planing.

(B) Full mouth debridement (D4355) allowed only once every two years.

(c) Periodontal maintenance (D4910) allowed once every six months:

(A) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(B) Prior authorization for more frequent periodontal maintenance may be requested when:

(i) Medically/dentally necessary, such as due to presence of periodontal disease during pregnancy; and

(ii) Client's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).

(d) Records shall clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;

(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:

(A) D1110 (Prophylaxis — adult);

(B) D1120 (Prophylaxis — child);

(C) D4210 (Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant);

(D) D4211 (Gingivectomy or gingivoplasty — one to three contiguous teeth or bounded teeth spaces per quadrant);

(E) D4341 (Periodontal scaling and root planning — four or more teeth per quadrant);

(F) D4342 (Periodontal scaling and root planning — one to three teeth per quadrant);

(G) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(H) D4910 (Periodontal maintenance).

(8) REMOVABLE PROSTHODONTIC SERVICES:

(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);

(b) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;

(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;

(d) Resin partial dentures (D5211-D5212):

(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;

(B) For clients through age 20, the client shall have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) For clients age 21 and older, the client shall have one or more missing anterior teeth or six or more missing posterior teeth per arch with documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner shall note the teeth to be replaced and teeth to be clasped when requesting prior authorization (PA).

(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:

(A) For clients at least 16 years of age, the Division shall replace:

(i) Full dentures once every ten years, only if dentally appropriate;

(ii) Partial dentures once every five years, only if dentally appropriate.

(B) The five- and ten-year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO)/Coordinated Care Organization (CCO) enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2002, and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2012. The client gets a replacement partial on February 3, 2012 while FFS and a year later enrolls in a DCO or CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO, or FFS enrollment;

(C) Replacement of partial dentures with full dentures is payable five years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement.

(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:

(A) A maximum of four times per year for:

(i) Adjusting complete and partial dentures, per arch (D5410-D5422);

(ii) Replacing missing or broken teeth on a complete denture, each tooth (D5520);

(iii) Replacing broken tooth on a partial denture, each tooth (D5640);

(iv) Adding tooth to existing partial denture (D5650).

(B) A maximum of two times per year for:

(i) Repairing broken complete denture base (D5510);

(ii) Repairing partial resin denture base (D5610);

(iii) Repairing partial cast framework (D5620);

(iv) Repairing or replacing broken clasp (D5630);

(v) Adding clasp to existing partial denture (D5660).

(g) Replacement of all teeth and acrylic on cast metal framework (D5670, D5671):

(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;

(B) Ten years or more shall have passed since the original partial denture was delivered;

(C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another ten years; and

(D) Requires prior authorization as it is considered a replacement partial denture.

(h) Denture rebase procedures:

(A) The Division shall cover rebases only if a reline may not adequately solve the problem;

(B) For clients through age 20, the Division limits payment for rebase to once every three years;

(C) For clients age 21 and older:

(i) There shall be documentation of a current reline that has been done and failed; and

(ii) The Division limits payment for rebase to once every five years.

(D) The Division may make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;

(i) Denture reline procedures:

(A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;

(B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;

(C) The Division may make exceptions to this limitation under the same conditions warranting replacement;

(D) Laboratory relines:

(i) Are not payable prior to six months after placement of an immediate denture; and

(ii) For clients through age 20, are limited to once every three years;

(iii) For clients age 21 and older, are limited to once every five years.

(j) Interim partial dentures (D5820-D5821, also referred to as "flippers"):

(A) Are allowed if the client has one or more anterior teeth missing; and

(B) The Division shall reimburse for replacement of interim partial dentures once every five years but only when dentally appropriate.

(k) Tissue conditioning:

(A) Is allowed once per denture unit in conjunction with immediate dentures; and

(B) Is allowed once prior to new prosthetic placement.

(9) MAXILLOFACIAL PROSTHETIC SERVICES:

(a) Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The dental practitioner shall document failure of those options prior to use of the fluoride gel carrier;

(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220:

(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format:

(B) For clients receiving services through a CCO or PHP, bill medical maxillofacial prosthetics to the CCO or PHP;

(C) For clients receiving medical services through FFS, bill the Division.

(10) ORAL SURGERY SERVICES:

(a) Bill the following procedures in an accepted dental claim format using CDT codes:

(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical condition or diagnosis, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;

(B) Services performed in a dental office setting or an oral surgeon's office:

(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs, and follow-up visits;

(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures.

(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD-10 diagnosis codes:

(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);

(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer).

(c) Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;

(d) For clients enrolled in a DCO or CCO responsible for dental services, the DCO or CCO shall pay for those services in the dental plan package;

(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:

(A) Require PA;

(B) For clients enrolled in a CCO, the CCO shall pay for the facility charge and anesthesia services. For clients enrolled in a Physician Care Organization (PCO), the PCO shall pay for the outpatient facility charge (including ASCs) and anesthesia. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410, division 130 for more information;

(C) If a client is enrolled in a CCO or PHP, the provider shall contact the CCO or PHP for any required authorization before the service is rendered.

(f) All codes listed as "by report" require an operative report;

(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;

(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;

(i) The Division does not cover surgical excisions of soft tissue lesions (D7410-D7415);

(j) Extractions — Includes local anesthesia and routine post-operative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;

(k) Surgical extractions:

(A) Include local anesthesia and routine post-operative care;

(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, or unusual swelling of the face or gums;

(C) The Division does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;

(D) The Division covers alveoplasty not in conjunction with extractions (D7320-D7321) only for clients under 21 years of age or who are pregnant.

(L) Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):

(A) The Division covers either frenulectomy or frenuloplasty once per lifetime per arch only for clients under age 21;

(B) The Division covers maxillary labial frenulectomy only for clients age 12 through 20;

(C) The Division shall cover frenulectomy/frenuloplasty in the following situations:

(i) When the client has ankyloglossia;

(ii) When the condition is deemed to cause gingival recession; or

(iii) When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension.

(m) The Division covers excision of pericoronal gingival (D7971) only for clients under age 21 or who are pregnant.

(11) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-10-CM diagnosis of:

(i) Cleft palate; or

(ii) Cleft palate with cleft lip; and

(B) Whose orthodontia treatment began prior to 21 years of age; or

(C) Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21.

(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate or cleft lip shall be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record shall include diagnosis, length, and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander), and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase separately;

(f) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist shall refund to the Division any unused amount of payment after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;

(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8690 — PA required.

(12) ADJUNCTIVE GENERAL AND OTHER SERVICES:

(a) Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;

(b) Anesthesia:

(A) Only use general anesthesia or IV sedation for those clients with concurrent needs: age; physical, medical or mental status; or degree of difficulty of the procedure (D9223 and D9243);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9223 or D9243: For each 15-minute period, up to three and a half hours on the same day of service;

(ii) Each 15-minute period represents a quantity of one. Enter this number in the quantity column.

(C) The Division reimburses administration of Nitrous Oxide (D9230) per date of service, not by time;

(D) Oral pre-medication anesthesia for conscious sedation (D9248):

(i) Limited to clients under 13 years of age;

(ii) Limited to four times per year;

(iii) Includes payment for monitoring and Nitrous Oxide; and

(iv) Requires use of multiple agents to receive payment.

(E) Upon request, providers shall submit a copy of their permit to administer anesthesia, analgesia, and sedation to the Division;

(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication.

(c) The Division limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;

(d) Oral devices/appliances (E0485, E0486):

(A) These may be placed or fabricated by a dentist or oral surgeon but are considered a medical service;

(B) Bill the Division, CCO, or the PHP for these codes using the professional claim format.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13; DMAP 68-2013, f. 12-5-13, cert. ef. 12-23-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 10-2014(Temp), f. & cert. ef. 2-28-14 thru 8-27-14; DMAP 19-2014(Temp), f. 3-28-14, cert. ef. 4-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14; DMAP 56-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 7-2015(Temp), f. & cert. ef. 2-17-15 thru 8-15-15; DMAP 28-2015, f. & cert. ef. 5-1-15; DMAP 46-2015(Temp), f. 8-26-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 65-2015, f. 11-3-15, cert. ef. 12-1-15; DMAP 74-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 5-2016(Temp), f. & cert. ef. 2-9-16 thru 6-28-16; DMAP 36-2016, f. 6-30-16, cert. ef. 7-1-16; DMAP 45-2016, f. & cert. ef. 7-13-16

410-123-1490
Hospital Dentistry

(1) The purpose of hospital dentistry is to provide safe, efficient dental care when providing routine (non-emergency) dental services for Division of Medical Assistance Programs (Division) clients who present special challenges that require the use of general anesthesia or IV conscious sedation services in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting. Refer to OAR 410-1231060 for definitions.

(2) Division reimbursement for hospital dentistry is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit:

(a) See OAR 410-123-1060 for a definition of Division hospital dentistry services;

(b) Refer to OAR 410-123-1220 and the "Covered and Non-Covered Dental Services" document.

(3) Hospital dentistry is intended for the following Division clients:

(a) Children (18 or younger) who:

(A) Through age 3 — Have extensive dental needs;

(B) 4 years of age or older — Have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;

(C) Have acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;

(D) Need the use of general anesthesia (or IV conscious sedation) to protect the developing psyche;

(E) Have sustained extensive orofacial or dental trauma;

(F) Have physical, mental or medically compromising conditions; or

(G) Have a developmental disability or other severe cognitive impairment and one or more of the following characteristics that prevent routine dental care in an office setting:

(i) Acute situational anxiety and extreme uncooperative behavior;

(ii) A physically compromising condition;

(b) Adults (19 or older) who:

(A) Have a developmental disability or other severe cognitive impairment, and one or more of the following characteristics that prevent routine dental care in an office setting:

(i) Acute situational anxiety and extreme uncooperative behavior;

(ii) A physically compromising condition;

(B) Have sustained extensive orofacial or dental trauma; or

(C) Are medically fragile, have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client.

(4) Hospital dentistry is not intended for:

(a) Client convenience. Refer to OAR 410-120-1200;

(b) A healthy, cooperative client with minimal dental needs; or

(c) Medical contraindication to general anesthesia or IV conscious sedation.

(5) Required documentation: The following information must be included in the client's dental record:

(a) Informed consent: client, parental or guardian written consent must be obtained prior to the use of general anesthesia or IV conscious sedation;

(b) Justification for the use of general anesthesia or IV conscious sedation. The decision to use general anesthesia or IV conscious sedation must take into consideration:

(A) Alternative behavior management modalities;

(B) Client's dental needs;

(C) Quality of dental care;

(D) Quantity of dental care;

(E) Client's emotional development;

(F) Client's physical considerations;

(c) If treatment in an office setting is not possible, documentation in the client's dental record must explain why, in the estimation of the dentist, the client will not be responsive to office treatment;

(d) The Division, Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) may require additional documentation when reviewing requests for prior authorization (PA) of hospital dentistry services. See OAR 410-123-1160 and section (6) of this rule for additional information;

(e) If the dentist did not proceed with a previous hospital dentistry plan approved by the Division for the same client, the Division will also require clinical documentation explaining why the dentist did not complete the previous treatment plan.

(6) Hospital dentistry always requires prior authorization (PA) for the medical services provided by the facility:

(a) If a client is enrolled in a CCO or PHP and a Dental Care Organization (DCO):

(A) The dentist is responsible for:

(i) Contacting the CCO or PHP for PA requirements and arrangements; and

(ii) Submitting documentation to both the CCO or PHP and DCO;

(B) The CCO or PHP and DCO should review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;

(C) The total response time should not exceed 14 calendar days from the date of submission of all required documentation for routine dental care and should follow urgent/emergent dental care timelines;

(D) The CCO or PHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services;

(b) If a client is enrolled in a Physician Care Organization (PCO) and a Dental Care Organization (DCO):

(A) The PCO is responsible for payment of all facility and anesthesia services provided in an outpatient hospital setting or an ASC. The Division is responsible for payment of all facility and

anesthesia services provided in an inpatient hospital setting. The DCO is responsible for payment of all dental professional services;

(B) The dentist is responsible for:

(i) Contacting the PCO, if services are to be provided in an outpatient setting or an ASC, for PA requirements and arrangements; or

(ii) Contacting the Division, if services are to be provided in an inpatient setting; and

(iii) Submitting documentation to both the PCO (or the Division) and the DCO;

(C) The PCO or the Division and the DCO should review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;

(D) The total response time should not exceed 14 calendar days from the date of submission of all required documentation for routine dental care and should follow urgent/emergent dental care timelines;

(c) If a client is fee-for-service (FFS) for medical services and enrolled in a DCO:

(A) The dentist is responsible for faxing documentation and a completed American Dental Association (ADA) form to the Division. Refer to the Dental Services Provider Guide;

(B) If the client is assigned to a Primary Care Manager (PCM) through FFS medical, the client must have a referral from the PCM prior to any hospital service being approved by the Division;

(C) The Division is responsible for payment of facility and anesthesia services. The DCO is responsible for payment of all dental professional services;

(D) The Division will issue a decision on PA requests within 30 days of receipt of the request;

(d) If a client is enrolled in an CCO or PHP and is FFS dental:

(A) The dentist is responsible for contacting the CCO or PHP to obtain the PA and arrange for the hospital dentistry;

(B) The dentist is responsible for submitting required documentation to the CCO or PHP;

(C) The CCO or PHP is responsible for all facility and anesthesia services. The Division is responsible for payment of all dental professional services;

(e) If a client is FFS for both medical and dental:

(A) The dentist is responsible for faxing documentation and a completed ADA form to the Division. Refer to the Dental Services Provider Guide;

(B) The Division is responsible for payment of all facility, anesthesia services and dental professional charges.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13; Administrative correction, 2-5-14

410-123-1510
Dental Care Access Standards for Pregnant Women

(1) This rule sets forth the access standards for dental care for pregnant women who receive Oregon Health Plan (OHP) benefits through the fee-for-service delivery system.

(2) Pregnant clients must be seen, treated, or referred to an OHP-covered service within the following time frames:

(a) For emergency dental care: within 24 hours;

(b) For urgent dental care: one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060;

(c) For routine dental care: an average of four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate;

(d) For initial dental screening or examination: four weeks.

(3) Nothing in this rule obligates a pregnant woman who receives dental care through the fee-for-service delivery system to accept an offered appointment.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 82-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 28-2016, f. & cert. ef. 6-28-16

410-123-1540
Citizen/Alien-Waived Emergency Medical (CAWEM)

(1) CAWEM clients who are not pregnant (benefit package identifier CWM) have a limited benefit package. Dental coverage is limited to dental services provided in an emergency department hospital setting. Refer to OAR 410-120-1210(4)(e).

(2) CAWEM clients who are pregnant (benefit package identifier CWX) receive the OHP Plus dental benefit package as described in OAR 410-123-1260.

(3) All CAWEM clients are exempt from enrollment in a Dental Care Organization (DCO) or Coordinated Care Organization (CCO). Providers must bill the Division directly for any allowable services provided.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14

410-123-1600
Managed Care Organizations

(1) The Division contracts with Managed Care Organizations (MCO) and Primary Care Managers (PCM) to provide medical services for clients under the Division (Title XIX and Title XXI services):

(a) MCOs for dental services are called Dental Care Organizations (DCO). See General Rules OAR 410-120-0250 — Managed Care Organizations for definitions and responsibilities of MCOs;

(b) See General Rules OAR 410-120-1210(4) — Medical Assistance Programs and Delivery Systems for a description of how clients receive services through MCOs and PCMs.

(2) The Division prepays DCOs to cover dental services, including the professional component of any services provided in an Ambulatory Surgical Center (ASC) or an outpatient or inpatient hospital setting for hospital dentistry. See OAR 410-123-1490 for more information about hospital dentistry.

(3) The Division will not pay for services covered by a MCO; reimbursement is a matter between the MCO and the provider.

(4) For clients enrolled in a DCO, it is the responsibility of the dental provider to coordinate all dental services with the client's DCO prior to providing services.

Stat. Auth.: ORS 413.042, 414.065 & 414.651
Stats. Implemented: ORS 414.651
Hist.: OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13; Administrative correction, 2-5-14

410-123-1620
Procedure and Diagnosis Codes

(1) The Division requires providers to use the standardized code sets adopted by the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(2) Procedure codes:

(a) For dental services, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association. Contact the American Dental Association (ADA) to obtain a current copy of the CDT reference manual. Current Dental Terminology (including procedure codes, definitions (descriptors) and other data) is copyrighted by the ADA. © 2012 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation Clauses/Department of Defense Federal Acquisition Regulation Supplement (FARS/DFARS) apply;

(b) For physician services and other health care services, use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes.

(3) Diagnosis codes:

(a) International Classification of Diseases 10th Clinical Modification (ICD-10-CM) diagnosis codes are not required for dental services submitted on an ADA claim form;

(b) When Oregon Administrative Rule (OAR) 410-123-1260 requires services to be billed on a professional claim form, ICD-10-CM diagnosis codes are required. Refer to the Medical-Surgical administrative rules for additional information, OAR 410 division 130.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-123-1640
Prescriptions

(1) Follow criteria outlined in OAR 410-121-0144.

(2) Practitioner-Managed Prescription Drug Plan (PMPDP) — Follow criteria outlined in PMPDP — OAR 410-121-0030.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03

DIVISION 124

TRANSPLANT SERVICES

410-124-0000
Transplant Services

(1) The Division of Medical Assistance Programs (Division) will make payment for prior authorized and emergency transplant services identified in these rules as covered for eligible clients receiving the OHP Plus benefit package and when the Division transplant criteria described in OAR 410-124-0010 and 410-124-0060 through 410-124-0160 is met. All other Benefit Packages do not cover transplant.

(2) The Division will only prior authorize and reimburse for transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(3) Simultaneous multiple organ transplants are covered only if specifically identified as paired on the same currently funded line on the Oregon Health Plan (OHP) Prioritized List of Health Services whether the transplants are for the same underlying disease or for unrelated, but concomitant, underlying diseases.

(4) Not Covered Transplant Services: The following types of transplants are not covered by the Division:

(a) Transplants which are considered experimental or investigational or which are performed on an experimental or investigational basis, as determined by the Division;

(b) Transplant services which are contraindicated, as described in OAR 410-124-0060 through 410-124-0160;

(c) Transplants which have not been prior authorized for payment by the Division or the client's managed health care plan;

(d) Transplants which do not meet the guidelines for an emergency transplant in OAR 410-124-0040;

(e) Transplants which are not described as covered in OAR 410-141-0480 and 410-141-0520.

(5) Selection of Transplant Centers: Transplant services will be reimbursed only when provided in a transplant center that provides quality services, demonstrates good patient outcomes and compliance with all Division facility criteria. The transplant center must have provided transplant services for a period of at least two years and must have completed a minimum of 12 cases in the most recent year. The patient-and-graft-survival rates must be equal to or greater than the appropriate standard indicated in this rule. A transplant center which has had at least two years of experience in transplantation of any solid organ (heart, liver, lung, pancreas) and which has met or exceeded the appropriate standards may be considered for reimbursement for the transplantation of other solid organs and/or autologous or allogeneic bone marrow transplantation:

(a) An experienced and proficient transplant team and a well established transplant support infrastructure at the same physical location as the transplant service is required for transplant services rendered to Division clients. These transplant criteria are crucial to successful transplant outcome. Therefore, consortia will not be approved or contracted with for the provision of transplant services for Division clients. No Division transplant contract, prior approval or reimbursement will be made to consortia for transplant services

where, as determined by the Division, there is no assurance that the individual facilities that make up the consortia independently meet Division criteria. The Division's transplant criteria must be met individually by a facility to demonstrate substantial experience with the procedure;

(b) Once a transplant facility has been approved and contracted for Division transplant services, it is obliged to report immediately to the Division any events or changes that would affect its approved status. Specifically, a transplant facility is required to report, within a reasonable period of time, any significant decrease in its experience level or survival rates, the departure of key members of the transplant team or any other major changes that could affect the performance of transplants at the facility. Changes from the terms of approval may lead to prospective withdrawal of approval for Division coverage of transplants performed at the facility;

(c) Coordinated care organizations (CCOs) that contract with non-Division contracted facilities for OHP Plus clients will develop and use appropriate transplant facility criteria to evaluate and monitor for quality services at the transplant facility;

(d) Transplant centers which have less than two years' experience in solid organ transplant may be reimbursed, at the Division's discretion, for allogeneic or autologous bone marrow transplants upon completion of two years of experience in bone marrow transplantation with patient survival rates equal to or exceeding those defined in section (5) of this rule;

(e) The Division will discontinue the contract with a transplant center when the graft and/or survival rates fall below the standards indicated in this rule for a period of two consecutive years.

(6) Standards for Transplant Centers:

(a) Heart, heart-lung and lung transplants:

(A) Heart: One-year patient survival rate of at least 80%;

(B) Heart-Lung: One-year patient survival rate of at least 65%;

(C) Lung: One-year patient survival rate of at least 65%.

(b) Bone Marrow (autologous and allogeneic), peripheral stem cell (autologous and allogeneic) and cord blood (allogeneic) transplants: One-year patient survival rate of at least 50%;

(c) Liver transplants: One year patient survival rate of at least 70% and one year graft survival rate of at least 60%;

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants: One year patient survival rate of at least 90% and one year graft survival rate of at least 60%;

(e) Kidney transplants: One year patient survival rate of at least 92% and one year graft survival rate of at least 85%.

(7) Selection of transplant centers by geographic location: If the services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers. Out-of-state centers will be considered only if:

(a) The type of transplant required is not available in the state of Oregon and/or the type of transplant (for example, liver transplant) is available in the state of Oregon but the Oregon transplant center does not provide that type of transplant for all clients or all covered diagnoses, (e.g., pediatric transplants); and

(b) An in-state transplant center requests the out-of-state transplant referral; and

(c) An in-state transplant facility recommends transplantation based on in-state facility and Division criteria; or

(d) It would be cost effective as determined by the Division. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant center; or

(e) It is a contiguous, out-of-state transplant center that has a contract or special agreement for reimbursement with the Division.

(8) Professional and other services will be covered according to administrative rules in the applicable provider guides.

(9) Reimbursement for covered transplants and follow-up care for transplant services is as follows:

(a) For transplants for fee-for-service clients:

(A) Transplant facility services — by contract with the Division;

(B) Professional services — at the Division's maximum allowable rates.

(b) For emergency services, when no special agreement has been established, the rate will be:

(A) 75% of standard inpatient billed charge; and

(B) 50% of standard outpatient billed charge; or

(C) The payment rate set by the Medical Assistance program of the state in which the center is located, whichever is lower.

(c) For clients enrolled in CCOs, reimbursement for transplant services will be by agreement between the CCO and the transplant center.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 37-1990, f. 11-6-90, cert. ef. 11-9-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; HR 17-1997, f. & cert. ef. 7-11-97; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2004(Temp), f. 9-14-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 92-2004(Temp), f.& cert. ef. 12-10-04 thru 3-15-05; OMAP 95-2004(Temp), f. & cert. ef, 12-30-04 thru 3-15-05; Administrative correction, 3-17-05; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0005
Donor Services

(1) Living and cadaver donor search and procurement services are covered for covered transplants.

(2) All living or cadaver donor services are payable under the recipient's Medicaid identification number and not under the donor.

(3) Living donor services — prior authorization requirements for fee-for-service and Primary Care Case Manager (PCCM) clients:

(a) Bone marrow, stem cells and cord blood:

(A) Screening of potential living related donors does not require prior authorization;

(B) Unrelated/voluntary donor search requires prior authorization;

(C) Collection and testing of related cord blood requires prior authorization;

(D) Donor search costs up to the maximum amount of $15,000 are covered only if donor search is prior authorized;

(E) Procurement requires prior authorization of the transplant.

(b) Kidney alone — no prior authorization required for testing of or procurement from living or cadaver donors;

(c) Other solid organs — testing and procurement are covered if transplant is prior authorized;

(d) Payment is limited to donor expenses incurred directly in connection with the transplant. Complications of the donor that are directly and immediately related or attributable to the donation procedure are covered.

(4) Cadaver procurement services — prior authorization requirements for fee-for-service and PCCM clients:

(a) Covered if transplant is prior authorized;

(b) Procurement charges are included in the Organ Procurement Organization (OPO) charges to the transplant facility;

(c) Payable only to the transplant facility per contract.

(5) For Fully Capitated Health Plan (FCHP) clients, contact the client's FCHP for authorization requirements.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00

410-124-0010
Eligibility for Transplant Services

(1) To be eligible for transplant services the client must be on the Basic Health Care Package at the time the transplant services are provided.

(2) Clients covered under the following Benefit Packages do not have coverage for transplants:

(a) Limited Benefit Package (LMH, LMM) — coverage only for mental health, alcohol/drug, pharmacy, and medical transportation services;

(b) Qualified Medicare Beneficiary (MED) — coverage only for services covered by Medicare;

(c) Citizen/Alien-Waived Emergency Medical (CAWEM) — Federal rules exclude coverage of transplants, even if emergent.

(3) If an individual is not eligible for the Basic Health Care Package at the time the transplant is performed, but is later made retroactively eligible for the Basic Health Care Package, the Division of Medical Assistance Programs (Division) will apply the same criteria found in OAR 410-124-0020 through OAR 410-124-0160 in determining whether to cover the transplant and transplant-related services. Payment can only be made for services provided during the period of time the individual is eligible.

(4) The Division prior authorization is valid for transplant services provided only while the client is enrolled under fee-for-service or a Primary Care Case Manager. If a client moves from the fee-for-service arena to a Fully Capitated Health Plan (FCHP), any prior authorizations which had been approved by the Division are void and prior authorization must be obtained from the new FCHP. If a client moves out of an FCHP into another FCHP, or into fee-for-service, any prior authorizations approved by the original FCHP or Division are void, and prior authorization must again be obtained from the new FCHP or the Division.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 37-1990, f. 11-6-90, cert. ef. 11-9-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00

410-124-0020
Prior Authorization for All Covered Transplants, Except Cornea and Kidney

(1) The following services require prior authorization:

(a) All non-emergency transplant services, except for kidney alone and cornea transplants which require prior authorization only if performed out-of-state;

(b) Pre-transplant evaluations provided by the transplant center (for covered transplants only).

(2) The prior authorization request for all covered transplants is initiated by the client's in-state referring physician or the transplant physician. The initial request should contain all available information outlined in subsection (3) of this rule, below:

(a) For fee-for-service clients, the request should be sent to the Division of Medical Assistance Programs (Division);

(b) For clients enrolled in a coordinated care organization (CCO), requests for transplant services should be sent directly to the CCO.

(3) A completed request for authorization must contain the following information. Failure to submit all the information will delay processing of the request. An optional form (DMAP 3084 – Request for Transplant or Transplant Evaluation) is provided on the Transplant Services Web page at www.oregon.gov/OHA/healthplan/pages/transplant.aspx for provider convenience in submitting requests:

(a) The name, age, Oregon Health ID number, and birth date of the client;

(b) A description of the medical condition and full ICD-10-CM coding which necessitates a transplant;

(c) The type of transplant proposed, with CPT code;

(d) The results of a current HIV test, (completed within 6 months of request for transplant authorization);

(e) Any other evidence of contraindications for the type of transplant being considered (see contraindications under each transplant type);

(f) The client's prognosis, with and without a transplant, including estimated life expectancy with and without the transplant;

(g) Transplant treatment alternatives:

(A) A history of other treatments which have been tried;

(B) Treatments that have been considered and ruled out, including discussion of why they have been ruled out.

(h) An evaluation based upon a comprehensive examination completed by a board certified specialist in a field directly related to the condition of the client which necessitates the transplant;

(i) If already done before requesting prior authorization, the results of any medical and/or social evaluation completed by a transplant center should be included in the prior authorization request. The completion of an evaluation by a transplant center before receiving prior authorization from the Division does not obligate the Division to reimburse that transplant center for the evaluation or for any other transplant services not prior authorized.

(4) Prior authorization approval process and requirements:

(a) For clients receiving services on a fee-for-service basis:

(A) After receiving a completed request, the Division will notify the referring physician within two weeks if an evaluation at a transplant center is approved or denied;

(B) A final determination for the actual transplant requires an evaluation by a selected transplant center, which will include:

(i) A medical evaluation;

(ii) An estimate of the client's motivation and ability, both physical and psychological, to adhere to the post-transplant regimen;

(iii) The transplant center's assessment of the probability of a successful outcome, based on the type of transplant requested, the condition of the client, and the client's ability to adhere to the post-transplant regimen; and

(iv) A recommendation using both the transplant center's own criteria, and the Division criteria.

(b) For Oregon Health Plan (OHP) transplant eligible clients who are in an CCO: Refer to the CCO for approval process and requirements;

(c) The prior authorization request will be approved if:

(A) All Division criteria are met; and

(B) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(C) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services.

(5) The referring physician, transplant center, and the client will be notified in writing by the Division or the CCO of the prior authorization decision.

(6) Prior authorization of a transplant does not guarantee reimbursement for the services of any provider if, at the time the transplant is performed, intercurrent events have caused the individual's medical condition to deteriorate to the point at which survival with or without transplant for a period of more than sixty days is unlikely.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; HR 17-1997, f. & cert. ef. 7-11-97; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0040
Emergency Transplants

(1) An Emergency Transplant is one in which medical appropriateness requires that a covered transplant be performed less than five days after determination of the need for a transplant.

(2) Emergency transplants are subject to post transplant review of the client's medical records by the Division of Medical Assistance Programs (Division), or the Fully Capitated Health Plan (FCHP), to determine if the client and the transplant center met the criteria in these rules at the time of the transplant. Related charges, including transportation, physician's services, and donor charges will be covered if payment is approved. The Division will make payment as described in OAR 410-124-0000(9) for Division-covered transplants. FCHPs will make payment as described in their contract.

(3) Transplants are not covered by Citizen/Alien-Waived Emergency Medical (CAWEM) clients, even when emergent.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-124-0060
Criteria and Contraindications for Heart Transplants

(1) Prior authorization for a heart transplant will only be approved for a client in whom irreversible heart disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart transplant must have a poor prognosis (i.e., less than a 50% chance of survival for 18 months without a transplant) as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early congenital heart disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;

(e) Irreversible pulmonary hypertension;

(f) Serious psychological disorders;

(g) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for heart transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0063
Criteria and Contraindications for Heart-Lung Transplants

(1) Prior authorization for a heart-lung transplant will only be approved for a client in whom irreversible cardio-pulmonary disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart-lung transplant must have cardio-pulmonary failure with a poor prognosis (i.e., less than a 50% chance of survival for 18 months without a transplant) as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart-lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early cardio-pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart-lung transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for heart-lung transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0065
Criteria and Contraindications for Single Lung Transplants

(1) Prior authorization for a single lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis (i.e., less than a 50% chance of survival for 18 months without a transplant) as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of single lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for single lung transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for single lung transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0070

Criteria and Contraindications for Bilateral Lung Transplants

(1) Prior authorization for a bilateral lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis (i.e., less than a 50% chance of survival for 18 months without a transplant) as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of bilateral lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for bilateral lung transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for bilateral lung transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0080

Criteria and Contraindications for Autologous and Allogeneic Bone Marrow, Autologous and Allogeneic Peripheral Stem Cell and Allogeneic Cord Blood Transplants

(1) The following criteria will be used to evaluate the prior authorization request for all bone marrow and peripheral stem cell transplants:

(a) Transplantation must be the most effective medical treatment, when compared to other alternatives, in prolonging life expectancy to a reasonable degree;

(b) The client must have a maximum probability of a successful clinical outcome and the expectation of not less than a 20 percent five (5) year survival rate, subsequent to the transplant, as supported by medical literature considering each of the following factors:

(A) The type of transplant (i.e., autologous or allogeneic);

(B) The specific diagnosis of the individual;

(C) The stage of illness (i.e., in remission, not in remission, in second remission);

(D) Satisfactory antigen match between donor and recipient in allogeneic transplants;

(c) All alternative treatments with a one-year survival rate comparable to that of bone marrow transplantation must have been tried or considered.

(2) Allogeneic transplants will be approved for payment only when there is a minimum of 5-out-of-6 antigen match for bone marrow and peripheral stem cell transplants, or 4-out-of-6 match for cord blood transplants, considering the HLA-A, B, and DR loci. Donor search costs up to an amount of $15,000 will be covered only if prior authorized.

(3) Donor leukocyte infusions are covered only when:

(a) An early failure or relapse post allogeneic bone marrow transplant occurs; and

(b) Peripheral stem cells are from the original donor.

(4) The following are contraindications for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(5) The following may be considered contraindications to the extent the evaluating transplant center and/or the specialist who

completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(6) The Division of Medical Assistance Programs (Division) will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants only if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(7) The Division will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants for pediatric solid malignancies only if:

(a) Requirements of 410-124-0080(6)(a), (b) and (c) are met; and

(b) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520.

(8) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant; the patient must meet the criteria specified above and in 410-124-0020 at the time the transplant is performed.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 35-1991(Temp), f. & cert. ef. 8-29-91; HR 47-1991, f. & cert. ef. 10-16-91; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 34-1994, f. & cert. ef. 12-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; HR 17-1997, f. & cert. ef. 7-11-97; OMAP 14-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 29-1998, f. & cert. ef. 9-1-98; OMAP 33-1999(Temp), f. & cert. ef. 10-1-99 thru 2-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 49-2002, f. & cert. ef. 10-1-02; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0090
Criteria and Contraindications for Harvesting Autologous Bone Marrow and Peripheral Stem Cells

(1) The following are contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a potential transplant. The potential transplant recipient has:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(2) The following may be considered contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a transplant to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process. The potential transplant recipient has:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(3) The Division of Medical Assistance Programs (Division) will prior authorize and reimburse for the harvesting and storage of autologous bone marrow or autologous peripheral stem cells for a potential transplant recipient only if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and the CPT bone marrow or peripheral stem cell harvesting for transplantation procedure code(s) are paired on a currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520; and

(d) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520; and

(e) The client's marrow meets the clinical standards of remission at the time of storage; and

(f) A board certified hematologist/oncologist with specific experience in bone marrow transplant (BMT) services (i.e., cryopreservation and immunosuppressive treatment) has recommended the storage of autologous bone marrow or peripheral stem cell collection for possible future transplant/reinfusion; and

(g) The client has no contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells; and

(h) The client has no contraindications for bone marrow transplant or peripheral stem cell transplant.

(4) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant. The client must meet the criteria specified in this rule and OAR 410-124-0080, and the transplant must be prior authorized by the Division before reimbursement will be approved.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 49-2002, f. & cert. ef. 10-1-02; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0100
Criteria and Contraindications for Liver and Liver-Kidney Transplants

(1) Prior authorization for liver or liver-kidney transplants will be approved only for a client in whom irreversible, progressive liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Liver-kidney transplant is covered only for a medically documented diagnosis of Caroli's disease (ICD-10-CM Q44.6).

(3) The following are contraindications for liver or liver-kidney transplants:

(a) Incurable and untreatable malignancy outside the hepatobiliary system;

(b) Terminal state due to diseases other than liver disease;

(c) Uncontrolled sepsis, or active systemic infection;

(d) HIV positive test results;

(e) Active alcoholism or active substance abuse;

(f) Alternative effective medical or surgical therapy;

(g) Presence of uncorrectable significant organ system failure other than liver (excluding short-bowel syndrome or congenital intractable diarrhea).

(4) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Crigler-Najjar Syndrome Type II;

(b) Amyloidosis;

(c) Other major system diseases affecting brain, lung, heart, or renal systems;

(d) Major, not correctable congenital anomalies;

(e) Serious psychological disorders.

(5) The transplant center will review for current risk of alcohol or other substance abuse and risk of recidivism and will inform the Division of Medical Assistance Programs (Division) of its findings prior to the provision of the transplant.

(6) The Division will only prior authorize and reimburse for liver and liver-kidney transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0105
Criteria and Contraindications for Intestine and Intestine-Liver Transplants

(1) Prior authorization for intestine and intestine-liver transplants will be approved only for:

(a) A client who has failed Total Parenteral Nutrition (TPN) or who has developed life-threatening complications from TPN;

(b) A client in whom irreversible, progressive intestine and/or liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate subsequent to the transplant, is at least twenty (20) percent as supported by the medical literature.

(2) Intestine and Intestine-Liver transplant is covered only for a medically documented diagnosis of Short Bowel Syndrome and for patients age 5 years or under with diagnosis of ICD-10-CM K55.0-K55.9, ICD-10-CM K91.2, or ICD-10-CM P77.9.

(3) Small intestine transplant using a living related donor is considered investigational and will not be covered by The Division of Medical Assistance Programs (Division).

(4) The following are contraindications for intestine or intestine-liver transplants:

(a) Incurable and untreatable malignancy outside the hepatobiliary system;

(b) Terminal state due to diseases other than liver or intestinal disease;

(c) Uncontrolled sepsis, or active systemic infection;

(d) HIV positive test results;

(e) Alternative effective medical or surgical therapy;

(f) Presence of uncorrectable significant organ system failure other than liver or Short-Bowel Syndrome.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Crigler-Najjar Syndrome Type II;

(b) Amyloidosis;

(c) Other major system diseases affecting brain, lung, heart, or renal systems;

(d) Major, non-correctable congenital anomalies;

(e) Serious psychological disorders.

(6) The Division will prior authorize and reimburse for intestine and intestine-liver transplant if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0120
Criteria and Contraindications for Simultaneous Pancreas-Kidney and Pancreas After Kidney Transplants

(1) Prior authorization for a Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplant will be approved only for a client in whom irreversible kidney and/or pancreatic disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Simultaneous pancreas-kidney (SPK) transplant is covered only for Type I diabetes mellitus with end stage renal disease (ICD-10-CM codes E10.21, E10.22, E10.29, E10.21, E10.65).

(3) Pancreas after kidney (PAK) transplantation will be considered for clients suffering from insulin dependent Type I diabetes after prior successful renal transplant. Pancreas after kidney (PAK) transplant is covered only for Type I diabetes mellitus (ICD-10-CM codes E10.8-E10.11, E10.31, E10.36, E10.39-E10.40-E10.41, E10.44, E10.49, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.349, E10.351, E10.359, E10.610, E10.618, E10.620-E10.622, E10.628, E10.630, E10.638-E10.649, E10.69, T86.10-T86.13, T86.19, T86.890-T86.92, T86.898-T86.99

(4) The following are contraindications to SPK and PAK transplants:

(a) Uncorrectable severe coronary artery disease;

(b) Major irreversible disease of any other major organ system likely to limit life expectancy to five years or less;

(c) HIV positive test results.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Drug abuse or alcohol abuse.

(6) The Division of Medical Assistance Programs (Division) will only prior authorize and reimburse for Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplants if:

(a) All Division criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-10-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-124-0140
Kidney Transplants

(1) Kidney transplants do not require prior authorization when accomplished in-state.

(2) Out-of-state kidney transplant services are prior authorized by the Division or the Fully Capitated Health Plan (FCHP):

(a) Submit the request to the FCHP or Division;

(b) The request must contain the following information:

(A) Name and Medical Assistance Identification number of the client;

(B) A description of the condition which necessitates a transplant;

(C) The results of any evaluation performed by an in-state provider of kidney transplant services;

(D) An explanation of the reason out-of-state services are requested.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-124-0160
Cornea Transplants

(1) Cornea transplants do not require prior authorization when accomplished in-state.

(2) Out-of-state corneal transplant services are prior authorized by the Division or the Fully Capitated Health Plan (FCHP):

(a) Submit the request to the FCHP or Division;

(b) The request must contain the following information:

(A) Name and Medical Assistance Identification number of the client;

(B) A description of the condition which necessitates a transplant;

(C) The results of any evaluation performed by an in-state provider of cornea transplant services;

(D) An explanation of the reason out-of-state services are requested.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

DIVISION 125

HOSPITAL SERVICES

410-125-0000
Determining When the Patient Has Medical Assistance

(1) The Medical Card gives the client's name as listed with the Oregon Health Plan (OHP) and their alpha-numeric prime number.

(2) Eligibility may change on a monthly basis. In some instances, eligibility will change during the month. Eligibility should be verified each time services are provided in order to assure that the client is eligible for date(s) of service. For ways to verify client eligibility see General Rule 410-120-1140.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0150; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08

410-125-0020
Retroactive Eligibility

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

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

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0160, 461-015-0230 & 461-015-0370; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0160 & 410-125-0440; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-125-0030
Hospital Hold

(1) A hospital hold is a process which allows an in-state general hospital or an out-of-state contiguous general hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the Oregon Health Plan due to inpatient hospitalization.

(2) The Division of Medical Assistance Programs (Division) will accept hospital holds for inpatient stays. Hospitals must either submit a DMAP 3261 or a hospital generated form to Division within 24 hours of the admission time or the next working day. If a hospital uses its own form, the form must contain all the information found on the DMAP 3261.

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

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 12-2000(Temp), f. 8-16-00, cert. ef. 8-17-00 thru 2-1-01; OMAP 39-2000, f. 11-14-00, cert. ef. 11-15-00; OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0040
Title XIX/Title XXI Clients

(1) Title XIX /Title XXI clients are eligible for medical assistance through programs established by the Federal government and for which the State receives federal assistance. Most Title XIX/Title XXI clients are eligible for the Plus or Standard Benefit packages. See the General rules (chapter 410 division 120) for more information on eligibility, benefit package, and covered services. Most Title XIX/Title XXI clients are enrolled in a FCHP, a MHO and a DCO. Some Title XIX clients are Medicare Beneficiaries.

(2) The Division of Medical Assistance Programs (Division) contracts with Prepaid Health Plans (PHPs): Fully-Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), and Dental Care Organizations (DCOs), to provide certain medical, mental health and dental services on a prepaid basis.

(a) FCHPs provide a comprehensive package of health care benefits including hospital, physician, laboratory, X-ray and other diagnostic imaging, Medicheck (EPSDT), pharmacy, physical therapy, speech-language therapy, occupational therapy, case management, and other services;

(b) MHOs provide mental health services. They can be fully-capitated health plans, community mental health programs, private behavioral organizations or a combination thereof;

(c) DCOs provide dental care;

(d) If the client is enrolled in a Prepaid Health Plan, the name, address and phone number of the plan will appear on the Medical Care Identification. Always check with the plan listed if there is a question about coverage;

(e) PHP clients receive most of their primary care services through the PHP or upon referral from the PHP. In emergency situations, all services may be provided without prior authorization or referral. However, all claims for emergency services must be sent to the prepaid health plan. The hospital must work with the client's prepaid health plan to arrange for billing and payment for emergency and non-emergency services;

(f) Division will not reimburse for services that can be provided by the client's PHP and are included in the PHP's contract as covered services. Reimbursement is between the service provider and the PHP.

(3) Medicare Clients: Some Title XIX clients also have Medicare coverage. Most Medicare beneficiaries who are also eligible for Medicaid will have the full range of covered benefits for both Medicare and Medicaid. However, a few individuals who are Medicare eligible are eligible for only partial coverage through Medicaid. Refer to the General rules (chapter, 410 division 120) for information on eligibility.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0170 & 461-015-0180; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0060; HR 22-1992, f. 7-31-92, cert. ef. 8-1-92; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0041
Non-Title XIX/XXI Clients

(1) State-funded clients are clients who have not qualified for medical assistance through a federal program but have access to medical benefits through state funded programs. There are two categories of clients who are in State-funded programs.

(2) Program General Assistance (GA) clients: Program GA clients are children in foster care, in Services to Children and Families (SCF) custody, who are not eligible for Title XIX/Title XXI programs. They have access to the full range of Medicaid covered services, but payment for services provided may be different from that for Title XIX/Title XXI clients. For additional reimbursement information see the Hospital Services Supplemental Information

on the Division of Medical Assistance Programs (Division) web site.

(3) Program SF clients: Program SF clients are individuals who are receiving treatment in a state facility, such as Oregon State Hospital, or the Eastern Oregon Training Center. These clients may need to receive hospital care outside the state facility. They are entitled to the full range of Medicaid covered hospital services. These individuals will be referred by the state facility for services. They do not have Medical Care Identification cards. They are not enrolled in a Fully Capitated Health Plan. The state facility from which the client is transferred will contact the hospital regarding billing instructions for these clients.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0045
Coverage and Limitations

In general, most medically appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the Division of Medical Assistance Programs' (Division) General Rules Program for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are:

(1) Prior authorization (PA): Some services require PA for the Oregon Health Plan (OHP) Plus Benefit Package check OAR 410-125-0080.

(2) Non-covered services:

(a) Services that are not medically appropriate, unproven medical efficacy or services that are the responsibility of another Department of Human Services (Department) or Oregon Health Authority (Authority) Division are not covered by the Division of Medical Assistance Programs;

(b) Service coverage is based on the Health Evidence Review Commission's (HERC) Prioritized List of Services and the client's benefit package;

(c) See the General Rules Program (chapter 410, division 120) and other program divisions in chapter 410 for a list of not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

(3) Limitations on hospital benefit days: Clients have no hospital benefit day limitations for treatment of covered services.

(4) Dental services: Clients have dental/denturist services identified as covered on the HERC Prioritized List (OAR 410-141-520).

(5) Services provided outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by Division as hospital services. The only exceptions to this are Maternity Case Management services and specific nursing or physician services provided during a ground or air ambulance transport.

(6) Dialysis services require a written physician prescription. The prescription must indicate the ICD-10 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules Program.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; HR 3-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 37-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-125-0050
Client Copayments

Copayments may be required for certain services and/or benefit package(s). See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 77-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0080
Inpatient Services

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

(a) Coordinated Care Organization (CCO) and Mental Health Organization (MHO) clients: Contact the client's CCO, or MHO. The health plan may have different prior authorization (PA) requirements than the Division;

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

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

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

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

(2) Transplant services:

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

(b) Clients are eligible for transplants covered by the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria. (3) Out-of-State non-contiguous hospitals:

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

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

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

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Services program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA. (b) For transfers to a skilled nursing facility, intermediate care facility, or swing bed, contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO clients, transfers require authorization and payment (for first 20 days) from the CCO;

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

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

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

(d) Exceptions:

(A) Emergency transfers do not require PA;

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

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

(6) Dental procedures provided in a hospital setting:

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

(b) Emergency dental services do not require PA;

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, http://www.oregon.gov/OHA/healthplan/pages/dental.aspx);

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

(7) Long-term acute care (LTAC) hospital services authorization requirements:

(a) For an initial thirty-day stay:

(A) LTAC provider must, before admitting the client, submit a request for prior authorization to the Division;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Meet the clinical criteria outlined in the LTAC Hospital guide at: http:www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

(b) Extension of stay:

(A) Submit request for prior authorization to the Division;

(B) Include sufficient medical justification for the extended stay.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 11-1983, f. 3-8-83, ef. 4-1-83; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 36-1984, f. & ef. 8-20-84; AFS 22-1985, f. 4-23-85, ef. 6-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 45-1989, f. & cert. ef. 8-21-89; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0190; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 7-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 9-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 27-2007(Temp), f. & cert. ef. 12-20-07 thru 5-15-08; DMAP 12-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 17-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 37-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

410-125-0085
Outpatient Services

(1) Outpatient services that may require prior authorization (PA) include (see the individual program in the Authority's Health Systems Division (Division)) Oregon Administrative Rules:

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

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

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

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

(e) Hearing Aids (chapter 410, division 129);

(f) Dental Procedures (chapter 410, division 123);

(g) Drugs (chapter 410, division 121);

(h) Apnea monitors, services, and supplies (chapter 410, division 122);

(i) Home Parenteral/Enteral Therapy (chapter 410, division 148);

(j) Durable Medical Equipment and Medical supplies (chapter 410, division 122);

(k) Certain hospital services.

(2) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

(3) Outpatient surgical procedures:

(a) For Coordinated Care Organization (CCO) members: Contact the CCO. The CCO may have different PA requirements than the Division. Some services are not covered under CCO contracts and require PA from the Division, or the Division's Dental Services program analyst;

(b) For Medicare clients enrolled in a CCO: These services must be authorized by the CCO even if Medicare is the primary payer. Without this authorization, the provider may not be paid beyond any Medicare payments (see also OAR 410-125-0103);

(c) For fee-for-service clients on the OHP Plus benefit package:

(A) Surgical procedures listed in OAR 410-125-0080 require PA when performed in an outpatient or day surgery setting, unless they are urgent or emergent;

(B) Contact the Division for PA (unless indicated otherwise in OAR 410-125-0080).

(d) Out-of-State services: Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require PA unless specified in the Division's Hospital Services Program rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require PA. For clients enrolled in a CCO, contact the CCO for authorization. For clients not enrolled in a health plan, contact the Division's Provider Clinical Support Unit.

(4) Psychiatric Emergency Services (PES):

(a) Psychiatric emergency services as defined by OAR 309-023-0110 delivered in a PES facility as described in OAR 309-023-0120 shall be reimbursed for a maximum of 20 hours per admittance;

(b) Psychiatric emergency services shall be reimbursed with a bundled, hourly rate using a fee-for-service rate methodology that is based on rates paid for similar services, using similar providers at a similar level-of-care.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 37-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 63-2016(Temp), f. & cert. ef. 11-10-16 thru 5-8-17

410-125-0086
Prior Authorization for FCHP/MHO Clients

Most non-emergent inpatient and outpatient services require prior authorization by a Fully Capitated Health Plan (FCHP) or a Mental Health Organization (MHO). Emergency hospital services must be covered by an FCHP or MHO without regard to prior authorization or the emergency care provider's contractual relationship with the FCHP or MHO. Emergency hospital services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. Once a client's condition is considered stabilized, or a medical screening examination has determined that the client's medical condition is not emergent, an FCHP or MHO may require prior authorization for hospital admission, follow-up care, or further treatment. Failure to obtain prior authorization from the FCHP or MHO may result in a denial of payment for services. Contact the client's FCHP or MHO for further information on prior authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01

410-125-0090
Inpatient Rate Calculations — Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory and radiology services are based on the Division of Medical Assistance Program's (Division) fee schedule;

(b) Retrospective cost-based reimbursement is made during the annual cost settlement period for all covered inpatient services, except for the hospitals that have payment contracts with managed care plans;

(c) Cost-based reimbursement; is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

(3) Type A, Type B, and Critical Access Hospitals are:

(a) Eligible for disproportionate share reimbursements, but must meet the same criteria as other hospitals. See OAR 410-125-0150 for eligibility criteria and reimbursement calculation;

(b) Type A, Type B, and Critical Access Hospitals do not receive cost outlier, capital, or medical education payments.

(4) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until Division determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient-covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory services which are based on the Division fee schedule;

(b) Retrospective cost-based reimbursement is made for all fee-for-service covered inpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 68-1981, f. 9-30-81, ef. 10-1-82; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-0095
Hospitals Providing Specialized Inpatient Services

(1) Some hospitals provide specific highly specialized in patient services by arrangement with the Division.

(2) Reimbursement is made according to the terms of a contract between the Division and the hospital.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 68-1981, f. 9-30-81, ef. 10-1-82; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860

410-125-0101
Hospital-Based Nursing Facilities and Medicaid Swing Beds

To receive reimbursement for hospital-based long-term care nursing facility services or Medicaid swing beds, the hospital must enter into an agreement with Aging and People with Disabilities (APD). These services must be provided, billed, and accounted for separately from other hospital services and in accordance with APD rules. Contact APD client's branch office for further information.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 68-1981, f. 9-30-81, ef. 10-1-82; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0102
Medically Needy Clients

(1) The QIO can give prior authorization for non-emergency inpatient services for clients who are in the Medically Needy Program but have not yet met their spend-down. Only Medically Needy Program clients under age 21 and pregnant women have coverage for inpatient services if enrolled in the Medically Needy Program.

(2) Prior authorization cannot be granted for outpatient services, which require prior authorization. However, you may contact the Division Medical/ Dental Group once the client has been made eligible and request retroactive authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0103
Medicare Clients

When Medicare is the primary payer, services provided in the inpatient or out-patient setting do not require prior authorization. However, if the Division is the primary payer because the service is not covered by Medicare; the prior authorization requirements listed in chapter 410 division 125 would apply.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0115
Non-Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such

hospitals have an agreement or contract with Division of Medical Assistance Programs (Division) for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for non-contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations from Other Hospitals, DRG Rate Methodology, OAR 410-125-0141 for the methodology used to calculate the unit value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. 11-18-91, Renumbered from 410-125-0840; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04

410-125-0120
Transportation To and From Medical Services

(1) Transportation to and from medical services, including hospital services, is a covered service. However, all non-emergency transports require prior authorization in order for the transportation provider to be paid.

(2) The transportation must be the least expensive obtainable under existing conditions and appropriate to the client's needs.

(3) Contact the Division of Medical Assistance Program (Division)-contracted regional Transportation Brokerage (Brokerage) for prior authorization for the transport or instruct the transportation provider to contact the Brokerage. Brokerage map and contact information is available at http://www.oregon.gov/oha/healthplan/Pages/medical-transportation.aspx.

(4) Hospitals must follow the after hours procedures for the Brokerages and contact the appropriate after hours providers for non-emergent transportation for hospital discharges.

(5) No prior authorization is required when the client's condition requires emergency transport.

(6) When a hospital sends a patient to another facility or provider during the course of an inpatient stay and the client is returned to the admitting hospital within 24 hours, the hospital must arrange for and pay for the transportation. See billing instructions contained in the Hospital Supplemental Information on the Division website for additional information.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0210; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 32-2012, f. 6-29-12, cert. ef. 7-1-12

410-125-0121
Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with Division of Medical Assistance Programs (Division) for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations for Other Hospitals, DRG Rate Methodology OAR 410-125-0141 for the methodology). Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04

410-125-0124
Retroactive Authorization

Retroactive authorization for payment can be granted after the service is provided only in the following circumstances:

(1) The person was not yet eligible for Medicaid/CHIP at the time the services were provided. Payment can be made if the services are covered Medicaid/CHIP services and the client's eligibility is extended back to the date the hospital provided services. See: the Hospital Services Supplemental Information on the Division of Medical Assistance Programs (Division) website for additional billing information.

(2) If another insurer denied the claim because the service is not covered by that insurer, and the hospital did not seek prior authorization because it had good reason to believe the service was covered by the insurer. Payment can be made by the Division if the services are covered by Medicaid. See: the Hospital Services Supplemental Information on the Division website for additional billing information.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0125
Free-Standing Inpatient Psychiatric Facilities

Free-standing inpatient psychiatric facilities (institutions for mental diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the terms of an agreement between the Addictions and Mental Health, Aging and People with Disabilities, and the hospital.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 68-1981, f. 9-30-81, ef. 10-1-82; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987 (Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989 (Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89,

Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991 (Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0140
Prior Authorization Does Not Guarantee Payment

(1) Prior authorization (PA) is valid for the date range approved only as long as the client remains eligible for services. For example, a client may become ineligible after the PA has been granted but before the actual date of service, or a client's hospital benefit days may be used prior to the time the claim for the prior authorized service is submitted to the Division of Medical Assistance Programs (Division) for payment.

(2) All prior authorized treatment are subject to retrospective review. If the information provided to obtain PA cannot be validated in a retrospective review, payment shall be denied or recovered.

(3) Hospitals should develop their own internal monitoring system to determine if the admitting physician has received PA for the service from the Division.

(4) For the Plus Benefit Package PA information refer to the PA chart in the Hospital Services Program OAR 410-125-0080.

(5) Hospitals may also verify PA requirements by calling the Division's Provider Services Unit or the RN Benefit Hotline (contact phone numbers are located on the Division's website).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0220; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 37-2011, f. 12-13-11, cert. ef. 1-1-12

410-125-0141
DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Division uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Division may modify the logic of the grouper program. The Division will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Division DRG weight tables can be found on the Division web site:

(a) Acute Care Hospitals larger than fifty beds are considered DRG hospitals and reimbursed using Medicare's MS-DRG grouper;

(b) Hospitals enrolled as long-term acute care (LTAC) are reimbursed using Medicare's MS-LTC DRG grouper.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, the Division establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, the Division uses the following methodology: Using the formula N = where Z = 1.15 (a 75 percent confidence level), S is the standard deviation, and R = 10 percent of the mean. The Division determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, the Division sets a relative weight using:

(A) Division non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the Division Title XIX caseload;

(c) When a test shows at the 90 percent confidence level that an externally derived weight is not representative of the average cost of services provided to the Division Title XIX population in that DRG, the weight derived from the Division Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by the Division. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty beds or enrolled as a long-term acute care (LTAC) hospital are reimbursed using the Diagnosis Related Grouper (DRG) as described in section (2). Effective for services on or after:

(a) August 15, 2005, the operating unit payment is 100 percent of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(b) May 1, 2009, the operating unit payment is 108.5 percent of the 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(c) Effective October 1, 2009 the operating unit payment is 100 percent of the most recent version of the Medicare base payment rates. The Division will revise the base payment rates each year in October when Medicare posts the rates.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital or LTAC hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out-of-state hospitals do not receive the capital amount).

(7) DRG Hospital Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients;

(b) For dates of service on and after March 1, 2004, the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold ($25,000 or 270 percent of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270 percent of the DRG or $25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50 percent), equals;

(vii) Cost Outlier Payment;

(E) Third party reimbursements are deducted from the Division calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and cost statement template, adjusted to reflect the Medicaid mix of services.

(8) LTAC Short Stay Outliers: Occurs when a covered length of stay is between one day and up to and including 5/6ths of the average length of stay for the LTC-DRG grouping. The Short Stay Outlier payment for the hospital will be the lesser of:

(a) Per Diem for Short Stay Outlier Calculation:

(A) MS-LTC DRG payment, divided by;

(B) Geometric Length of Stay (GLOS,) multiplied by;

(C) Actual length of stay, multiplied by;

(D) 120 percent equals;

(E) Per Diem payment;

(b) Full MS-LTC DRG payment.

(9) LTAC High Cost Outliers: Are an additional payment when the estimated cost of a claim exceeds the outlier threshold (LTC DRG payment plus a fixed loss amount):

(a) The fixed loss amount is published annually by Medicare;

(b) If the estimated cost of a claim is greater than the outlier threshold, an additional payment is added to the LTC DRG payment;

(c) The outlier payment is 80 percent of the difference between the estimated cost of the claim and the outlier threshold (LTC DRG payment plus the fixed loss amount);

(d) The estimated cost of the claim is calculated by multiplying the Division's allowable charge on the claim by the hospital's cost-to-charge ratio.

(10) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Division uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004, the Capital cost per discharge is 100 percent of the published Medicare capital rate for fiscal year 2004, see section (5). The capital cost is added to the Unit Value and paid per discharge;

(c) Effective October 1, 2009, the Capital cost per discharge is one 100 percent of the current year Medicare capital rate and updated every October thereafter, see section (5). The capital cost is added to the Unit Value and paid per discharge.

(11) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Division uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct medical education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986, through June 30, 1987, are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;

(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;

(c) Direct medical education payment per discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85 percent. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity, and other relevant factors.

(C) Notwithstanding section (9) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006, and thereafter direct medical education payments will not be made to hospitals; and

(ii) On July 1, 2008, and thereafter direct medical education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

(12) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the state's fiscal year is the Division indirect medical education factor. This factor is used for the entire Oregon Fiscal Year;

(d) For dates of service on and after March 1, 2004, the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital-specific February 29, 2004, Unit Value, multiplied by the Indirect Factor, equals the Indirect Medical Education Payment;

(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital unit value, see (5)(c), multiplied by the indirect factor, equals the Indirect Medical Education Payment;

(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter;

(g) Notwithstanding section (10) of this rule, this subsection becomes effective for dates of service:

(A) On July 1, 2006, and thereafter Indirect Medical Education payment will not be made to hospitals; and

(B) On July 1, 2008, and thereafter Indirect Medical Education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-

0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570, 461-015-0590, 461-015-0600 & 461-015-0610; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 42-1990, f. & cert. ef. 11-30-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840, 410-125-0880, 410-125-0900, 410-125-0920, 410-125-0960 & 410-125-0980; HR 35-1993(Temp), f. & cert. ef. 12-1-93; HR 23-1994, f. 5-31-94, cert. ef. 6-1-94; HR 11-1996(Temp), f. & cert. ef. 7-1-96; HR 22-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 45-1998, f. & cert. ef. 12-1-98; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 37-2005(Temp) f. & cert. ef. 8-15-05 thru 1-15-06; OMAP 70-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 10-2009(Temp), f. 4-29-09, cert. ef. 5-1-09 thru 10-28-09; DMAP 31-2009, f. 9-22-09, cert. ef. 10-1-09; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

410-125-0142
Graduate Medical Education Reimbursement for Public Teaching Hospitals

(1) Graduate medical education payment is reimbursement made to an institution for the costs of an approved medical training program. The State makes GME payments to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. Funding for public teaching hospital GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans.

(2) For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (becomes base year).

(3) The GME payment is calculated as follows:

(a) Total direct medical education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME.

(b) Indirect medical education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount — other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

(c) The total net Title XIX GME is the sum of Title XIX IME and DME costs. The GME reimbursement is made quarterly. Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population. GME is rebased yearly.

(4) Total GME payments will not exceed that determined by using Medicare reimbursement. The Medicare upper limit will be determined from the most recent Medicare Cost Report and performed for all inpatient acute hospitals and separately for State operated inpatient acute hospitals in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the GME payment is made.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 30-1999(Temp), f. & cert. ef. 6-15-99 thru 11-1-99; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0146
Supplemental Reimbursement for Public Academic Teaching University Medical Practitioners

(1) Effective for dates of service on or after November 17, 2005, physician and other practitioner services provided by practitioners affiliated with a public academic medical center that meets the following eligibility standards shall be eligible for a supplemental teaching practitioner's payment for these services provided to eligible Medicaid recipients and paid for directly on a fee-for-service basis, subject to subsections (3) and (4) of this rule. This supplemental payment shall be equal to the difference between the Medicare allowable and Medicaid reimbursement received.

(2) Eligible academic medical centers must be:

(a) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(b) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(3) Payments under this rule shall be made only to the eligible academic medical centers in accordance with the terms of an intergovermental agreement between the eligible academic medical center and Division of Medical Assistance Programs (Division). Such payments may be made quarterly, but shall be at least paid annually, at the end of each federal fiscal year. Calculation of the payment amount will be based on the annual difference between the practitioners' Medicare allowable and the Medicaid allowable payments to eligible practitioners for the Medicaid claims paid during the most recently completed state fiscal year. Services included are physician and other practitioners' services with RVU weights and physician-administered drugs. The RVU rates used for the payment calculation are the Division's fee established in rule for the date of service payment period.

(4) Allowable Medicaid payments including this supplemental payment remain subject to OAR 410-125-0220(12) and 410-130-0225. For purposes of this rule, the allowable Medicaid payments used to calculate the supplemental payment shall be limited to the services that are billed fee-for-service to the Division on the electronic 837P or the paper CMS-1500, and as to which the physician or practitioner is receiving no reimbursement from the eligible academic medical center and the cost of their service is not reported as a direct medical education cost on the Medicare and the Division's cost report.

Stat. Auth.: ORS 413.042
Stats. Implemented: 414.065
Hist.: OMAP 33-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 43-2006, f. 12-15-06, cert. ef. 1-1-07

410-125-0150
Disproportionate Share

(1) The Disproportionate-share hospital (DSH) payment is an additional reimbursement made to hospitals that serve a disproportionate share of low-income patients with special needs.

(a) To receive DSH payments, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital that performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital that had discontinued or did not offer non-emergency obstetric services as of December 21, 1987. No hospital may qualify for disproportionate share payments unless the hospital has, at a minimum, a Medicaid utilization rate of 1 percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another State are also accounted for;

(b) Information on total inpatient days is taken from the most recent Medicare Cost Report.

(2) A hospital's eligibility for DSH payments is determined at the beginning of each fiscal year. Hospitals that are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1.

(3) Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state:

(a) Criteria 1: One or more standard deviation above the mean

(A) The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) to total inpatient days is one or more standard deviations above the mean for all Oregon hospital;

(B) Information on total inpatient days is taken from the most recent audited Medicare Cost Report. The total paid Medicaid inpatient days is based on Division of Medical Assistance Programs' (Division) records for the same cost reporting period;

(C) Information on total paid Medicaid days is taken from Division reports of paid claims for the same fiscal period as the Medicare Cost Report.

(b) Criteria 2: A low-income utilization rate exceeding 25 percent

(A) The Low income utilization rate is the sum of percentages (3)(b)(A)(i) and (3)(b)(A)(ii) below:

(i) The Medicaid percentage: The total of Medicaid inpatient and outpatient revenues paid to the hospital for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus any cash subsidies received directly from State and local governments in the most recent Medicare cost reporting period. This amount is divided by the total amount of inpatient and outpatient revenues and cash subsidies of the hospital for patient services in the most recent Medicare cost reporting period. The result is expressed as a percentage;

(ii) The charity care percentage: The total hospital charges for inpatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage;

(iii) Charity care is provided to individuals who have no source of payment, including third party and personal resources.

(B) Charity care shall not include deductions from revenues or the amount by which inpatient charges are reduced due to contractual allowances and discounts to other third party payers, such as Fully-Capitated Health Plans (FCHPs), Medicare, Medicaid, etc;

(C) The information used to calculate the low income utilization rate is taken from the following sources:

(i) The most recent Medicare Cost Reports;

(ii) The Division's records of payments made during the same reporting period;

(iii) Hospital-provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period;

(iv) Hospital-provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period;

(v) Any other information that the Division, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

(D) The Division determines within 30 days of receipt of all required information if a hospital is eligible under the low income utilization rate criteria.

(c) Disproportionate-share payment calculations:

(A) All hospitals that have been deemed DSH hospitals will always qualify for DSH payments under criteria 1 or criteria 2. Hospital ranking is done on an annual basis for all hospitals. Once eligible hospitals are determined Division calculates the standard deviations for the hospitals to determine if they will be eligible under criteria 1 or criteria 2.

(B) Criteria 1: One or more deviations above the mean The quarterly DSH payment to hospitals eligible under criteria 1 is the sum of Diagnosis Related Groups (DRG) weights for paid Title XIX non-Medicare claims for the quarter multiplied by a percentage of the hospital-specific Unit Value; this determines the hospital's DSH payment for the current quarter. The Unit Value used for eligible Type A, Type B, and Critical Access Hospitals is set at the same rate as for out-of-state hospitals. The calculation is as follows:

(i) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5% to determine the DSH payment;

(ii) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. The amount is multiplied by 0.10 to determine the DSH payment.

(iii) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 0.25 to determine the DSH payment.

(C) Eligibility under Criteria 2: For hospitals eligible under Criteria 2 (low income utilization rate), the payment is the sum of DRG weights for claims paid by the Division in the quarter, multiplied by the hospital's disproportionate share adjustment percentage established under Section 1886(d)(5)(F)(iv) of the Social Security Act multiplied by the hospital's unit value;

(D) For out-of-state hospitals, the quarterly DSH payment is 5% of the out-of-state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals that have entered into agreements with the Division for payment are reimbursed according to the terms of the agreement or contract.

(d) Public Academic Medical Center Disproportionate Share adjustments:

(A) Public academic medical centers that meet the following eligibility standards shall be deemed eligible for additional DSH payments up to 100% of their cost for serving Medicaid fee for service clients and indigent and uninsured patients:

(i) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and

(ii) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(iii) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(B) 100% of the costs for hospitals qualifying for this DSH payment will be determined from the following sources:

(i) The most recent Medicare Cost Reports; or

(ii) The Division's record of payments made during the same reporting period; or

(iii) Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period; or

(iv) Any information which the Division, working in conjunction with representatives of Oregon hospitals, determines necessary to establish cost.

(e) Additional Disproportionate Adjustments:

(A) For all hospitals with a Medicaid utilization rate above one percent of all payer utilization, the DSH payment is the ratio of the hospital's low income shortfall to the low income shortfall for all eligible hospitals multiplied by the total Federal disproportionate share allotment remaining after disproportionate payments have been made.(B) The low income shortfall is the Medicaid costs for inpatient and outpatient hospitals services plus uncompensated

care for the uninsured cost for inpatient and outpatient hospital services less total Medicaid and self-pay payments for inpatient and outpatient hospital services.

(f) Disproportionate-share payment schedule:

(A) Hospitals qualifying for DSH payments under section (3)(c) above will receive quarterly payments based on claims paid during the preceding quarter. Hospitals that were eligible during one fiscal year but are not eligible for disproportionate share status during the next fiscal year will receive DSH payments based on claims paid in the quarter in which they were eligible. Hospitals qualifying for DSH payments under section (3)(e) above will receive quarterly payments of 25 percent of the amount determined under this section;

(B) Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, DSH payments to hospitals will not exceed 100 percent of the "basic limit" which is:

(i) The inpatient and outpatient costs for services to Medicaid patients, less the amounts paid by the State under the non-DSH payment provisions of the State plan, plus

(ii) The inpatient and outpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who has no other resources to cover the costs of services delivered. The costs attributable to uninsured patients are determined through disclosures in the Medicare (HCFA-2552) cost report and state records on indigent care.

(C) The State has a contingency plan to assure that disproportionate share hospital payments will not exceed the State disproportionate share hospital allotment (allotment). A reduction in payments in proportion to payments received will be effected to meet the requirements of section 1923(f) of the Social Security Act. DSH payments are made quarterly. Before payments are made for the last quarter of the Federal fiscal year, payments for the first three quarters and the anticipated payment for the last quarter are cumulatively compared to the allotment.

(i) If the allotment will be exceeded, the DSH payments for the last quarter will be adjusted proportionately for each hospital qualifying for payments under section (3)(d).

(ii) If the allotment will still be exceeded after this adjustment, DSH payments to out-of-state hospitals will be adjusted in proportion to DSH payments received during the previous three quarters.

(iii) If this second adjustment still results in the allotment being exceeded, hospitals qualifying for payments under section (3)(c) (Criteria 1 and 2) will be adjusted by applying each hospital's proportional share of payments during the previous three quarters to total DSH payments to all hospitals for that period.

(D) Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to DSH payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0620; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0940; HR 36-1993, f. & cert. ef. 12-1-93; HR 24-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 6-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 23-1998, f. & cert. ef. 7-15-98; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 32-2012, f. 6-29-12, cert. ef. 7-1-12

410-125-0155
Upper Limits on Payment of Hospital Claims

(1) Supplemental payments:

(a) Private Hospital Supplemental Payments:

(A) From the private Upper Payment Limit (UPL) gap, payments shall be made to all private Diagnosis Related Groups (DRG) hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of the payment;

(B) This payment will be equal to one quarter of the gap amount divided by the total private DRG hospital Medicaid fee-for-service discharges from the quarter proceeding the month of payment;

(C) The supplemental payments for Private Hospitals will not exceed the UPL for inpatient hospital services.

(b) Non-State Government Owned Hospital Supplemental Payments:

(A) From the non-state government owned hospital upper payment limit gap, payments shall be made to all non-state government owned DRG hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of the payment;

(B) This payment will be equal to one quarter of the gap amount divided by the total non-state government owned DRG hospital Medicaid fee-for-service discharges from the quarter proceeding the month of payment;

(C) The supplemental payments for non-state government owned Hospitals will not exceed the UPL for inpatient hospital services.

(2) For Type A, Type B and Critical Access Hospitals, reimbursement shall be limited to the lesser of allowable costs or billed charges. This limitation shame be applied separately to inpatient and outpatient services.

(3) Payments will not exceed final approved plan:

(a) Total reimbursements to a state-operated facility made during the Division of Medical Assistance Program (Division) fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in the final approved plan;

(b) Total aggregate inpatient and outpatient reimbursements to all hospitals made during the Division's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in the final approved plan.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 53-1991, f. & cert. ef. 11-18-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 32-2012, f. 6-29-12, cert. ef. 7-1-12

410-125-0162
Hospital Transformation Performance Program

(1) The Hospital Transformation Performance Program (HTPP) is established by the Oregon Health Authority (Authority) to allow hospitals to earn incentive payments by meeting specific performance standards that advance health systems transformation, reduce hospital costs, and improve patient safety.

(a) The total amount of funds available through the program is equal to the federal financial participation received from one-percentage point of the assessment. Hospitals that pay an assessment on their net patient revenue, as required by OAR 410-050-0870, are eligible to participate.

(b) The performance standards shall be established by the Authority based on recommendations of the Hospital Performance Advisory Committee (Committee) and as approved by the Centers for Medicare and Medicaid Services (CMS). The Committee shall be appointed by the Authority director and comprise four hospital representatives, two Coordinated Care Organization (CCO) representatives, and three members with expertise in measuring health outcomes.

(2) To qualify for incentive payments, eligible hospitals must meet the performance standards and measures as determined by the Authority.

(3) The Authority will:

(a) Establish baselines and targets for performance measures;

(b) Post the data specs and formats, forms to be used, schedule and frequency of data submission, frequency of incentive distributions, and other technical information on the Authority's website once determined;

(c) Analyze performance data submitted by hospitals;

(d) Determine if hospitals achieve targeted goals or demonstrate sufficient improvement to qualify for incentive payments; and

(e) Distribute incentive payments to performing hospitals.

Stat. Auth.: 2013 OL Ch. 608, Sec. 1, 13 & 25

Stats. Implemented: ORS 414.065 & 2013 OL Ch. 608, Sec. 1, 13 & 25

Hist.: DMAP 59-2014, f. 10-3-14, cert. ef. 10-7-14

410-125-0165
Transfers and Reimbursement

(1) When a patient is transferred between hospitals, the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the per diem inter-hospital transfer payment rate.

(2) The per diem inter-hospital transfer payment rate = the DRG payment divided by the geometric mean length of stay for the DRG. The geometric mean length of stay is reported in the DRG tables on the Division's website.

(3) Payment to the transferring hospital will not exceed the DRG payment.

(4) The final discharging hospital receives the full DRG payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 44-1985, f. & ef. 7-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0135; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0390; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0480; HR 53-1991, f. & cert. ef. 11-18-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0170
Death Occurring on Day of Admission

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840

410-125-0175
Hospitals Providing Specialized Outpatient Services

Some hospitals provide specific highly specialized outpatient services by arrangement with the Division. Reimbursement is made according to the terms of a written agreement or contract.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 53-1991, f. & cert. ef. 11-18-91

410-125-0180
Public Rates

Rates billed to Division of Medical Assistance Programs cannot exceed the facility's public billing rate.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0015; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0240; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0181
Non-Contiguous and Contiguous Area Out-of-State Hospitals — Outpatient Services

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Division of Medical Assistance Programs (Division) regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services will be reimbursed under a Division fee schedule.

(2) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(3) Notwithstanding subsections (1)–(2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until Division determines all necessary federal approvals have been obtained. Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with Division regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(a) Clinical laboratory services will be reimbursed under a Division fee schedule;

(b) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(4) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0190
Outpatient Rate Calculations — Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services which are based on the Division of Medical Assistance Programs (Division) fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

(3) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory, which are based on the Division's fee schedule;

(b) Retrospective cost-based reimbursement is made for all fee-for-service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0195
Outpatient Services In-State DRG Hospitals

(1) The National Drug Code (NDC) must be included on all claim formats for physician administered drug codes required by the Deficit Reduction Act of 2005.

(2) For discharges prior to January 1, 2012, In-State Diagnostic Related Grouper (DRG) hospital outpatient and emergency services are reimbursed under a cost-based methodology.

(a) Interim reimbursement:

(A) The interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges;

(B) The interim payment is the estimated percentage needed to achieve 100 percent of hospital cost in aggregate; and

(C) This interim percentage is applied to all outpatient charges except for clinical laboratory services. Interim reimbursement for clinical laboratory services is calculated according to rates published in the Division of Medical Assistance Programs' (Division) fee schedule.

(b) Settlement reimbursement:

(A) For Medicaid and Children's Health Insurance Program-eligible (Titles XIX and XXI of the Social Security Act) clients, an adjustment to 100 percent of outpatient costs is made during the cost settlement process;

(B) For General Assistance (GA) clients, outpatient hospital services are reimbursed at 50 percent of billed charges or 59 percent of costs, whichever is less.

(3) Effective for discharges on or after January 1, 2012:

(a) In-State DRG hospital outpatient and emergency services will be reimbursed in accordance with Code of Federal Regulations 42 Part 419 Prospective Payment System for Hospital Outpatient Department Services, using the Ambulatory Payment Classification (APC) Group methodology, and

(b) Payments will be based on rates determined by State Actuarial Services to be equivalent to 100 percent of Medicare outpatient payments for each DRG hospital.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 43-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 10-2009(Temp), f. 4-29-09, cert. ef. 5-1-09 thru 10-28-09; DMAP 31-2009, f. 9-22-09, cert. ef. 10-1-09; DMAP 48-2011(Temp), f. 12-23-11, cert. ef. 1-1-12 thru 6-25-12; DMAP 32-2012, f. 6-29-12, cert. ef. 7-1-12

410-125-0200
Time Limitation for Submission of Claims

Division of Medical Assistance Programs (Division) will accept a claim up to 12 months after the date of service. The date of discharge is the date of service for an inpatient hospital claim.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0250; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0201
Independent ESRD Facilities

(1) Independent End Stage Renal Dialysis (ESRD) Facilities:

(a) ESRD facilities are reimbursed for Continuous Ambulatory Peritoneal Dialysis.

(b) (CAPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemodialysis:

(A) Composite at 80% of the Medicare allowed amount, except for Epoetin.

(B) Epoetin is reimbursed at 100% of the Medicare maximum allowed amount.

(2) Other dialysis related charges which are allowed by Medicare, are reimbursed at 80% of the Medicare maximum allowed amount. Allowable clinical laboratory charges are reimbursed according to the Division's fee schedule. Billed charges may not exceed the Medicare maximum allowable amount.

(3) The Division follows Medicare's criteria for coverage of Epoetin, Intradialytic Parenteral Nutrition services, and the frequency schedule for laboratory tests for ESRD services. When laboratory tests are performed at a frequency greater than specified by Medicare, the additional tests must be billed separately, and are covered by the Division only if the tests are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0560; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0820; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-0210
Third Party Resources and Reimbursement

(1) The Division of Medical Assistance Programs (Division) establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the Division's maximum allowable payment.

(2) The Division will not make any additional reimbursement when a third party pays an amount equal to or greater than the Division's reimbursement. The Division will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

(3) When Medicare is Primary:

(a) The Division's calculates the reimbursement for these claims in the same manner as described in the Inpatient and Outpatient Rates Calculations Sections above;

(b) Payment is the Division allowable payment, less the Medicare payment, up to the amount of the deductible and/or coinsurance due. For clients who are Qualified Medicare Beneficiaries the Division does not make any reimbursement for a service that is not covered by Medicare. For clients who are Qualified Medicare/Medicaid Beneficiaries Division payment is the Division's allowable, less the Part A payment up to the amount of the deductible due for services by either Medicare or Medicaid.

(4) When Medicare is Secondary:

(a) An individual admitted to a hospital may have Medicare Part B, but not Part A. The Division calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations section above. Payment is the Division's allowable payment, less the Medicare Part B payment;

(b) An individual receiving services in the outpatient setting may have most services covered by Medicare Part B. The Division payment is the Division's allowable payment, less the Part B payment, up to the amount of the coinsurance and deductible due. For services provided in the outpatient setting which are not covered by Medicare, (for example, Take Home Drugs), the Division payment is the Division's allowable payment as calculated in the Outpatient Rates Calculation section above;

(c) Most Medicare-Medicaid clients have Medicare Part A, Part B, and full Medicaid coverage. The Division refers to these clients as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. the Division refers to these clients as Qualified Medicare Beneficiaries (QMB). For QMB clients, the Division does not make reimbursement for a service that is a not covered service for Medicare.

(d) Clients who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services that are not covered by Medicare if those services are covered by the Division.

(5) For clients with Physician Care Organization (PCO) or Prepaid Health Plan (PHP) Coverage, Division payment is limited to those services that are not the responsibility of the PCO or PHP. Payment is made at Division rates.

(6) Other Insurance:

(a) The Division pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any third party payments;

(b) The Division will not make additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the Division reimbursement, or 100 percent of billed charges.

(7) Medically Needy with Spend-Down. Reimbursement is the Division's maximum allowable payment for covered services less the amount of the spend-down due.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 46-1987, f. & ef. 10-1-87; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0056; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0640; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-1000; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0220
Services Billed on the Electronic 837I or on the Paper UB-04 and Other Claim Forms

(1) All inpatient and outpatient services provided by the hospital or hospital employees, unless otherwise specified below, are billed on the electronic 837I (837 Institutional) or on the paper CMS 1450 (UB-04) claim form.

(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper CMS 1450 (UB-04) along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost.

(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by the Division of Medical Assistance Programs (Division) through graduate medical education, for the hospitals that qualify (See OAR 410-125-0141) for payments and may not be billed on the electronic 837I or paper CMS 1450 (UB-04).

(4) Diagnostic and similar services provided by another provider or facility outside the hospital: When diagnostic or short-

term services are provided to an inpatient by another provider or facility because the admitting hospital does not have the equipment or facilities to provide all services required and the patient is returned within 24 hours to the admitting hospital, the admitting hospital should add the following charges to the inpatient electronic 837I or paper CMS 1450 (UB-04) claim:

(a) Charges from the other provider or hospital under the appropriate Revenue Code. The admitting hospital is responsible for reimbursing the other provider or hospital. The Division will not reimburse the other provider or hospital; and

(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. The Division will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper CMS 1450 (UB-04).

(5) Orthotics, prosthetics, durable medical equipment and implants:

(a) When a provider of orthotic or prosthetic devices provides services or materials to an inpatient through an agreement or arrangement with the hospital, the cost of those services will be billed by the hospital on the electronic 837I or the paper CMS 1450 (UB-04), along with all other inpatient services. The hospital is responsible for reimbursing the provider. The Division will not reimburse the provider;

(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the durable medical equipment supplier or by the hospital if the hospital is the supplier.

(6) Pharmaceutical and home parenteral/enteral services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB-04, except home parenteral and enteral services and medications provided to patients who are in nursing homes:

(a) Home parenteral and enteral services, including home hyperalimentation, Home IV antibiotics, home IV analgesics, home enteral therapy, home IV chemotherapy, home IV hydrational fluids, and other home IV drugs, require prior authorization and must be billed on the Pharmacy Invoice Form in accordance with the rules in the Home Enteral/Parenteral Program rules (chapter 410, division 148);

(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services Program rules (chapter 410, division 121).

(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper CMS 1450 (UB-04). For hospital dentistry requirements refer to the Dental Service Program rules (chapter 410, division 123).

(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper CMS 1450 (UB-04) as described in these rules and instructions and will be reimbursed at the hospital's interim rate.

(9) Maternity case management:

(a) Hospital clinics may serve as maternity case managers for pregnant clients. The Medical-Surgical Program rules (chapter 410, division 130) contain information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-04); and

(b) Providers must bill using Revenue Code 569.

(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Division's Home Health Care Services Program rules (chapter 410, division 127).

(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to the Division for a provider number as an air or ground ambulance provider. If costs for staff and equipment are reported on the Medicare Cost Report, these costs must be identifiable. The Division will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation Program rules (chapter 410, division 136).

(12) Supervising physicians providing services in a teaching setting:

(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper CMS 1450 (UB-04) with other inpatient or outpatient charges only when:

(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and

(B) The hospital does not report these services as a direct medical education cost on the Medicare and the Division's cost report.

(b) The services of supervising faculty physicians are not to be billed to the Division on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper CMS 1450 (UB-04)if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and the Division's cost report; and

(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (chapter 410, division 130) or additional information on billing on the electronic 837P or the paper CMS-1500.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 44-1985, f. & ef. 7-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0055, 461-015-0130, 461-015-0135; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0260, 461-015-0290, 461-015-0300, 461-015-0310, 461-015-0320, 461-015-0420, 461-015-0430; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0280, 410-125-0300, 410-125-0320, 410-125-0340, 410-125-0540 & 410-125-0560; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 13-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 37-2011, f. 12-13-11, cert. ef. 1-1-12

410-125-0221
Payment in Full

The payment made by Medicaid towards any inpatient or outpatient services, including cost outlier, disproportionate share, and capital payments, constitutes payment in full for the service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989 (Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989 (Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-

0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990 (Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0360
Definitions and Billing Requirements

(1) Total days on an inpatient claim must equal the number of accommodation days. Do not count the day of discharge when calculating the number of accommodation days.

(2) Inpatient services are reimbursed based on the admission date and discharge diagnosis.

(3) Inpatient services are services to patients who typically are admitted to the hospital before midnight and listed on the following day's census, with the following exceptions:

(a) A patient admitted and transferred to another acute care hospital on the same day is considered an inpatient;

(b) A patient who expires on the day of admission is an inpatient; and

(c) Births.

(4) Outpatient services:

(a) Outpatient services are services to patients who are treated and released the same day;

(b) Outpatient services also include services provided prior to midnight and continuing into the next day if the patient was admitted for ambulatory surgery, admitted to a birthing center, a treatment or observation room, or a short term stay bed;

(c) Outpatient observation services are services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation shall be reimbursed. An outpatient observation stay that exceeds 48 hours shall be billed as inpatient; and

(d) Outpatient observation services do not include the following:

(A) Services provided for the convenience of the patient, patient's family or physician but that are not medically necessary;

(B) Standard recovery period; and

(C) Routine preparation services and recovery for diagnostic services provided in a hospital outpatient department.

(5) Outpatient and inpatient services provided on the same day: If a patient receives services in the emergency room or in any outpatient setting and is admitted to an acute care bed in the same hospital on the same day, combine the emergency room and other outpatient charges related to that admission with the inpatient charges. Bill on a single UB-04 for both inpatient and outpatient services provided under these circumstances:

(a) If on the day of discharge, the client uses outpatient services at the same hospital, these shall be billed on the UB-04 along with other inpatient charges, regardless of the type of service provided or the diagnosis of the client. Prescription medications provided to a patient being discharged from the hospital may be billed separately as outpatient Take Home Drugs if the patient receives more than a three-day supply;

(b) Inpatient and outpatient services provided to a client on the same day by two different hospitals shall be reimbursed separately. Each hospital shall bill for the services provided by that hospital;

(c) Inpatient and psychiatric emergency services (PES) as defined in OAR 309-023-0110 provided to the patient on the same day, whether in the same hospital or two different hospitals, shall be reimbursed separately.

(6) Outpatient procedures that result in an inpatient admission: If, during the course of an outpatient procedure, an emergency develops requiring an inpatient stay, place a "1" in the Type of Admission field. The principal diagnosis should be the condition or complication that caused the admission. Bill charges for the outpatient and inpatient services together.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 37-1983 (Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0055; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0330, 461-015-0340 & 461-015-0380; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0380 & 410-125-0460; HR 22-1993 (Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 63-2016(Temp), f. & cert. ef. 11-10-16 thru 5-8-17

410-125-0400
Discharge

(1) A discharge from a hospital is the formal release of a patient to home, to another facility such as an intermediate care facility or nursing home, to a home health care agency, or to another provider of health care services.

(2) For services beginning January 1, 1993, and later, the transfer of a patient from acute care to a distinct part physical rehabilitation unit (i.e., a unit exempt from the Medicare Prospective Payment System) within the same hospital will be considered a discharge. The admission to the rehabilitation unit is billed separately. All other transfers occurring within a hospital, including transfers to Medicare PPS-exempt psychiatric units, will not be considered discharges, and all charges for services must be submitted on a single UB-04 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another acute care hospital, to a long-term acute care hospital, to a skilled nursing facility, or an intermediate care facility. When a physician sends a patient directly to another hospital for further inpatient care, the discharge should be billed as a transfer, regardless of the mode of transportation.

(4) When the Division receives claims from two hospitals for the same patient, and the date of discharge from one hospital is the same as the date of admission to the other, the Division will assume that a transfer has occurred. The Division will change the discharge status code on the first claim to 02 (Transferred to Another Acute Care Facility), automatically generating an adjustment if the claim has already been adjudicated, unless discharge status on the claim is already 02 (Transfer) or 07 (Discharge AMA). If it is believed that the Division made an error in assigning Discharge Status code 02 to a claim, the hospital may submit an Adjustment Request along with supporting documentation from the medical record.

(5) A transfer between units within a hospital is not a transfer for billing purposes, except in the case of transfers to distinct part physical rehabilitation units. Note that transfers in the other direction from rehabilitative care to acute care are not considered discharges from the rehabilitation unit unless the stay in the acute setting exceeds seven days. Stays of seven days or less in the acute care setting may not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

410-125-0401
Definitions: Emergent, Urgent, and Elective Admissions

(1) EMERGENT ADMISSION — an admission which occurs after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of

health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) Placing their health or the health of an unborn child in serious jeopardy;

(b) Serious impairment of bodily functions; or

(c) Serious dysfunction of any bodily organ or part. "Immediate medical attention" is defined as medical attention which could not be delayed by 24 hours.

(2) URGENT ADMISSION — an admission which occurs for evaluation or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychological suffering by the patient. An urgent admission is defined as one which could not have been delayed for a period of 72 hours.

(3) ELECTIVE ADMISSION — an admission which is or could have been scheduled in advance and for which a delay of 72 hours or more in the delivery of medical treatment or diagnosis would not have substantially affected the health of the patient. See Prior Authorization section of the Hospital Services rules for requirements.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01

410-125-0410
Readmission

(1) A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status, and both admissions must be combined into a single billing. The Division of Medical Assistance Programs (Division) will make one payment for the combined service. Examples of planned readmissions include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

(2) A patient whose discharge and readmission to the hospital is within thirty (30) days for the same or related diagnosis must be combined into a single billing. Division shall make one payment for the amount appropriate for the combined service.

(3) This rule does not apply to:

(a) Readmissions for an unrelated diagnosis;

(b) Readmissions occurring more than 30 days after the date of discharge;

(c) Readmissions for a diagnosis that may require episodic (a series) acute care hospitalizations to stabilize the medical condition such as, but not limited to: diabetes, asthma, or chronic obstructive pulmonary disease. See billing instructions in the Hospital Supplemental guide on the Division's website for additional information.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 36-1993, f. & cert. ef. 12-1-93; ; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 13-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 32-2012, f. 6-29-12, cert. ef. 7-1-12

410-125-0450
Provider Preventable Conditions

(1) Health Care-Acquired Conditions (HCAC):

(a) Formally known as Medicare's list of "hospital acquired conditions" (HAC) that apply to inpatient hospital settings with dates of admission on or after January 1, 2011 except those hospitals exempt from the reporting requirements.

(b) For inpatient hospital admissions on or after July 1, 2012, all in-state, contiguous and non-contiguous hospitals must report health care-acquired conditions.

(A) A HCAC is a condition that is reasonably preventable and was not present or identified at the hospital admission.

(B) A "present on admission" (POA) indicator is a status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that developed during an outpatient encounter. This includes, but is not limited to the emergency department, observation, and outpatient surgery.

(C) The Division of Medical Assistance Program (Division) shall use the most recent list of conditions identified as non-payable by Medicare. The Division may revise through addition or deletion the selected conditions at any time during the fiscal year.

(D) Diagnosis-related groups (DRG) and percentage paid hospitals must submit a POA indicator for the principal diagnosis and every secondary diagnosis code. A valid POA indicator must be included all inpatient hospital claims. Claims without a valid POA indicator shall be denied.

(E) Critical Access Hospitals (CAH) must implement the POA reporting requirements by September 1, 2013.

(F) For a complete list of HCACs and billing instructions please see the hospital supplemental guide.

(2) Other Provider-Preventable Conditions (OPPC):

(a) Applies to any health care setting, including but not limited to inpatient and outpatient hospital settings.

(b) Effective July 1, 2012 the Agency shall no longer cover the following conditions identified by the National Coverage Determinations (NCD):

(A) Wrong surgical or other invasive procedure performed on a patient;

(B) Surgical or other invasive procedure performed on the wrong body part;

(C) Surgical or other invasive procedure performed on the wrong patient.

(c) To protect the access to care the Division requires:

(A) No reduction in payment for a Provider Preventable Conditions (PPC) will be imposed on a provider when an identified PPC for a client existed prior to the initiation of treatment for that client by that provider.

(B) Reductions in provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Division reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

(3) For clients with both Medicare and Medicaid (duals) the agency may not act as secondary payer for Medicare non-payment of HCAC.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 49-2011(Temp), f. 12-23-11, cert. ef. 1-1-12 thru 6-25-12; DMAP 32-2012, f. 6-29-12, cert. ef. 7-1-12; DMAP 47-2013, f. 8-29-13, cert. ef. 9-3-13

410-125-0550
X-Ray or EKG Procedures Furnished in Emergency Room

The Division pays for only one interpretation of an x-ray or EKG procedure furnished to an emergency room patient, and that is for the interpretation and report that directly contributed to the diagnosis and treatment of the patient. A second interpretation of an x-ray or EKG is considered to be for quality control purposes only, and is not reimbursable. Payment will be made for a second interpretation only under unusual circumstances, such as questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

Stat. Auth.: ORS 413.042

Stats. Implemented : ORS 414.065

Hist.: OMAP 28-2000, 9-29-00, cert. ef. 10-1-00

410-125-0600
Non-Contiguous Out-of-State Hospital Services

(1) Non-contiguous out-of-state hospitals are those hospitals located more than 75 miles from the Oregon border.

(2) The hospital must be enrolled as a provider with Oregon Medical Assistance Programs to receive payment. Contact the

Division of Medical Assistance Programs (Division) for information on enrollment.

(3) Billings are sent to the Division.

(4) When the service provided is emergent or urgent, no prior authorization is required. The claim should be sent to the Division along with documentation supporting the emergent or urgent requirement for treatment.

(5) In a non-emergency situation, prior authorization is required for all services. Contact: the Division.

(6) Claims must be billed on the electronic 837I or on a paper CMS 1450 (UB-04), unless other arrangements are made for billing through the Division.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0450; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0620
Special Reports and Exams and Medical Records

Refer to the Division's Administrative Exams and Reports Billing rules (chapter 410 division 150) for information and instructions on billing for administrative exams and reports.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0040; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0460; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 3-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0640
Third Party Payers — Other Resources, Client Responsibility and Liability

(1) Medicare: Do not send claims to the Division of Medical Assistance Programs (Division) until they have been billed to and adjudicated by Medicare:

(a) Exception: Take home drugs and other services, which are not covered by Medicare, may be billed directly to the Division without billing Medicare first;

(b) See: billing instructions in the Hospital Services Supplemental Information on the Division's website for additional information on billing Medicare claims.

(2) Other Insurance. With the exception of services described in the General Rules, bill all other insurance first before billing the Division. Report the payments made by the other insurers.

(3) Motor vehicle accident fund:

(a) Enter 01 (Auto Accident) in the Occurrence Code Block and give the date of the accident;

(b) For all other clients, bill all other resources before billing the Division. Do not bill the Motor Vehicle Accident Fund.

(4) Employment Related Injuries: Enter 04 (Employment Related Accident) in the Occurrence Code Block and give the date of the injury.

(5) Liability:

(a) Liability refers to insurance that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages;

(b) The provider may bill the insurer for liability prior to billing the Division. The provider may not bill both the Division and the insurer;

(c) The provider may bill the Division after receiving a payment denial from the insurer; however, the Division billing must be within 12 months of date of service. Payment accepted from Division is payment in full;

(d) The provider may bill the Division without billing the liability insurer. However, payment accepted from the Division is payment in full. The payment made by the Division may not later be returned in order to pursue payment from the liability insurer. When the provider bills the Division, the provider agrees not to place any lien against the client's liability settlement;

(e) The provider has 12 months from the date of service to bill the Division. No payment will be made by Division under any circumstances once the one year limit has passed if no billing has been received within that time.

(6) Adoption agreements. Adopting parents and/or an adoption agency may be considered a prior resource. In some instances, the Division makes reimbursement to hospitals and other providers for services provided to a mother whose baby is to be adopted. The Division may also make reimbursement for services provided to the infant. Some adoption agreements, however, stipulate that the adoptive parents will make payment for part or all of the medical costs for the mother and/or the child. In these instances, the adoptive parent(s) and/or agency are a third party resource and should be billed before billing the Division for this service.

(7) Veteran's Administration benefits:

(a) Some clients have limited benefits through the Veterans' Administration. Hospitals must bill the Veterans' Administration for VA covered services before billing the Division;

(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.

(8) Trust funds. Some individuals will have trust funds that will pay for medical expenses. Occasionally a special trust fund will be set up to pay for extraordinary medical expenses, such as a transplant. These, and other trusts which pay medical expenses, are considered a prior resource. Bill the trust fund prior to billing the Division for services that are covered by the trust fund.

(9) Billing the client. A provider may bill the client or any financially responsible relative or representative of that individual only as allowed in OAR 410-120-1280.

(10) The hospital may not bill the client under the following circumstances:

(a) For services which are covered by the Division;

(b) For services for which the Division has made payment;

(c) For services billed to the Division for which no payment is made because third party reimbursement exceeds the Division maximum allowed amount;

(d) For any deductible, coinsurance or co-pay amount;

(e) For services for which the Division has denied payment to the hospital as a result of one of the following:

(A) The hospital failed to supply the correct information to the Division to allow processing of the claim in a timely manner as described in these rules and the General Rules;

(B) The hospital failed to obtain prior authorization as described in these rules;

(C) The service provided by the hospital was determined by or the Division not to be medically appropriate; or

(D) The service provided by the hospital was determined by the QIO not to be medically appropriate, necessary, or reasonable.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0080 & 461-015-0126; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0470 & 461-015-0480; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0660; HR 22-1992, f. 7-31-92, cert. ef. 8-1-92; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0641
Medicare

(1) A Medicare/Medicaid claim can automatically be sent to the Division after adjudicated by Medicare. This saves the effort of

a second submission, as well as ensuring a more accurate and speedier payment by the Division. Medicare will automatically transmit the correct Medicare payment, coinsurance, and deductible information to Division.

(2) Hard copy billings sent to Medicare can also be automatically sent to the Division. Refer to the Hospital Services Supplemental Information for specific billing instructions.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0720
Adjustment Requests

(1) Most overpayment and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a CMS 1450 (UB-04) for processing. All overpayments must be reported. Overpayments will be taken from future payments.

(2) Much of the information required on the Adjustment Request Form is printed on the paper Remittance Advice or the electronic 835. Documentation may be submitted to support the request. Attach a copy of the claim and paper Remittance Advice or the electronic 835 to the Adjustment Request (Division 1036). Adjustment requests must be submitted in writing to the Division of Medical Assistance Programs (Division).

(3) Complete adjustment instructions can be found in Hospital Services Supplemental Information.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21 1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0510; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-1020
Filing of Cost Statement

(1) The hospital must file an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital with Division of Medical Assistance Programs (Division):

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with the Division, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the Division 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., Diagnosis-Related Groups (DRG) payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(2) Twelve months after the hospital's fiscal year end, the Division will send the hospital a computer printout listing all transactions between the hospital and the Division during that auditing period. The Calculation of Reasonable Cost statement (DMAP 42) is due within 90 days of receipt by the hospital of the computer printout. Failure to file within 90 days may result in a 20 percent reduction in the payment rate:

(a) Hospitals without an agreement with Medicare may be subject to a field audit;

(b) Hospitals without an agreement with Medicare are required to submit a financial statement giving details of all assets, liabilities, income, and expenses, audited by a Certified Public Accountant.

(3) Improperly completed or incomplete Calculation of Reasonable Cost statements will be returned to the hospital for proper completion. The statement is not considered to be filed until it is received in a correct and complete form.

(4) If a hospital knowingly, or has reason to know, files a cost statement containing false information, such action constitutes cause for termination of its agreement with the Division. Hospitals filing false reports may also be referred to prosecution under applicable statutes.

(5) Each Calculation of Reasonable Cost statement submitted to the Division must be signed by the individual who normally signs the hospital's Medicare reports, federal income tax return, and other reports. If the hospital has someone, other than an employee prepare the cost statement, that individual will also sign the statement and indicate his or her status with the hospital.

(6) Notwithstanding subsection (1) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained. The hospital must file with the Division, an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital:

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with the Division, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the DMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(7) Inpatient rehabilitation facilities are exempt from filing an annual calculation of reasonable Cost (DMAP 42) and not cost settled.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Former (2) thru (5) Renumbered to 461-015-0121 thru 461-015-0124; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 39-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0105, 461-015-0120 & 461-015-0122; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0650; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11

410-125-1040
Accounting and Record Keeping

(1) All records for a given fiscal period must be kept for three years after the Medicare audit for that period has been finalized.

(2) Each hospital is required to make its financial records available for auditing within the state of Oregon at a location specified by the provider.

(3) All hospital records are subject to inspection and review by Division personnel and Department personnel during the period the records are required to be held.

(4) All expenses must be documented in detail as a part of the record. All capital expenditures requiring approval under the Certificate of Need process, and not having such approval, will be disallowed.

(5) Hospitals without a Medicare agreement must use the Hospital Administrative Services (HAS) system of reporting.

(6) Record keeping and reporting must be based on date of service, not date of payment. Billings for patients determined by

the Division to be eligible for Title XIX or Program 5 must be included as accruals, even those billings not yet paid.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(2); AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0121; HR 21-1990, f. & cert ef. 7-9-90, Renumbered from 461-015-0660; HR 42-1991, f. & cert. ef. 10-1-91

410-125-1060
Fiscal Audits

(1) Year-end fiscal audits will include retrospective examination and verification of claims and the determination of allowable charges and costs of hospital services provided to Division clients.

(2) The principal source document for the fiscal audit of Title XIX/Title XXI and General Assistance patient billings and payments for a given fiscal period is the Division's data processing printout. This printout includes all transactions for the audit period. Using gross totals from this printout and applying other information from Division records, information received from the hospital, and other sources, the Division will compile detailed schedules of adjustments and revise the gross totals. A revised Calculation of Reasonable Cost Statement (DMAP 42) will be prepared using revised totals and information from the Medicare report.

(3) Cost Settlements: The Division will send the hospital a letter stating the amount of underpayment or overpayment calculated by the Division for the fiscal year examined. The letter will also state the hospital's inpatient/outpatient interim reimbursement rate for the period from the effective date of the change until the next fiscal year's audit is completed. Payment of the cost-settlement amount is due and payable within 30 days from the date of the letter.

(4) The Division, at its discretion, may grant a thirty-day (30) extension for the purpose of reviewing the cost settlement upon a written request by the hospital. If a thirty-day (30) extension is granted, payment of the cost settlement amount is due within sixty (60) days from the date of the letter. If the provider chooses to appeal the decision or rate, a written request for an administrative review, or contested case must be received by the Division within thirty (30) days of the date of the letter notifying the hospital of the settlement amount and interim rate, or within sixty (60) days if the Division has granted a thirty (30) day extension, not withstanding the time limits in OAR 410-120-1580(3) or 410-120-1660(1). Upon receipt of the request, the Division will attempt to resolve any differences informally with the provider before scheduling the administrative review or hearing.

(5) Under extraordinary circumstances, the Division, at its discretion, may negotiate a repayment schedule with a hospital. The hospital may be required to submit additional information to support the hospital's request for a repayment schedule. The hospital will be required to pay interest associated with extended payments granted by the Division.

(6) The revised Calculation of Reasonable Cost, copies of adjustment schedules, and a copy of the printout are available to the hospital upon request. For Type A rural hospitals the Calculation of Reasonable Cost Statement will reflect the difference between payment at 100% of costs and payment for dates-of-services on or after January 1, 2006 under the fee schedule for clinical laboratory services provided by the hospital. An adjustment to the Cost Settlement will be made to reimburse a Type A hospital at 100% of costs for laboratory and radiology services provided to Medical Assistance Program clients during the period the hospital was designated a Type A hospital. Settlements to Type B and Critical Access hospitals will be made within the legislative appropriation.

(7) The adjusted Professional Component Cost-to-Charge ratio(s) will be applied to all corresponding revenue code charges as listed on the Hospital Claim Detail Reports for cost settlements finalized on or after October 1, 1999.

(8) Hospital Based Rural Health Clinics shall be subject to the rules in the Hospital Services for the Oregon Health Plan Guide for Type A and B Hospitals. Hospital Based Rural Health Clinics cost settlements for dates of service from January 1, 2001 shall be finalized to cost.

(9) No interim settlements will be made. No settlements will be made until after receipt and review of the audited Medicare cost report.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(3); AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0122; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0670; HR 33-1990(Temp), f. & cert. ef. 10-1-90; HR 43-1990, f. & cert. ef. 11-30-90; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; HR 24-1995, f. 12-29-95, cert. ef. 1-1-96; HR 3-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-1070
Type A and Type B Hospitals

(1) Type A and Type B hospitals must submit the following information to the Division:

(a) The aggregate percent increase in patient charges and the effective date of the increase within 30 days following the end of their fiscal year for increases in the preceding year. Aggregate percent increase in patient charges is defined as the percent increase in patient revenues due to charge increases; and

(b) The amount of payment received by the hospital, from each Division-contracted managed care plan and third-party payers, for inpatient and outpatient hospital services provided to managed care members, within the hospital's fiscal year.

(2) When a hospital is contracted with a Prepaid Health Plan (PHP), within thirty (30) days of the Division's request the hospital will supply the Division the following information:

(a) The name of the contracting PHP; and

(b) The dates for which the contract will be effective; and

(c) The contracted services and reimbursement rates.

(3) The hospital and PHP must coordinate payment information to verify and return the PHP payment data file sent by the Division within ninety (90) days from date the data file is received by the hospital.

(4) Failure to supply the requested information within timelines stated may result in a discretionary sanction or fine (see OAR 410-120-1440). No sanction or fine will be imposed if the Division determines, at its sole discretion, that the hospital was unable to coordinate payment information with the PHP through no fault of the hospital's own.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2005, f. 6-20-05, cert. ef. 7-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-1080
Documentation

(1) Federal regulations require Medicaid providers to maintain records that fully support the extent of services for which payment has been requested, and that such records be furnished to the Division upon request (42 CFR 431.107).

(2) When requested by the Division or its medical review contractor, hospitals must submit sufficient medical documentation to verify the emergency nature, medical necessity, quality and appropriateness of treatment, and appropriateness of the length of stay for inpatient and outpatient hospital services. The Division may request sufficient information to evaluate the accuracy and appropriateness of ICD-10-CM Coding for the claim. In addition, the Division may request an itemized billing for all services provided. The Division will specify in its request what documentation is required.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0040; HR 21-

1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0680; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-125-2000
Access to Records

(1) Providers must furnish requested medical and financial documentation within 30 calendar days from the date of request. Failure to comply within 30 calendar days shall result in recovery of payment(s) made by the Division for services being reviewed.

(2) The Division conducts post payment review of admissions and claim records. The Division may request records from a hospital or may request access to records while at the hospital.

(3) The hospital has 30 days to provide the Division with copies of records. In some cases, there may be a more urgent need to review records.

(4) The Medical Payment Recovery Unit (MPRU) conducts recovery activities for the Division involving third party liability resources. MPRU may request records from the hospital. This unit has the same right to medical and financial information as the Division.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0040; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0690; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11

410-125-2020
Post Payment Review

(1) All services provided by a hospital in the inpatient or outpatient setting are subject to post-payment review by the Division. Both emergency and non-emergency services may be reviewed. Claims for services may be reviewed to determine:

(a) The medical necessity of the admission or outpatient services provided;

(b) The appropriateness of the length of stay;

(c) The appropriateness of the plan of care;

(d) The accuracy of the ICD-10 coding and DRG assignment;

(e) The appropriateness of the setting selected for service delivery;

(f) The quality of care of the services provided;

(g) The nature of any service coded as emergent;

(h) The accuracy of the billing;

(i) The care furnished is appropriately documented.

(2) If the Division determines that a hospital service was not within Division coverage parameters, the hospital and attending physician shall be notified in writing and will have twenty days to provide additional written documentation to support the medical necessity of the admission and/or procedure(s).

(3) If the recommendation for denial is upheld by the Division, the hospital and/or practitioner may request a reconsideration of the denial within 30 days of the receipt of the denial.

(4) If the reconsidered decision is to uphold the denial, payment to all providers of service shall be recovered.

(5) The hospital and/or practitioner may appeal any final decision through the Division administrative appeals process.

(6) No payment shall be made by the Division for inpatient services if the Division or Medicare has determined the service is not medically necessary and/or appropriate.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 1-1984, f. & ef. 1-9-84; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0090; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0700; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-125-2030
Recovery of Payments

(1) Payments made by the Division of Medical Assistance Programs (Division) shall be recovered for:

(a) Services identified by the provider as emergent or urgent, but determined on retrospective review not to have been emergent or urgent. Payment shall also be recovered from the admitting and/or performing physician;

(b) Services determined by the Division that the readmission to the same hospital was the result of a premature discharge;

(c) Services were billed but not provided;

(d) Services provided at an inappropriate level of care, which includes the setting selected for service delivery;

(e) The Division non-covered services;

(f) Services, which were covered by a third party payer or other resources; or

(g) Services denied by a third party payer as not medically necessary.

(2) Payment to a physician and other providers of service for inpatient non-urgent or non-emergent services requiring prior authorization is subject to recovery by the Division if recovery is made from the hospital.

(3) If review by the Division results in a denial, the hospital may appeal any final decision through the Division Administrative Appeals process. See Administrative Hearings (chapter 410, division 120).

(4) As part of the Utilization Review Program, the Division shall develop and maintain a data system profiling the patterns of practice of institutions and practitioners. As a result of these profiles, the Division may initiate focused reviews. Any practitioner or hospital subject to a focused review shall be notified in advance of the review.

(5) All providers having a pattern of inappropriate utilization or inappropriate quality of care according to the current standards of the medical community and/or abuse of the Division rules or procedures shall be subject to corrective action. Actions taken shall be those determined appropriate by the Division, or sanctions established under the Oregon Revised Statues (ORS) or Oregon administrative rule and/or referral to a State or Federal authority, licensing body or regulatory agency for appropriate action.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11

410-125-2040
Provider Appeals — Administrative Review

(1) A provider may request an administrative review regarding the decision(s) by the Division that affect the services they provide or have provided. See General Rules (chapter 410 division 120).

(2) A requests for an administrative review must be submitted in writing to the Medicaid Administrator, 500 Summer Street NE, E49, Salem, OR 97301-1079.

(3) The request must be received within 30 days of the date of notification of the payment decision or notification of change in reimbursement.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0710; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-2060
Provider Appeals — Hearing Request

If the hospital disagrees with the Division calculation of reasonable costs for outpatient services or inpatient services, the outpatient interim rate, Diagnosis-Related Groups based prospective payment for inpatient services, the calculation of the hospital's unit value, or any other hospital reimbursement methodologies or payments, a written request for an appeal may be made to the Division

in accordance with the General rules (chapter 410 division 120). A hearing request must be received not later than 30 days following the date of the notice of action. At the time of appeal, the hospital must submit any data the hospital wants the Division to consider in support of the appeal. The appeal will be conducted as described in General rules.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(4); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 49-1989 (Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0123; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0720; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-2080
Administrative Errors

(1) If a hospital has been given incorrect information by the Division of Medical Assistance Programs, or Children, Adults, and Families Programs, or Aging and People with Disabilities/staff, and services were provided on the basis of this information, and payment has been denied as a result, the hospital may submit a request for payment as an administrative error.

(2) Include the following:

(a) An explanation of the problem;

(b) Any documents supporting the request for payment;

(c) A copy of any paper remittance advice or electronic 835 printouts received on this claim;

(d) A copy of the original claim.

(3) Send the request: Division of Medical Assistance Programs, Provider Inquiry, Administrative Errors, 500 Summer Street NE, E-44, Salem, OR 97301-1077.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0730; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

DIVISION 127

HOME HEALTH CARE SERVICES

410-127-0020
Definitions

(1) Acquisition Cost — The net invoice price of the item, supply, or equipment plus shipping and/or postage for the item.

(2) Assessment — Procedures by which a client's health strengths, weaknesses, problems, and needs are identified.

(3) Custodial Care — Provision of services and supplies that can safely be provided by non-medical or unlicensed personnel.

(4) Evaluation — A systematic objective assessment of the client for the purpose of forming a plan of treatment; and, a judgment of the effectiveness of care and measurement of treatment progress. The evaluation of direct care and effectiveness of care plans and interventions is an ongoing activity.

(5) Home — A place of temporary or permanent residence used as a person's home. This does not include a hospital, nursing facility, or intermediate care facility, but does include assisted living facilities, residential care facilities and adult foster care homes.

(6) Home Health Agency A public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by the Authority as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997. Home health agency does not include:

(a) Any visiting nurse service or home health service conducted by and for those who rely upon spiritual means through prayer alone for healing in accordance with tenets and practices of a recognized church or religious denomination;

(b) Health services offered by county health departments that are not formally designated and funded as home health agencies within the individual departments;

(c) Personal care services that do not pertain to the curative, rehabilitative or preventive aspect of nursing.

(7) Home Health Aide — A person who meets the criteria for Home Health Aide defined in the Medicare Conditions of Participation 42 CFR 484.36 and certified by the Board of Nursing.

(8) Home Health Aide Services — Services of a Home Health Aide must be provided under the direction and supervision of a registered nurse or licensed therapist. The focus of care shall be to provide personal care and/or other services under the plan of care which supports curative, rehabilitative or preventive aspects of nursing. These services are provided only in support of skilled nursing, physical therapy, occupational therapy, or speech therapy services. These services do not include custodial care.

(9) Home Health Services — Only the services described in the Division of Medical Assistance Programs (Division) Home Health Services provider guide.

(10) Medicaid Home Health Provider — A Home Health Agency licensed by Health Services, Health Care Licensure and Certification certified for Medicare and enrolled with the Division as a Medicaid provider.

(11) Medical Supplies — Supplies prescribed by a physician as a necessary part of the plan of care being provided by the Home Health Agency.

(12) OASIS (Outcome and Assessment Information Set) — a client specific comprehensive assessment that identifies the client's need for home care and that meets the client's medical, nursing, rehabilitative, social and discharge planning needs.

(13) Occupational Therapy Services — Services provided by a registered occupational therapist or certified occupational therapy assistant supervised by a registered occupational therapist, due to the complexity of the service and client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a client's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function and/or independence in the activities of daily living is included in this skilled service. Occupational Therapy Licensing Board ORS 675.210-675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.

(14) Physical Therapy Services — Services provided by a licensed physical therapist or licensed physical therapy assistant under the supervision of a licensed physical therapist, due to the inherent complexity of the service and the client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver the necessary techniques, exercises or precautions for treatment and/or prevention of illness or injury is included in this skilled service. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapy Assistant established by the American Physical Therapy Association govern the practice of physical therapy. Physical Therapy shall not include radiology or electrosurgery.

(15) Plan of Care — Written instructions describing how care is to be provided. The plan is initiated by the admitting registered nurse, physical therapist, occupation therapist or speech therapist and certified by the prescribing physician. The plan of care must include the client's condition, rationale for the care plan, including justification for the skill level of care and the summary of care for additional certification periods. This includes, but is not limited to:

(a) All pertinent diagnoses;

(b) Mental status;

(c) Types of services;

(d) Specific therapy services;

(e) Frequency, and duration of service delivery;

(f) Supplies and equipment needed;
(g) Prognosis;
(h) Rehabilitation potential;
(i) Functional limitations;
(j) Activities permitted;
(k) Nutritional requirements;
(l) Medications and treatments;
(m) Safety measures;
(n) Discharge plans;
(o) Teaching requirements;
(p) Individualized, measurably objective short-term and /or long-term functional goals;
(q) Other items as indicated.

(16) Practitioner — A person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitioner's license and certification.

(17) Responsible Unit — The agency responsible for approving or denying payment authorization.

(18) Skilled Nursing Services — The client care services pertaining to the curative, restorative or preventive aspects of nursing performed by a registered nurse or under the supervision of a registered nurse, pursuant to the plan of care established by the prescribing practitioner in consultation with the Home Health Agency staff. Skilled nursing emphasizes a high level of nursing direction, observation and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct client care and the teaching, delegation and supervision of others who provide tasks of nursing care to clients, as well as phlebotomy services. Such services will comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing and Health Division, division 27, Home Health Agencies, which rules are by this reference made a part hereof.

(19) Speech and Language Pathology Services — Services provided by a licensed speech-language pathologist due to the inherent complexity of the service and the patient's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatment for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function, and/or compensatory techniques to improve the level of functional communication ability is included in this skilled service. Speech-Language Pathology and Audiologist Licensing Board ORS 681.205 to 681.991 and the Standards of Ethics established by the American Speech and Hearing Association, govern the practice of speech and language pathology.

(20) Title XVIII (Medicare) — Title XVIII of the Social Security Act.

(21) Title XIX (Medicaid) — Title XIX of the Social Security Act.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0001; HR 12-1991, f. & cert. ef. 3-1-91; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 4-1998(Temp), f. & cert. ef. 2-5-98 thru 7-15-98; OMAP 24-1998, f. & cert. ef. 7-15-98; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 36-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 29-2013, f. & cert. ef. 6-27-13

410-127-0040
Coverage

(1) Home health services are made available on a visiting basis to eligible clients in their homes as part of a written "plan of care."

(2) Home health services must be prescribed by a physician and the signed order must be on file at the home health agency. The prescription must include theICD-10-CM diagnosis code indicating the reason the home health services are requested. The orders on the plan of care must specify the type of services to be provided to the client, with respect to the professional who will provide them, the nature of the individual services, specific frequency and specific duration. The orders must clearly indicate how many times per day, each week and/or each month the services are to be provided. The plan of care must include the client's condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods.

(3) The plan of care must be reviewed and signed by the physician every two months to continue services.

(4) The following services or items are covered, if diagnoses are on the portion of the prioritized list above the line funded by the Legislature:

(a) Skilled nursing services;
(b) Skilled nursing evaluation (includes Outcome and Assessment Information Set (OASIS) assessment);
(c) Home Health aide services;
(d) Occupational therapy services;
(e) Occupational therapy evaluation (may include OASIS Assessment);
(f) Physical therapy services;
(g) Physical therapy evaluation (may include OASIS Assessment);
(h) Speech and language pathology services (may include OASIS Assessment;
(i) Speech and language pathology evaluation (may include OASIS assessment);
(j) Medical/surgical supplies.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; AFS 8-1979, f. 3-30-79, ef. 4-1-79; Renumbered from 461-019-0400 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0000; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; DMAP 29-2013, f. & cert. ef. 6-27-13; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-127-0050
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 79-2002, f. 12-24-02, cert. ef. 1-1-03; ; Suspended by DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14

410-127-0060
Reimbursement and Limitations

(1) Reimbursement. The Division of Medical Assistance Programs (Division) reimburses home health services on a fee schedule by type of visit (see home health rates and copayment chart on the Oregon Health Authority (OHA) Web site at: http://www.oregon.gov/OHA/healthplan/pages/home-health.aspx).

(2) The Division recalculates its home health services rates every other year. The Division will reimburse home health services at a level of 74% of Medicare costs reported on the audited, most recently accepted or submitted Medicare Cost Reports prior to the rebase date and pending approval from the Centers for Medicare and Medicaid Services (CMS), and if indicated, Legislative funding authority.

(3) The Division will request the Medicare Cost Reports from home health agencies with a due date, and will recalculate potential rates based on the Medicare Cost Reports received by the requested due date. It is the responsibility of the home health agency to submit requested cost reports by the date requested.

(4) The Division reimburses only for service which is medically appropriate.

(5) Limitations:

(a) Limits of covered services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) All therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy or speech and language pathology services. Therapy visits require payment authorization;

(C) The Division will authorize home health visits for clients with uterine monitoring only for medical problems, which could adversely affect the pregnancy and are not related to the uterine monitoring;

(D) Medical supplies must be billed at acquisition cost and the total of all medical supply revenue codes may not exceed $50 per day. Only supplies that are used during the visit or the specified additional supplies used for current client/caregiver teaching or training purposes as medically necessary are billable. Client visit notes must include documentation of supplies used during the visit or supplies provided according to the current plan of care;

(E) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not covered service:

(A) Service not medically appropriate;

(B) A service whose diagnosis does not appear on a line of the Prioritized List of Health Services which has been funded by the Oregon Legislature (OAR 410-141-0520);

(C) Medical Social Worker service;

(D) Registered dietician counseling or instruction;

(E) Drug and or biological;

(F) Fetal non-stress testing;

(G) Respiratory therapist service;

(H) Flu shot;

(I) Psychiatric nursing service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; PWC 854(Temp), f. 9-30-77, ef. 10-1-77 thru 1-28-78; Renumbered from 461-019-0420 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0010; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 77-2003, f. & cert. ef. 10.1.03; DMAP 16-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 39-2011, f. 12-15-11, cert. ef. 1-1-12; DMAP 29-2013, f. & cert. ef. 6-27-13

410-127-0065
Signature Requirements

(1) The Division of Medical Assistance Programs (Division) requires practitioners to sign for services they order. This signature shall be handwritten or electronic, and it must be in the client's medical record.

(2) The ordering practitioner is responsible for the authenticity of the signature.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: OMAP 38-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11

410-127-0080
Prior Authorization

(1) Home health providers must obtain prior authorization (PA) for services as specified in rule.

(2) Providers must request PA as follows (see the Home Health Supplemental Information booklet for contact information) and include the documentation requirements from the Supplemental (e.g. plan of care, primary diagnosis, initial assessment, evaluation, etc.):

(a) For clients enrolled in a Coordinated Care Organization (CCO) or a Prepaid Health Plan (PHP), from the CCO or the PHP;

(b) For all other clients, from the Division of Medical Assistance Programs (Division).

(3) For services requiring authorization, providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request will be honored as the request date. It is the provider's responsibility to obtain payment authorization. Authorization will be given based on medical appropriateness and appropriate level of care, cost and/or effectiveness as supported by submitted documentation. The plan of care submitted must include the client's condition, the rationale for the care plan, including justification for the required skill level of care and the summary of care for additional certification periods.

(4) Payment authorization does not guarantee reimbursement (e.g. eligibility changes, incorrect identification number, provider contract ends).

(5) For rules related to authorization of payment, including retroactive eligibility, see General Rules, 410-120-1320.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; AFS 8-1979, f. 3-30-79, ef. 4-1-79; Renumbered from 461-019-0410 by Chapter 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 6-1986, f. & ef. 4-24-86; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0005; HR 12-1991, f. & cert. ef. 3-1-91; HR 30-1992(Temp), f. & cert. ef. 9-25-92; HR 2-1993, f. 2-19-93, cert. ef. 2-20-93; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 15-1999, f. & cert. ef. 4-1-99; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; OMAP 91-2003, f. 12-30-03 cert. ef. 1-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 29-2013, f. & cert. ef. 6-27-13

410-127-0200
Home Health Revenue Center Codes

Payment authorization is required for those services indicated by the Code PA. Following are the procedure codes to be used for billing:

(1) Medical/surgical supplies and devices:

(a) 270 — General classification;

(b) 271 — Non sterile supply;

(c) 272 — Sterile supply.

(2) Physical Therapy:

(a) 421 — Visit charge — PA;

(b) 424 — Evaluation (includes Outcome and Assessment Information Set, OASIS assessment) or re-evaluation.

(3) Occupational Therapy:

(a) 431 — Visit charge — PA;

(b) 434 — Evaluation or re-evaluation.

(4) Speech-language pathology:

(a) 441 — Visit charge — PA;

(b) 444 — Evaluation (includes OASIS assessment) or re-evaluation.

(5) Skilled nursing:

(a) 551 — Visit charge — PA;

(b) 559 — Other skilled nursing — evaluation (includes OASIS assessment).

(6) Home health aid — 571 — Visit charge — PA.

(7) Total charge — 001 — Total Charge.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 12-1991, f. & cert. ef. 3-1-91; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

410-129-0020
Therapy Plan of Care, Goals/Outcomes and Record Requirements

(1) Therapy shall be based on a prescribing practitioner's written order and therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation.

(2) The therapy regimen shall be taught to individuals, including the patient, family members, foster parents, and caregivers who can assist in the achievement of the goals and objectives. The Division shall not authorize extra treatments for teaching.

(3) All speech-language pathology (SLP) treatment services require a therapy plan of care that is required for prior authorization (PA) for payment.

(4) The SLP therapy plan of care shall include:

(a) Client's name and diagnosis;

(b) The type, amount, frequency, and duration of the proposed therapy;

(c) Individualized, measurably objective, short-term and long-term functional goals;

(d) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and

(e) Evidence of certification of the therapy plan of care by the prescribing practitioner.

(5) SLP therapy records shall include:

(a) Documentation of each session;

(b) Therapy provided;

(c) Duration of therapy; and

(d) Signature of the speech-language pathologist.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065 & 681.205
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; DMAP 22-2014, f. & cert. ef. 4-2-14; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0040
Maintenance

(1) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached and no further goals are needed; or

(b) There is no progress toward the rehabilitative or habilitative treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The patient, family, foster parents, or caregiver have been taught the therapy regimen and can carry out the maintenance therapy.

(2) Therapy that becomes maintenance is not a covered service.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065, 681.205 & 688.135
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0060
Prescription Required

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing speech-language pathology, audiology and hearing aid services. Prescription shall specify the ICD-10-CM diagnosis code for all speech-language pathology, audiology and hearing aid services that require payment/prior authorization.

(2) The provision of speech therapy services shall be supported by a written order and a therapy treatment plan signed by the prescribing practitioner. A practitioner means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.

(3) A written order:

(a) Is required for the initial evaluation;

(b) For therapy, shall specify the ICD-10-CM diagnosis code, service, amount, and duration required.

(4) Written orders shall be submitted with the payment PA request and a copy shall be on file in the provider's therapy record. The written order and the treatment plan shall be reviewed and signed by the prescribing practitioner every six months.

(5) Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate for an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: AFS 67-1985, f. 11-19-85, ef. 12-1-85; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91, Renumbered from 461-021-0301; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; DMAP 6-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0065
Licensing Requirements

(1) The Division enrolls only the following types of providers as performing providers under the Speech-Language Pathology, Audiology and Hearing Aid Services program:

(a) An individual licensed by the relevant state licensing authority to practice speech-language pathology (SLP);

(b) An individual licensed by the relevant state licensing authority to practice audiology; and

(c) An individual licensed by the relevant state licensing authority for "dealing in hearing aids" as defined in Oregon Revised Statute 694.015.

(2) The Oregon Board of Examiners for SLP and Audiology licenses and the Division recognizes services provided by:

(a) Conditional Speech-Language Pathologists; and

(b) SLP Assistants.

(3) Services of graduate SLP students, furnished under a Conditional SLP License:

(a) Shall be provided in compliance with supervision requirements of the state licensing board and the American Speech-Language-Hearing Association;

(b) Shall be compliant with applicable record and documentation requirements (see also Oregon Administrative Rules in chapter 335, division 010); and

(c) Are reimbursed to the licensed supervising speech-language pathologist.

(4) The Division shall not reimburse for services of a licensed speech-language pathologist while the pathologist is teaching or supervising students in SLP.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065
Hist.: HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 59-2003, f. 9-5-03, cert. ef. 10-1-03; DMAP 22-2014, f. & cert. ef. 4-2-14; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0070
Limitations

(1) SLP services:

(a) Shall be provided by a practitioner as described in OAR 410-129-0065(1);

(b) Therapy treatment:

(A) May not exceed one hour per day, either group or individual;

(B) Shall be either group or individual and may not be combined in the authorization period; and

(C) Requires PA.

(c) The following SLP services do not require payment authorization but are limited to:

(A) Two SLP evaluations in a 12-month period;

(B) Two evaluations for dysphagia in a 12-month period;

(C) Up to four re-evaluations in a 12-month period;

(D) One evaluation for speech-generating/augmentative communication system or device and shall be reimbursed per recipient in a 12-month period;

(E) One evaluation for voice prosthesis or artificial larynx shall be reimbursed in a 12-month period;

(F) Purchase, repair or modification of electrolarynx;

(G) Supplies for speech therapy shall be reimbursed up to two times in a 12month period, not to exceed $5.00 each;

(d) The purchase, rental, repair or modification of a speech-generating/augmentative communication system or device requires PA. Rental of a speech-generating/ augmentative communication system or device is limited to one month. All rental fees shall be applied to the purchase price.

(2) Audiology and hearing aid services:

(a) All hearing services shall be performed by a licensed physician, audiologist, or hearing aid specialist;

(b) Reimbursement is limited to one (monaural) hearing aid every five years for adults (age 21 and older) who meet the following criteria: Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, and 3000 Hertz (Hz) in the better ear;

(c) Adults who meet the criteria above and, in addition, have vision correctable to no better than 20/200 in the better eye may be authorized for two hearing aids for safety purposes. A vision evaluation shall be submitted with the PA request;

(d) Two (binaural) hearing aids shall be reimbursed no more frequently than every three years for children (birth through age 20) who meet the following criteria:

(A) Pure tone average of 25dB for the frequencies of 500Hz, 1000Hz and 2000Hz; or

(B) High frequency average of 35dB for the frequencies of 3000Hz, 4000Hz and 6000Hz.

(e) An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear or who cannot benefit from a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a particular listening situation. It is restricted to a hand-held amplifier and headphones;

(f) Services that do not require payment authorization:

(A) One basic audiologic assessment in a 12-month period;

(B) One basic comprehensive audiometry (audiologic evaluation) in a 12month period;

(C) One hearing aid examination and selection in a 12-month period;

(D) One pure tone audiometry (threshold) test; air and bone in a 12-month period;

(E) One electroacoustic evaluation for hearing aid; monaural in a 12month period;

(F) One electroacoustic evaluation for hearing aid; binaural in a 12-month period;

(G) Hearing aid batteries — maximum of 60 individual batteries in a 12-month period. Clients shall meet the criteria for a hearing aid.

(g) Services that require payment authorization:

(A) Hearing aids;

(B) Repair of hearing aids, including ear mold replacement;

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices;

(E) Cochlear implant batteries.

(h) Services not covered:

(A) FM systems — vibro-tactile aids;

(B) Earplugs;

(C) Adjustment of hearing aids is included in the fitting and dispensing fee and is not reimbursable separately;

(D) Aural rehabilitation therapy is included in the fitting and dispensing fee and is not reimbursable separately;

(E) Tinnitus masker(s).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 & 681.325

Hist.: HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 17-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 22-2014, f. & cert. ef. 4-2-14; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0080
Prior Authorization

(1) Speech-language pathology, audiology and hearing aid providers shall obtain PA for services as specified in rule.

(2) Providers shall request PA as follows (see the Speech-Language Pathology, Audiology and Hearing Aid Services Program Supplemental Information booklet for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Authority MFCU;

(b) For clients enrolled in the fee-for-service Medical Case Management program, from the Medical Case Management contractor;

(c) For clients enrolled in a prepaid health plan, from the prepaid health plan;

(d) For all other clients, from the Division.

(3) For services requiring authorization, providers shall contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request will be honored as the request date. It is the provider's responsibility to obtain payment authorization.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 14-1982, f. 2-16-82, ef. 3-1-82; AFS 49-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 67-1985, f. 11-19-85, ef. 12-1-85; AFS 7-1988, f. & cert. ef. 2-1-88; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91, Renumbered from 461-021-0310; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 85-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 57-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 40-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0100
Medicare/Medicaid Claims

(1) When an individual not in managed care has both Medicare and Medicaid coverage, audiologists shall bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on Division reimbursement. For managed care clients with Medicare, contact the clients Managed Care Organization (MCO).

(2) Audiologists shall bill all hearing aids and related services directly to the Division on an OHP 505. Payment authorization is required on most of these services.

(3) If Medicare transmits incorrect information to the Division, or if an out-of-state Medicare carrier or intermediary was billed, providers shall bill the Division using an OHP 505 form. If any payment is made by the Division, an adjustment request shall be submitted to correct payment, if necessary.

(4) Send all completed OHP 505 forms to the Division.

(5) Hearing aid dealers shall bill all services directly to the Division on a CMS-1500. Payment authorization is required on most services.

(6) When a client not in managed care has both Medicare and Medicaid coverage, speech-language pathologists shall bill services to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on Division reimbursement. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.034, 414.065, 414.329, 414.706 & 414.710

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 57-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0180
Procedure Codes

(1) Procedure codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services Program rules are intended for use by licensed speech-language pathologists, licensed audiologists, and certified hearing aid dealers.

(2) Physicians and nurse practitioners are subject to the administrative rules contained in the Division Medical-Surgical Services Program rules and shall bill the Division using the processes and procedure codes identified in those rules.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0190
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist. OMAP 80-2002, f. 12-24-02, cert. ef. 1-1-03

410-129-0200
Speech-Language Pathology Procedure Codes

(1) Inclusion of a current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code in the following tables does not imply a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Speech therapy services codes: Table 129-0200-1.

(3) Other speech services codes: Table 129-0200-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 6-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 17-2007, f. 12-5-07, cert. ef. 1-1-08

410-129-0220
Augmentative Communications System or Device

(1) Augmentative Communications System or Device and the necessary attachment equipment to bed or wheelchair are a covered benefit of the Division.

(2) The requested system or device shall be approved, registered, or listed as a medical device with the Food and Drug Administration.

(3) Criteria for coverage: Providers shall meet each of the following components and submit documentation to the Division with the PA request for review:

(a) A physician's statement of diagnosis and medical prognosis (not a prescription for an augmentative device) documenting the inability to use speech for effective communication as a result of the diagnosis;

(b) Reliable cognitive ability and a consistent motor response to communicate that can be measured by standardized or observational tools:

(A) Object permanence — ability to remember objects and realize they exist when they are not seen; and

(B) Means end — ability to anticipate events independent of those currently in progress — the ability to associate certain behaviors with actions that will follow;

(c) The client shall be assessed by a speech-language pathologist and when appropriate an occupational therapist or physical therapist. The evaluation report shall include:

(A) A completed OHA 3047 form: Augmentative Communication Device Selection Report Summary (page 1) and required elements of the Formal Augmentative/Alternative Communication Evaluation (page 2). Attach additional pages required to complete information requested;

(B) An explanation of why this particular device is best suited for this client and why the device is the lowest level that will meet basic functional communication needs;

(C) Evidence of a documented trial of the selected device and a report on the client's success in using this device; and

(D) A therapy treatment plan with the identification of the individual responsible to program the device and monitor and reevaluate on a periodic basis;

(d) Providers send requests for augmentative communications systems or devices to the Division; and

(e) The manufacturer's MSRP and the vendor's acquisition cost quotations for the device shall accompany each request including where the device is to be shipped.

(4) The Division shall reimburse for the lowest level of service that meets the medical need.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 40-1990(Temp), f. & cert. ef. 11-15-90; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 59-2003, f. 9-5-03, cert. ef. 10-1-03; DMAP 26-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11; DMAP 3-2011, f. 3-23-11, cert. ef. 3-25-11; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0240
Audiologist and Hearing Aid Procedure Codes

(1) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Audiologist and hearing aid procedure codes: Table 0240-1.

(3) Special Otorhinolaryngologic services codes: Table 0240-2. These codes only apply to services for cochlear implants. These services include medical diagnosis evaluation by the otology physician.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065 & 681.205
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0260
Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing aids shall be billed to the Division at the provider's acquisition cost and shall be reimbursed at such rate. For purposes of this rule, acquisition cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for hearing aids.

(3) Procedure codes: Table 129-0260.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065 & 681.205
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-129-0280
Hearing Testing for Diagnostic Purposes (On Physician's Referral Only)

A physician's referral is required for the tests shown in this rule. The tests may only be performed and billed by a licensed audiologist or a licensed physician. Procedure codes: Table 0280.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065 & 681.205
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

DIVISION 130

MEDICAL-SURGICAL SERVICES

410-130-0000
Foreword

(1) The Division of Medical Assistance Programs (Division) Medical-Surgical Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers must follow the Division rules in effect on the date of service.

(2) The Division enrolls only the following types of providers as performing providers under the Medical-Surgical program:

(a) Doctors of medicine, osteopathy and naturopathy;
(b) Podiatrists;
(c) Acupuncturists;
(d) Licensed Physician assistants;
(e) Nurse practitioners;
(f) Laboratories;
(g) Family planning clinics;
(h) Social workers (for specified services only);
(i) Licensed Direct entry midwives;
(j) Portable x-ray providers;
(k) Ambulatory surgical centers;
(l) Chiropractors;
(m) Licensed Dieticians (for specified service only);
(n) Registered Nurse First Assistants;
(o) Certified Nurse Anesthetists;
(p) Clinical Pharmacists;
(q) Birthing Centers.

(3) For clients enrolled in a managed care plan, contact the client's plan for coverage and billing information.

(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All DMAP rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Health Services Commission's Prioritized List of Health Services is found on their website at: www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: PWC 868, f. 12-30-77, ef. 2-1-78; AFS 36-1981, f. 6-29-81, ef. 7-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS Branch offices; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0001; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0500; HR 6-1994, f. & cert. ef. 2-1-94; HR 23-1997, f. & cert. ef. 10-1-97; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12

410-130-0005
Federally Qualified Primary Care Provider

(1) Section 1202 of the Affordable Care Act (ACA) amended sections 1902(a)(13), 1902(jj), 1905(dd) and 1932(f) of the Social Security Act to require increased Medicaid payment for primary care services to qualified providers for calendar years 2013 and 2014 as specified in these rules.

(2) Federally Qualified Primary Care Services are designated as:

(a) Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes 99201 through 99499; and

(b) Vaccine administration CPT codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes; and

(c) Administration of vaccines under Vaccines for Children Program (refer to OAR 410-130-0255).

(3) To qualify for the increased payment, the individual physician must attest that:

(a) The physician has a primary practice in family medicine, general internal medicine, or pediatric medicine; and

(b) One or both of the following are true:

(A) The physician is Board-certified in a specialty or subspecialty of family medicine, general internal medicine, or pediatric medicine by one of the following boards:

(i) The American Board of Medical Specialties (ABMS);
(ii) The American Osteopathic Association (AOA);
(iii) The American Board of Physician Specialties (ABPS);

(B) The physician can demonstrate that at least 60 percent of the procedure codes billed and paid in Medicaid claims were qualifying primary care codes described in section 2 of this rule.

(i) Over the previous calendar year, if billings exist for this time period; or

(ii) Over the previous month, if billings do not exist for the previous calendar year.

(4) To qualify for the increased payment, a Physician Assistant (PA) or Nurse Practitioner (NP) must attest that they work under the direct supervision of a Physician who:

(a) Qualifies for increased primary care payments as described in these rules; and

(b) Assumes professional responsibility for the services rendered by the PA or NP.

(5) Providers seeking the reimbursement increase from the Division of Medical Assistance Programs (Division) must self-attest with the Division. Providers, not enrolled with the Division, seeking the increase from OHP health plans (MCO or CCO), must self-attest with the applicable MCO or CCO.

(6) Reimbursement: Effective for dates of service on or after January 1, 2013, the Division shall reimburse primary care providers as follows:

(a) Federally qualified primary care providers as described in this rule at the rate specified in OAR 410-120-1340(6)(C)(ii); or

(b) Other primary care providers, including potentially qualified providers who do not self-attest to the Division as described in part (3) of this rule, at the rate specified in OAR 410-120-1340(6)(C)(iii).

(7) Annual review of qualifying providers: The Division will review a statistically valid sample of providers to determine whether they satisfy the criteria described in (3) and (4) of these rules. Providers reviewed who do not satisfy the criteria will be required to reimburse the Division for the difference between the rate they should have received according to OAR 410-120-1340(6)(C)(iii) and enhanced rate in OAR 410-120-1340(6)(C)(ii). The sample will include the following providers:

(a) Physicians who have self-attested to qualifying for the increased rate; and

(b) Providers who have self-attested that they are under the direct supervision of a qualified physician.

(8) Supplemental information on primary care reimbursement under the Affordable Care Act is available at http://www.oregon.gov/OHA/healthplan/pages/pcp-rates.aspx.

Stat Auth.: ORS 413.042
Stats Implemented: 414.025 & 414.065
Hist.: DMAP 14-2013(Temp), f. & cert. ef. 3-29-13 thru 9-25-13; DMAP 49-2013, f. & cert. ef. 9-25-13

410-130-0015
Doula Services

(1) The primary purpose of providing concurrent doula services with the services of a licensed obstetrical practitioner is to optimize birth outcomes, including reduced Caesarian sections, epidural use, reduced assisted vaginal deliveries, and reduce the number of neonatal care unit admissions. These face-to-face services are provided only during the labor and delivery phase of the client's pregnancy. The following are expected to benefit most from doula services:

(a) A woman with a racially or ethnically diverse background including, Black/African American, Asian, Pacific Islander, Native American, Latino or multiracial;

(b) A homeless woman;

(c) A woman who speaks limited to no English;

(d) A woman who has limited to no family or partner support; or

(e) A woman who is under the age of 21;

(2) Doula services may be provided only at the request of the licensed obstetrical practitioner. The doula and licensed obstetrical practitioner must work concurrently. The licensed obstetrical practitioner must be a physician or advance practice nurse.

(3) Doulas must be certified and registered with the Authority pursuant to OAR 410-180-0325 through 0327. Certification must be effective at the time doula services are provided. Doulas must provide proof of certification to the practitioner.

(4) Doula services are covered for any woman whose benefit package covers labor and delivery.

(5) The provision of doula services during labor and delivery must be documented in the client's medical record by the licensed obstetrical practitioner.

(6) Payment for doula's services

(a) The licensed obstetrical practitioner may be eligible for an additional payment, as remuneration for the attending doula providing the doula services;

(b) Doulas may not receive direct payment from the Division;

(c) To be considered for the additional payment, the professional claim for the delivery services must include the unique Medicaid modifier of U9 appended to the appropriate obstetrical code billed at the time of delivery;

(d) This modifier may only be billed once per pregnancy. Multiples (i.e., twins, triplets) are not eligible for additional payment for the doula's services;

(e) Only one additional payment shall be made for doula services regardless of the number of doulas providing the services;

(f) Only providers with a provider type designation of 34 or 42 may bill the U9 modifier.

(7) Doula services at the time of delivery are the only services eligible for payment under this rule. Services provided during the prenatal and postnatal period are governed by OAR 410-130-0595 (Maternity Case Management).

Stat. Authority: ORS 413.042 and 414.065
Stat. Implemented: ORS 414.065
Hist.: DMAP 73-2013, f. 12-31-13, cert. ef. 1-1-14

410-130-0160
Codes

(1) ICD-10-CM Diagnosis Codes:

(a) Always use the principal diagnosis code in the first position to the highest degree of specificity. List additional diagnosis codes if the claim includes charges for services that relate to the additional diagnoses. However, it is not necessary to include more than one diagnosis code per procedure code;

(b) Diagnosis codes are required on all billings including those from independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers;

(c) Always supply the ICD-10-CM diagnosis code to ancillary service providers when prescribing services, equipment, and supplies.

(2) CPT and HCPCS Codes:

(a) Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;

(b) Effective January 1, 2005, HIPAA regulations prohibit the use of a grace period for codes deleted from CPT or HCPCS. In the past the grace period was from January 1 through March 31;

(c) The division may consider reimbursement for CPT category III codes included under the following headings: Adaptive Behavior Assessments, Adaptive Behavior Treatment, and Exposure Adaptive Behavior Treatment With Protocol Modification. All CPT category II (codes with fifth character of "F") and all other category III codes (codes with fifth character "T") are not Division of Medical Assistance Programs' (Division) covered services;

(d) Use the most applicable CPT or HCPCS code. Do not fragment coding when services can be included in a single code (see the "Bundled Services" section of this rule). Do not use both CPT and HCPCS codes for the same procedure. This is considered duplicate billing.

(3) The Medical-Surgical Service rules list the HCPCS/CPT codes that require authorization or have limitations. The Health Evidence Review Commission's Prioritized List of Health Services (rule 410-141-0520) determines covered services.

(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT and HCPCS codebook. Use the definitions to verify level of service, especially for office visits. Unless otherwise specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.

(5) Bundled Services: Reimbursements for some services are "bundled" into the payment for another service. The Division does not make separate payment for bundled services and clients may not be billed for bundled services. The Division's Not Covered/Bundled Services rule, OAR 410-130-0220, provides more information regarding bundled services.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0610; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f, 2-28-92, cert. ef. 3-1-92; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 74-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 15-2015, f. 3-27-15, cert. ef. 4-1-15; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-130-0180
Drugs

(1) The Division of Medical Assistance Programs' (Division) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. The Division does not reimburse practitioners for drugs that are self-administered by the client, except for contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate Current Procedural Terminology (CPT) therapeutic injection code for administration of injectables;

(b) Use an appropriate Healthcare Common Procedure Coding System (HCPCS) code for the specific drug. Do not bill for drugs under code 99070; The Division requires both the NDC number and HCPCS codes on all claim forms.

(c) When there is no specific HCPCS code for a drug or biological, use an appropriate unlisted code from the list below and bill at acquisition cost (purchase price plus postage):

(A) J3490;
(B) J3590;
(C) J7599;
(D) J7699;
(E) J7799;
(F) J8499;
(G) J8999;
(H) J9999;

(I) Include the name of the drug, National Drug Code (NDC) number and dosage.

(2) Do not bill for local anesthetics; reimbursement is included in the payment for the tray and/or procedure.

(3) For codes requiring prior authorization and codes that are Not Covered/Bundled, refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) Not covered services and supplies include:

(a) Laetrile;

(b) Home pregnancy kits and products designed to promote fertility;

(c) Dimethyl sulfoxide (DMSO), except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc.

(5) Follow criteria outlined in the following:

(a) Billing Requirements — OAR 410-121-0150;

(b) Brand Name Pharmaceuticals — OAR 410-121-0155;

(c) Prior Authorization Procedures — OAR 410-121-0060;

(d) Drugs and Products Requiring Prior Authorization — OAR 410-121-0040;

(e) Drug Use Review — OAR 410-121-0100;

(f) Participation in Medicaid's Drug Rebate Program — OAR 410-121-0157.

(A) The Division cannot reimburse providers for a drug unless the drug manufacturer has signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Drug Rebate Program.

(B) To verify that a drug manufacturer participates in the Medicaid Drug Rebate Program, visit the CMS website below to verify that the first five digits of the NDC number (labeler code) are listed as a participating drug company: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html.

(6) Clozaril/Clozapine therapy:

(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;

(b) Clozapine supervision is the management and record keeping of clozapine dispensing as required by the manufacturer of clozapine. This is part of an evaluation and management service conducted by the appropriately licensed prescribing medical practitioner;

(c) Pharmacies dispensing clozapine shall comply with OAR 410-121-0190.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0620; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 33-2002, f. & cert. ef. 8-1-02; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 52-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 58-2012(Temp), f. 12-27-12, cert. ef. 12-28-12 thru 6-25-13; DMAP 27-2013, f. & cert. ef. 6-25-13

410-130-0190
Tobacco Cessation

(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.

(2) Basic tobacco cessation treatment includes the following services:

(a) Ask — systematically identify all tobacco users — usually done at each visit;

(b) Advise — strongly urge all tobacco users to quit using;

(c) Assess — the tobacco user's willingness to attempt to quit using tobacco within 30 days;

(d) Assist — with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(e) Arrange — follow-up support and/or referral to more intensive treatments, if needed.

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions, less than 6 minutes, generally are provided during a visit for other conditions, and additional billing is not appropriate.

(4) Intensive tobacco cessation treatment is on the Health Services Commission's Prioritized List of Health Services and is covered if a documented quit date has been established. This treatment is limited to ten sessions every three months. Treatment is reserved for those clients who are not able to quit using tobacco with the basic intervention measures.

(5) Intensive tobacco cessation treatment includes the following services:

(a) Multiple treatment encounters (up to ten in a 3 month period);

(b) Behavioral and tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(c) Individual or group counseling, six minutes or greater.

(6) Telephone calls: the Division may reimburse a telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:

(a) The call must last six to ten minutes and provides support and follow-up counseling;

(b) The call must be conducted by the provider or other trained staff under the direction or supervision of the provider;

(c) Enter proper documentation of the service in the client's chart.

(7) Diagnosis Code ICD-10-CM (F17.200-F17.299; Nicotine Dependence):

(a) Use as the principal diagnosis code when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services;

(b) Use as a secondary diagnosis code when the primary purpose of this visit is not for tobacco cessation or when the tobacco use is confirmed during the visit.

(8) Billing Information: Coordinated care organizations and managed care plans may have tobacco cessation services and programs. This rule does not limit or prescribe services a Prepaid Health Plan provides to clients receiving OHP benefits.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: HR 36-1992, f. & cert. ef. 12-1-92; OMAP 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-130-0200
Prior Authorization

(1) For fee-for-service (FFS) clients, prior authorization (PA) is required for all procedure codes listed in Table 130-0200-1 regardless of the setting in which they are performed unless the setting is otherwise specified in Table 1 of this rule. For details on where to obtain PA, download a copy of the Medical-Surgical Services Supplemental Information booklet at: http://www.oregon.gov/oha/healthplan/Pages/medical-surgical.aspx.

(2) Providers must obtain PA from the OHP payer, either FFS or CCO; which shall be responsible for payment at the time the service is delivered.

(3) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and guideline notes, as referenced in OAR 410-141-0520.

(4) Codes for which medical need has not been specified by the HERC shall be authorized based on medical appropriateness as the term is defined in OAR 410-120-0000.

(5) For out-of-hospital birth PA requests, initial documentation adequate to assess pregnancy risk per OAR 410-130-0240 must be received before 27 weeks 6 days gestation. Exceptions to the 27 week 6 day limit may be granted in cases where the member has recently moved into Oregon, provided requirements for prior prenatal care documentation are met. Requests for ongoing documentation to continue the support of assessment of pregnancy risk must also be met per OAR 410-120-1320(2)(3).

(6) For bariatric surgery, PA is required in two steps from:

(a) The OHP primary care provider prior to referral to a bariatric surgery center, and

(b) The bariatric surgery center prior to surgery.

(7) PA is not required:

(a) For clients with both Medicare and Medical Assistance Program coverage, and the service is covered by Medicare. However, PA is still required for bariatric surgeries and evaluations and most transplants, even if they are covered by Medicare;

(b) For kidney and cornea transplants unless they are performed out-of-state;

(c) For emergent or urgent procedures or services;

(d) For hospital admissions unless the procedure requires PA.

(8) A second opinion may be requested by the Division or the contractor before PA is given.

(9) Treating and performing practitioners are responsible for obtaining PA.

(10) PA documentation must be complete and legible.

(11) PA shall be considered based on the documentation submitted.

(12) Refer to Table 130-0200-1 for all services and procedures requiring PA.

(13) **Table 130-0200-1**.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 868, f. 12-30-77, ef. 2-1-78; AFS 65-1980, f. 9-23-80, ef. 10-1-80; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 23-1986, f. 3-19-86, ef. 5-1-86; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0045; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0630; HR 25-1990(Temp), f. 8-31-90, cert. ef. 9-1-90; HR 44-1990, f. & cert. ef. 11-30-90; HR 17-1991(Temp), f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 27-2007(Temp), f. & cert. ef. 12-20-07 thru 5-15-08; DMAP 12-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 34-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 43-2014, f. & cert. ef. 7-8-14; DMAP 55-2014(Temp), f. 9-26-14, cert. ef. 10-1-14 thru 3-30-15; DMAP 13-2015, f. & cert. ef. 3-10-15; DMAP 68-2015(Temp), f. 11-25-15, cert. ef. 12-1-15 thru 5-28-16; DMAP 89-2015, f. 12-30-15, cert. ef. 1-1-16

410-130-0220
Not Covered/Bundled Services/Not Valid

(1) Refer to the Oregon Health Plan administrative rules (chapter 410, division 141) and General Rules (chapter 410, division 120) for coverage of services. Refer to Table 130-0220-1 in this rule for additional information regarding not covered services, for services that the Division considers to be bundled in other services, and for codes the Division considers not valid for claims processing.

(2) For additional information, see General Rules OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations.

(3) Table 130-0220-1.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0640; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, cert. ef. 5-1-91; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 16-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 30-1998, f. & cert. ef. 9-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 37-1999, f. & cert. ef. 10-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 55-2014(Temp), f. 9-26-14, cert. ef. 10-1-14 thru 3-30-15; DMAP 84-2014(Temp), .f & cert. ef. 12-24-14 thru 3-30-15; DMAP 13-2015, f. & cert. ef. 3-10-15; DMAP 30-2015(Temp), f. & cert. ef. 5-29-15 thru 11-24-15; DMAP 63-2015, f. 10-29-15, cert. ef. 11-1-15; DMAP 13-2016(Temp), f. & cert. ef. 3-4-16 thru 8-30-16; DMAP 17-2016, f. 4-28-16, cert. ef. 5-1-16

410-130-0225
Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Division of Medical Assistance Programs (Division) on a CMS-1500 or 837P when serving as an employee of the hospital during the time the service was provided or when the hospital reports the service as a direct medical education cost on the Medicare and Division cost report.

(2) For requirements for the provision of services, including documentation requirements, follow Medicare guidelines for Teaching Physician Services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0370, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0230
Administrative Medical Examinations and Reports

(1) This rule does not apply to Managed Health Care plans.

(2) These services are covered only when requested by an CAF, APD, AMH, OYA, Child Welfare branch office or approved by the Division of Medical Assistance Programs (Division). The branch office may request an administrative medical examination or a medical report (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) See the Administrative Examination and Report Billing rule for complete billing instructions.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97

Hist.: HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0900, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03

410-130-0240
Medical Services

(1) Coverage of medical and surgical services is subject to the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List). Medical and surgical services requiring prior authorization (PA) are listed in Oregon administrative rule (OAR or rule) 410-130-0200, PA Table 130-0200-1, and medical and surgical services that are Not Covered/Bundled services are listed in OAR 410-130-0220, Table 130-0220-1.

(2) Coverage for acupuncture services by an enrolled acupuncture provider are subject to the HERC Prioritized List and the client's benefit plan.

(3) Coverage for medically appropriate chiropractic services provided by an enrolled chiropractor is subject to the HERC Prioritized List and benefit plan for:

(a) Diagnostic visits including evaluation and management services;

(b) Chiropractic care including manipulative treatment;

(c) Laboratory and radiology services.

(4) Maternity care and delivery:

(a) The Division may consider payment for delivery within a hospital, clinic, birthing center, or home setting;

(b) For out-of-hospital births, the Division may only consider payment for labor and delivery care of women experiencing low

risk pregnancy. The Division will determine whether a pregnancy can be considered low risk and an out-of-hospital birth is eligible for payment;

(c) The Division adopts Table I from OAR 333-076-0650 to outline the absolute risk factors that, if present, would preclude payment for initiation or continuation of any out-of-hospital labor and delivery care. For a planned out-of-hospital birth, the Division requires that a contingency for an in-hospital birth be included in the medical record. The division considers all conditions listed in Table I of OAR 333-076-0650 to necessitate an in-hospital birth if present or anticipated to be present at the onset of labor. The Division may deny payment for labor and delivery services in an out-of-hospital setting if it determines that an in-hospital birth was necessary and appropriate steps to facilitate an in-hospital birth were not pursued. When an in-hospital birth becomes necessary for a client that was seeking a planned out-of-hospital birth and care is transferred from one provider to another, the Division will consider payment for both providers for the portion of care provided. Bill using appropriate CPT and HCPCS codes.

(d) When a provider is practicing within the authorization of his or her license, the division may consider payment for administration of drugs and devices that are used in pregnancy, birth, postpartum care, newborn care, or resuscitation and that are deemed integral to providing safe care.

(e) For out-of-hospital births, drugs authorized in subsection (d) or this section are limited:

(A) For out-of-hospital births, the Division will make no payment for general, spinal, caudal, or epidural anesthesia administered for care associated with labor and delivery;

(B) For out-of-hospital births, the Division will make no payment for inducing, stimulating, or using chemical agents to augment labor during the first or second stages of labor;

(C) For out-of-hospital births, the Division will consider payment for chemical agents administered to inhibit labor only as a temporary measure until referral or transfer of the client to a higher level of care is complete.

(f) Within the home setting, the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, and newborn screening cards;

(g) During labor in an out-of-hospital setting, should any of the risk factors outlined in Table II of OAR 333-076-0650 develop, the Division requires that the client will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. When labor management does not result in a delivery, and the client is appropriately transferred to a higher level of care, the provider shall code for labor management only. Bill code 59899 and attach appropriate clinical documentation of services performed with respect to labor management;

(h) For births in an out-of-hospital setting, should any of the risk factors outlined in Table III of OAR 333-076-0650 develop during the postpartum period in the mother or infant, the Division requires that the client will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. The Division will consider payment for both providers for the portion of care provided when appropriate;

(i) For multiple vaginal births, use the appropriate CPT code for the first delivery. Use the delivery-only code for the subsequent deliveries. The Division will reimburse the first delivery at 100 percent and the subsequent deliveries at 50 percent of the delivery-only code's maximum allowance. For multiple babies delivered via cesarean section, the Division pays for the cesarean section only once.

(5) Neonatal Intensive Care Unit (NICU) procedures:

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

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

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: PWC 839(Temp), f. & ef. 4-28-77; PWC 849, f. 7-15-77, ef. 8-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 14-1978(Temp), f. 4-14-78, ef. 4-15-78; AFS 31-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80, AFS 56-1980(Temp), f. 8-29-80, ef. 9-1-80; AFS 2-1981, f. 1-9-81, ef. 2-1-81; AFS 36-1981, f. 6-29-81, ef. 7-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 38-1983, f. & ef. 8-1-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0021 & 461-014-0056; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0650, 461-014-0690 & 461-014-0700; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 18-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 18-1992, f. & cert. ef. 7-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 16-1993, f. & cert. ef. 7-2-93; HR 6-1994, f. & cert. ef. 2-1-94, Renumbered from 410-130-0320, 410-130-0340, 410-130-0360 & 410-130-0740; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 88-2004, f. 11-24-04, cert. ef. 12-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 58-2012(Temp), f. 12-27-12, cert. ef. 12-28-12 thru 6-25-13; DMAP 27-2013, f. & cert. ef. 6-25-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 73-2014, f. 12-9-14, cert. ef. 1-1-15

410-130-0245

Early and Periodic Screening, Diagnostic and Treatment Program

(1) The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, formerly called Medicheck, offers "well-child" medical exams with referral for medically appropriate comprehensive diagnosis and treatment for all children (birth through age 20) covered by the Oregon Health Plan (OHP) Plus benefit package.

(2) Screening Exams:

(a) Physicians (MD or DO), nurse practitioners, licensed physician assistants and other licensed health professionals may provide EPSDT services. Screening services are based on the definition of "Preventive Services" in Oregon Health Plan OAR 410-141-0000, Definitions;

(b) Periodic EPSDT screening exams must include:

(A) A comprehensive health and developmental history including assessment of both physical and mental health development;

(B) Assessment of nutritional status;

(C) Comprehensive unclothed physical exam including inspection of teeth and gums;

(D) Appropriate immunizations;

(E) Lead testing for children under age 6 as required. See the "Blood Lead Screening" section of this rule;

(F) Other appropriate laboratory tests (such as anemia test, sickle cell test, and others) based on age and client risk;

(G) Health education including anticipatory guidance;

(H) Appropriate hearing and vision screening.

(c) The provider may bill for both lab and non-lab services using the appropriate Current Procedural Terminology (CPT) and Health care Common Procedure Coding System (HCPCS) codes. Immunizations must be billed according to the guidelines listed in OAR 410-130-0255;

(d) Inter-periodic EPSDT screening exams are any medically appropriate encounters with a physician (MD or DO), nurse practitioner, licensed physician assistant, or other licensed health professional within their scope of practice.

(3) Referrals:

(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the client may be referred to medical providers, Addictions and Mental Health Division (AMH), or dental providers for further diagnosis and/or treatment;

(b) The screening provider shall explain the need for the referral to the client, client's parent, or guardian;

(c) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate referral provider and making an appointment should be offered;

(d) The caseworker or local branch will assist in making other necessary arrangements.

(4) Blood Lead Screening: All children ages 12 months to 72 months are considered at risk for lead poisoning. Children ages 12 months to 72 months with Medical Assistance Program coverage must be screened for possible exposure to lead poisoning. Because the prevalence of lead poisoning peaks at age two, children screened or tested at age one should be re-screened or re-tested at age two. Screening consists of a Lead Risk Assessment Questionnaire (Division form 9033) and/or blood lead tests as indicated.

(5) Lead Risk Assessment Questionnaire: Complete the Lead Risk Assessment Questionnaire (Division form 9033) found in the Medical-Surgical Services Supplemental Information. Beginning at 1 year of age, the questionnaire must be used at each EPSDT exam to assess the potential for lead exposure. Retain this questionnaire in the client's medical record. Do not attach the Division 9033 form to the claim for reimbursement. The Division does not stock this form; photocopy the form and the instructions from the Medical-Surgical Services Supplement Information.

(6) Blood Lead Testing: Any "yes" or "don't know" answer in Part B, questions 1-8 on the Lead Risk Assessment Questionnaire (Division 9033) means that the child should receive a screening blood lead test. An elevated blood lead level is defined as greater than or equal to 10 μg/dL. Children with an elevated blood lead screening test should have a confirmatory blood lead test performed according to the schedule described in Table 130-0245-1 of this rule. If the confirmatory blood lead test is elevated, follow-up blood lead tests should be performed approximately every three months until two consecutive test results are less than 10 μg/dL. Comprehensive follow-up services based on the results of the confirmatory blood lead test are described in Table 130-0245-2 and section (7) of this rule.

(7) Children with a confirmatory blood lead level test of greater than or equal to 10 μg/dL are eligible for a one-time comprehensive environmental lead investigation, not including laboratory analysis, of the child's home. The child may also receive follow-up case management services.

(a) The investigation of the child's home and follow-up case management services must be provided by a Division-enrolled medical-surgical provider who has received Oregon Public Health Division training to perform these services. Refer to Medical-Surgical Services rule 410-130-0000 for a list of the medical-surgical providers Division enrolls.

(b) To bill for these services, use HCPCS code T1029. Payment for code T1029 includes the home investigation and any follow-up case management services provided after the home investigation is completed. The Division limits reimbursement of T1029 to one time per dwelling. For clients enrolled in managed care plans, the service is payable by the Division; do not bill the managed care plan.

(8) Method of Blood Collection: Either venipuncture or capillary draw is acceptable for the screening blood lead test. All confirmatory blood lead tests must be obtained by venipuncture. Erythrocyte protoporphyrin (EP) testing is not a substitute for either a screening or a confirmation blood lead test.

(9) Additional Lead-Related Services: Families should be provided anticipatory guidance and lead education prenatally and at each well-child visit, as described in Tables 130-0245-3 and 130-0245-4 of this rule.

(10) **Table 130-0245-1.**

(11) **Table 130-0245-2.**

(12) **Table 130-0245-3.**

(13) **Table 130-0245-4.**

(14) **Table 130-0245-5.**

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

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.150

Hist.: HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 16-1993, f. & cert. ef. 7-2-93; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 37-1999, f. & cert. ef. 10-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0080, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 15-2010, f. 6-10-10, cert. ef. 7-1-10

410-130-0255

Immunizations, Vaccines for Children, and Immune Globulins

(1) The Division of Medical Assistance Programs (Division) covers immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Oregon Immunization Program. The approved ACIP recommendations are found in Guideline Note 106 of the Health Evidence Review Commission's Prioritized List of Health Services as referenced in OAR 410-141-0520, http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx.

(2) Providers shall follow the (ACIP) guidelines for immunization schedules. Exceptions include:

(a) On a case-by-case basis, provider may use clinical judgment in accordance with accepted medical practice to provide immunizations on a modified schedule, and;

(b) On a case-by-case basis, provider may modify immunization schedule in compliance with the laws of the State of Oregon, including laws relating to medical and non-medical exemptions for immunizations.

(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective.

(4) Providers must use standard billing procedures for adults and for any vaccines that are not part of the Vaccines for Children (VFC) Program.

(5) Vaccines for Children (VFC) is a federal program that provides vaccine serums at no cost to providers for clients ages 0 through 18. All vaccines for this age group and for conditions covered by the VFC program must be obtained through the VFC program. The Division will not reimburse providers for the administration or purchase of privately purchased vaccines if the vaccine could have been obtained through the VFC program. For information about the VFC program or to enroll as a VFC provider, contact the Public Health Immunization Program. The Oregon VFC program website can be located at http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx

(6) The Division will only reimburse for the administration, not the serum, of vaccines available for free through the VFC Program. Refer to the 12/24/2013 Current Oregon Immunization Program State-Supplied Vaccine Billing Codes table available at http://bit.ly/1c3T6zy for a list of vaccines provided through the VFC Program.

(7) To receive reimbursement for vaccine administration, VFC program providers must bill the Division:

(a) With the appropriate vaccine common procedural terminology (CPT) code included;

(b) Including the appropriate modifier -SL or -26; and

(c) Reporting the vaccine administration in addition to an Evaluation and Management service (e.g., well-child visit) if provided on the same date of service;

(8) For clients with private insurance, providers may bill the Division or the client's managed care or coordinated care organization (MCO/CCO) directly for the administration of VFC vaccines. Medicaid and CHIP are not considered the "payer of last resort" for administration of VFC vaccines.

(9) In compliance with Section 1202 of the Affordable Care Act ,VFC providers who qualify for the federal primary care rate increase as specified under 42 Code of Federal Regulation (CFR) 447 Subpart G (see also OAR 410-130-0005) are eligible for reimbursement for the administration of VFC vaccines at the Regional Maximum amount:

(a) Effective 1/1/2013 the Regional Maximum amount is $21.96.

(b) For providers that have met the federal primary care definition, MCO and CCOs are required to reimburse the lessor of:

(A) The Regional Maximum administration fee, or

(B) Medicare 2014 RVU and 2009 conversion factor amount.

(c) MCO and CCOs are not required to reimburse the Regional Maximum amount to providers that have not met the federal primary care definition but may at their option.

(d) For all fee for service providers, the Division reimburses the Regional Maximum amount for the administration of VFC vaccines.

(10) The Division covers immune globulins based on the Prioritized List of Health Services. Synagis (palivizumab-rsv-igm) is covered with prior authorization only for high-risk infants and children. Refer to Guideline Note 69 of the Health Evidence Review Commission's List of Prioritized Services as referenced in OAR 410-141-0520, http://www.oregon.gov/oha/herc/Pages/Prioritizedlist.aspx and Oregon Medicaid Fee-For-Service Prior Authorization Approval Criteria as referenced in 410-121-0040, www.oregon.gov/OHA/healthplan/pages/medical-surgical.aspx.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0800, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 34-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 14-2013(Temp), f. & cert. ef. 3-29-13 thru 9-25-13; DMAP 49-2013, f. & cert. ef. 9-25-13; DMAP 12-2014, f. & cert. ef. 3-13-14

410-130-0365

Ambulatory Surgical Center and Birthing Center Services

(1) Ambulatory Surgical Centers (ASC) and Birthing Centers (BC) must be licensed by the Oregon Health Division. ASC and BC services are items and services furnished by an ASC or BC in connection with a covered surgical procedure as specified in the Medical-Surgical Services rule or in the Dental Services rule. Reimbursement is made at all-inclusive global rates based on the surgical procedure codes billed.

(2) If the client has Medicare in addition to Medicaid and Medicare covers a surgery, but not in an ASC setting, then the surgery may not be performed in an ASC.

(3) Global rates include:

(a) Nursing services, services of technical personnel, and other related services;

(b) Any support services provided by personnel employed by the ASC or BC facility;

(c) The client's use of the ASC's or BC's facilities including the operating room and recovery room;

(d) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the provision of the surgical procedure(s);

(e) Diagnostic or therapeutic items and services related to the surgical procedure;

(f) Administrative, record-keeping, and housekeeping items and services;

(g) Blood, blood plasma, platelets;

(h) Materials for anesthesia;

(i) Items not separately identified in section (4) of this rule.

(4) Items and services not included in ASC or BC Global Rate:

(a) Practitioner services such as those performed by physicians, licensed physician assistants, nurse practitioners, certified registered nurse anesthetists, dentists, podiatrists and Licensed Direct Entry Midwives (for birthing centers only);

(b) The sale, lease, or rental of durable medical equipment to ASC or BC clients for use in their homes;

(c) Prosthetic and orthotic devices;

(d) Ambulance services;

(e) Leg, arm, back and neck brace, or other orthopedic appliances;

(f) Artificial legs, arms, and eyes;

(g) Services furnished by a certified independent laboratory.

(5) ASCs and BCs will not be reimbursed for services that are normally provided in an office setting unless the practitioner has justified the medical appropriateness of using an ASC or BC through documentation submitted with the claim. Practitioner's justification is subject to review by the Division. If payment has been made and the practitioner fails to justify the medical appropriateness for using an ASC or BC facility, the amount paid is subject to recovery by Division.

(6) Procedure coding for non-Birthing Centers:

(a) Bill the same procedure codes billed by the surgeon;

(b) For reduced or discontinued procedures, use Common Procedural Terminology (CPT) instructions and add appropriate modifiers;

(c) Attach a report to the claim when billing an unlisted code;

(d) For billing instructions regarding multiple procedures, see rule 410-130-0380.

(7) Procedure coding for Birthing Centers:

(a) Bill code 59409 only once for a single vaginal delivery regardless of the total days that the client was in the facility for labor management, delivery and immediate postpartum care;

(b) For delivery of twins:

(A) Bill the delivery of the first twin with 59409; and

(B) Bill the delivery of the second twin with code 59409 on a separate line;

(c) When labor was managed in the BC but a delivery did not result, bill S4005 (Interim labor facility global) and attach a report documenting the circumstances.

(8) Prior authorization is required for all services listed in Table 130-0200-1. Refer to Rule 410-130-0200.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0940, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09

410-130-0368

Anesthesia Services

(1) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520).

(2) Effective January 1, 2012 all anesthesia claims submitted must be billed in minutes only. This includes;

(a) Claims for services provided prior to 1/1/12 that are submitted for the first time in 2012;

(b) Resubmitted unpaid claims for services provided prior to 1/1/12; and

(c) Adjustments made to claims for services performed prior to 1/1/12. Units must be converted by the provider from units to minutes.

(3) Qualifier MJ (indicating minutes) must be added to all claims;

(a) Claims with qualifier UN (indicating units) will be denied; and

(b) Claims without a qualifier will be denied.

(4) Reimbursement is based on the base units assigned to each anesthesia code listed in the current American Society of Anesthesiology Relative Value Guide plus one unit per each 15 minutes of anesthesia time, except for anesthesia for neuraxial labor analgesia/anesthesia/anesthesia (code 01967). See (5) below for reimbursement of neuraxial labor analgesia/anesthesia.

(a) The Division of Medical Assistance Programs (Division) will automatically calculate payment by adding the base units of the billed anesthesia code plus a unit per each 15 minutes of anesthesia time;

(b) Reimbursement will be made at a fraction of a unit for the last 1-14 minutes of anesthesia time;

(c) Do not add base units in addition to minutes.

(5) Anesthesia for neuraxial labor analgesia/anesthesia (code 01967) will be paid at a flat rate regardless of the units billed.

(6) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100-01999.

(7) A valid consent form is required for all hysterectomies and sterilizations.

(8) If prior authorization (PA) was not obtained for a procedure that requires PA, then the anesthesia services may not be paid. Refer to OAR 410-130-0200 PA Table 130-0200-1.

(9) Anesthesia services are not payable to the provider performing the surgical procedure except for moderate (conscious) sedation.

(10) Moderate (conscious) sedation must be billed with codes 99143-99150.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12

410-130-0380
Surgery Guidelines

(1) The Division of Medical Assistance Programs (Division) reimburses all covered surgical procedures as global packages. Global payments do not include initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.

(2) Surgical procedures listed in the Medical-Surgical Services administrative rules with prior authorization (PA) indicated require authorization unless they are emergent.

(3) Global payment for major surgery includes:

(a) Surgery;

(b) Pre-operative visits within 15 days of the surgery (except the initial consultation);

(c) Initial admission history and physical;

(d) Related follow-up visits within 90 days after the surgery;

(e) Treatment of complications not requiring a return trip to the operating room;

(f) Hospital discharge.

(4) Global payment for minor surgery includes:

(a) Surgery;

(b) Pre-operative visits within 15 days of the surgery;

(c) Initial admission history and physical;

(d) Related follow-up visits for 10 days after the surgery;

(e) Hospital discharge.

(5) Global payment for endoscopy includes:

(a) Surgery;

(b) Related visit on the same day as the endoscopy procedure;

(c) No follow-up days for this procedure;

(d) Pre-operative and post-operative care provided by the surgeon's associate(s) or by another physician "on call" for the surgeon are considered included in the reimbursement to the surgeon and will not be paid in addition to the payment to the surgeon;

(e) Do not bill separately for procedures which are considered to be bundled in another procedure. Payment for bundled services is included in the primary surgery payment.

(6) Co-surgeons — Two or more surgeons/same or different specialties/separate functions/one major or complex surgery:

(a) Add modifier -62 to procedure code(s);

(b) Payment will be determined by medical review.

(7) Team Surgeons — Two or more surgeons/different specialties performing/separate surgeries/same operative session:

(a) Add modifier -66 to procedure code(s);

(b) Payment will be determined by medical review.

(8) Multiple Surgical Procedures performed during the same operative session:

(a) Primary Procedure paid at 100% of the Division maximum fee for that procedure;

(b) Second and third procedure paid at 50% of the Division maximum fee;

(c) Fourth, fifth, etc. paid at 25% or less as determined by the Division;

(d) Endoscopic procedures paid at 100% of the Division maximum fee for the primary level procedure. The Division fee for insertion will be deducted from the maximum allowable for each additional procedure performed at the same site;

(e) Bill each procedure on separate lines (even multiples of the same procedure) unless the code description specifies "each additional";

(f) Bilateral procedures must be billed on two lines unless a single code identifies a bilateral procedure. Use modifier -50 only on the second line;

(g) Reimbursement for laparotomy is included in the surgical procedure and should not be billed separately or in addition to the surgical procedure;

(h) For Integumentary System codes 10000 thru 17999, bill multiples of the same procedure on the same line with the appropriate quantity unless the code indicates the first in a series (i.e., code 11100) or the code is for multiple procedures (i.e., code 11900).

(9) Surgical Assistance — Payment is restricted to physicians, naturopaths, podiatrists, dentists, nurse practitioners, licensed physician assistants, and registered nurse first assistants:

(a) The assistance must be medically appropriate;

(b) No payment will be made for surgical assistant for minor surgical or diagnostic procedures, e.g., "scoping" procedures;

(c) Only one surgical assistant may receive payment (except when the need is clinically documented);

(d) Use an appropriate modifier to indicate assistance.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: PWC 868, f. 12-30-77, ef. 2-1-78; AFS 32-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 2-1983, f. 1-31-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 4-1984, f. & ef. 2-1-84; AFS 30-1984, f. 7-26-84, ef. 8-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-1984; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 30-1987, f. 7-15-87, ef. 8-1-87; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0048, 461-014-0049, 461-014-0053, 461-014-0055 & 461-014-0056; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0710; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02

410-130-0562
Abortion

For medically induced abortions by oral ingestion of medication use S0199 for all visits, counseling, lab tests, ultrasounds, and supplies. S0199 is a global package except for medication:

(1) Bill medications with codes S0190-S0191 and appropriate HCPCS codes.

(2) For surgical abortions use CPT codes 59840 through 59857:

(3) For services related to surgical abortion such as lab, ultrasound and pathology bill separately. Add modifier U4 (a Division of Medical Assistance Programs (Division) modifier) for surgical abortion related services.

(4) Use the most appropriate ICD-10 diagnosis code.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-130-0580
Hysterectomies and Sterilization

(1) Refer to OAR 410-130-0200 Prior Authorization, Table 130-0200-1 and 410-130-0220 Not Covered/Bundled Services, Table 130-0220-1.

(2) Hysterectomies performed for the sole purpose of sterilization are not covered.

(3) All hysterectomies, except radical hysterectomies, require prior authorization (PA).

(4) A properly completed Hysterectomy Consent form (DMAP 741) or a statement signed by the performing physician, depending upon the following circumstances, is required for all hysterectomies:

(a) When a woman is capable of bearing children:

(A) Prior to the surgery, the person securing authorization to perform the hysterectomy must inform the woman and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing;

(B) The woman or her representative, if any, must sign the consent form to acknowledge she received that information.

(b) When a woman is sterile prior to the hysterectomy, the physician who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of the sterility;

(c) When there is a life-threatening emergency situation that requires a hysterectomy in which the physician determines that prior acknowledgment is not possible, the physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible and describe the nature of the emergency.

(5) In cases of retroactive eligibility:

The physician who performs the hysterectomy must certify in writing one of the following:

(a) The woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;

(b) The woman was previously sterile and states the cause of the sterility;

(c) The hysterectomy was performed because of a life-threatening emergency situation in which prior acknowledgment was not possible and describes the nature of the emergency.

(6) Do not use the Consent to Sterilization form (DMAP 742A or B) for hysterectomies.

(7) Submit a copy of the Hysterectomy consent form with the claim.

(8) Sterilization Male & Female: A copy of a properly completed Consent to Sterilization form (DMAP 742 A or B), the consent form in the federal brochure DHHS Publication No. (05) 79-50062 (Male), DHHS Publication No. (05) 79-50061 (Female) or another federally approved form must be submitted to the Division for all sterilizations. The original consent form must be retained in the clinical records. Prior authorization is not required.

(9) Voluntary Sterilization:

(a) Consent for sterilization must be an informed choice. The consent is not valid if signed when the client is:

(A) In labor;

(B) Seeking or obtaining an abortion; or

(C) Under the influence of alcohol or drugs.

(b) Ages 15 years or older who are mentally competent to give informed consent:

(A) At least 30 days, but not more than 180 days, must have passed between the date of the informed written consent (date of signature) and the date of the sterilization except:

(i) In the case of premature delivery by vaginal or cesarean section the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement;

(ii) In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before the sterilization was performed.

(B) The client must sign and date the consent form before it is signed and dated by the person obtaining the consent. The date of signature must meet the above criteria. The person obtaining the consent must sign the consent form anytime after the client has signed but before the sterilization is performed. If an interpreter is provided to assist the individual being sterilized, the interpreter must also sign the consent form on the same date as the client;

(C) The client must be legally competent to give informed consent. The physician performing the procedure, and the person obtaining the consent, if other than the physician, must review with the client the detailed information appearing on the Consent to Sterilization form regarding effects and permanence of the procedure, alternative birth control methods, and explain that withdrawal of consent at any time prior to the surgery will not result in any loss of other program benefits.

(10) Involuntary Sterilization — Clients who lack the ability to give informed consent and are 18 years of age or older:

(a) Only the Circuit Court of the county in which the client resides can determine that the client is unable to give informed consent;

(b) The Circuit Court must determine that the client requires sterilization;

(c) When the court orders sterilization, it issues a Sterilization Order. The order must be attached to the billing invoice. No waiting period or additional documentation is required.

(11) Submit the Consent to Sterilization Form (DMAP 742 A or B) along with the claim. The Consent to Sterilization form must be completed in full:

(a) Consent forms submitted to the Division without signatures and/or dates of signature by the client or the person obtaining consent are invalid;

(b) The client and the person obtaining consent may not sign or date the consent retroactively;

(c) The performing physician must sign the consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: PWC 803(Temp), f. & ef. 7-1-76; PWC 813, f. & ef. 10-1-76; PWC 834, f. 3-31-77, ef. 5-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 4-1979(Temp), f. & ef. 3-8-79; AFS 11-1979, f. 6-18-79, ef. 7-1-79; AFS 50-1981(Temp), f. & ef. 8-5-81; AFS 79-1981, f. 11-24-81, ef. 12-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1985, f. & ef. 7-1-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; Renumbered from 461-014-0030, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0840; HR 43-1991, f. & cert.

ef. 10-1-91; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 27-2007(Temp), f. & cert. ef. 12-20-07 thru 5-15-08; DMAP 12-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 34-2010, f. 12-15-10, cert. ef. 1-1-11

410-130-0585
Family Planning Services

(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.

(2) The Division of Medical Assistance Programs (Division) covers family planning services for clients of childbearing age (including minors who are considered to be sexually active).

(3) Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Laboratory tests;

(d) Radiology services;

(e) Medical and surgical procedures, including tubal ligations and vasectomies;

(f) Pharmaceutical supplies and devices.

(4) Clients may seek family planning services from any provider enrolled with the Division, even if the client is enrolled in a Prepaid Health Plan (PHP). Reimbursement for family planning services is made either by the client's PHP or the Division. If the provider is:

(a) A participating provider with the client's PHP, bill the PHP;

(b) An enrolled Division provider, but is not a participating provider with the client's PHP, bill the Division and add modifier –FP to the billed code.

(5) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, subdermal implants, condoms, and diaphragms.

(6) Bill all family planning services with the most appropriate ICD-10-CM diagnosis code the most appropriate CPT or HCPCS code and add modifier –FP.

(7) For annual family planning visits use the appropriate CPT code in the Preventative Medicine series (9938X-9939X) and add modifier -FP. These codes include comprehensive contraceptive counseling.

(8) When comprehensive contraceptive counseling is the only service provided at the encounter, use a CPT code from the Preventative Medicine, Individual Counseling series (99401-99404) and add modifier -FP.

(9) Bill contraceptive supplies with the most appropriate HCPCS codes.

(10) Where there are no specific CPT or HCPCS codes, use an appropriate unlisted code and add modifier -FP. Bill supplies at acquisition cost.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.152

Hist.: HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-130-0587
Family Planning Clinic Services

(1) This rule pertains only to Family Planning Clinics.

(2) To enroll with the Division of Medical Assistance Programs (Division) as a family planning clinic, a provider must also be enrolled with the Office of Family Health as an Oregon Contraceptive Care (CCare) provider.

(3) Family planning clinics must follow all applicable CCare and the Division rules.

(4) The Division will reimburse family planning clinics an encounter rate only when the primary purpose of the visit is for family planning.

(5) Bill HCPCS code T1015 "Clinic visit/encounter, all-inclusive; family planning" for all encounters where the primary purpose of the visit is contraceptive in nature:

(a) This encounter code includes the visit and any procedure or service performed during that visit including:

(A) Annual family planning exams;

(B) Family planning counseling;

(C) Insertions and removals of implants and IUDs;

(D) Diaphragm fittings;

(E) Dispensing of contraceptive supplies and contraceptive medications;

(F) Contraceptive injections.

(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or HCPCS codes;

(c) Bill only one encounter per date of service;

(d) Reimbursement for educational materials is included in T1015. Educational materials are not billable separately.

(6) Reimbursement for T1015 does not include payment for family planning (FP) supplies and medications:

(a) Bill contraceptive supplies and contraceptive medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code:

(A) Bill spermicide code A4269 per tube;

(B) Bill contraceptive pills code S4993 per monthly packet;

(C) Bill emergency contraception with code S4993 and bill per packet.

(b) Bill all contraceptive supplies and contraceptive medications at acquisition cost;

(c) Add modifier -FP after all codes for contraceptive services, supplies and medications;

(d) Non-contraceptive medications are not billable under this program.

(7) Reimbursement for T1015 does not include payment for laboratory tests:

(a) Clinics and providers who perform lab tests in their clinics and are CLIA certified to perform those tests may bill CPT and HCPCS lab codes in addition to T1015;

(b) Add modifier -FP after lab codes to indicate that the lab was performed during an FP encounter;

(c) Labs sent to outside laboratories, such as PAP smears, can be billed only by the performing laboratory.

(8) Encounters where the primary purpose of the visit is not contraceptive in nature, use appropriate CPT codes and do not add modifier -FP.

(9) When billing providers who are not participants in a Prepaid Health Plan (PHP) for services provided to clients enrolled in a PHP, add modifier -FP to the billed code.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 414.152

Hist.: OMAP 78-2003, f. & cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2010, f. 12-15-10, cert. ef. 1-1-11

410-130-0595
Maternity Case Management

(1) The primary purpose of the Maternity Case Management (MCM) program is to optimize pregnancy outcomes, including reducing the incidence of low birth weight babies. MCM services are tailored to the individual client needs. These services are provided face-to-face throughout the client's pregnancy, unless specifically indicated in this rule.

(2) This program:

(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month postpartum period;

(c) Must be initiated during the pregnancy and before delivery;

(d) Is an additional set of services over and above medical management of pregnant clients;

(e) Allows billing of intensive nutritional counseling services.

(3) Any time there is a significant change in the health, economic, social, or nutritional factors of the client, the prenatal care provider must be notified.

(4) Only one provider at a time may provide MCM services to the client. The provider must coordinate care to ensure that duplicate claims for MCM services are not submitted to the Division.

(5) Definitions:

(a) Case Management — An ongoing process to assist and support an individual pregnant client in accessing necessary health, social, economic, nutritional, and other services to meet the goals defined in the Client Service Plan (CSP)(defined below);

(b) Case Management Visit — A face-to-face encounter between a Maternity Case Manager and the client that must include two or more specific training and education topics, address the CSP and provide an on-going relationship development between the client and the visiting provider.

(c) Client Service Plan (CSP) — A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in the Initial Assessment (defined below) and includes a client discharge plan/summary;

(d) High Risk Case Management — Intensive level of services provided to a client identified and documented by the Maternity Case Manager or prenatal care provider as being high risk;

(e) High Risk Client — A client who has a current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who is 17 or under, or has other conditions identified by the case manager anytime during the course of service delivery;

(f) Home/Environmental Assessment — A visit to the client's primary place of residence to assess the health and safety of the client's living conditions;

(g) Initial Assessment — Documented, systematic collection of data with planned interventions as outlined in a CSP to determine current status and identify needs and strengths in physical, psychosocial, behavioral, developmental, educational, mobility, environmental, nutritional, and emotional areas;

(h) Nutritional Counseling — Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (12)(a)(A-I) in this rule;

(i) Prenatal/Perinatal care provider — The physician, licensed physician assistant, nurse practitioner, certified nurse midwife, or licensed direct entry midwife providing prenatal or perinatal (including labor and delivery) and/or postnatal services to the client;

(j) Case Management Visit Outside the Home — An encounter outside the client's home between a Maternity Case Manager and the client where identical services of a Case Management Home Visit (G9012) are provided.

(6) Maternity case manager qualifications:

(a) Maternity case managers must be currently licensed as a:

(A) Physician;

(B) Physician assistant;

(C) Nurse practitioner;

(D) Certified nurse midwife;

(E) Direct entry midwife;

(F) Social worker; or

(G) Registered nurse;

(b) The maternity case manager must be a Division enrolled provider or deliver services under an appropriate Division enrolled provider. See provider qualifications in the Division's General Rule 410-120-1260.

(c) All of the above must have a minimum of two years of related and relevant work experience;

(d) Other paraprofessionals may provide specific services with the exclusion of the Initial Assessment (G9001) while working under the supervision of one of the practitioners listed above in this section;

(e) The maternity case manager must sign off on all services delivered by a paraprofessional;

(f) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

(7) Nutritional counselor qualifications — nutritional counselors must be:

(a) A licensed dietician (LD) licensed by the Oregon Board of Examiners of Licensed Dieticians; and

(b) A registered dietician (RD) credentialed by the Commission on Dietetic Registration of the American Dietetic Association (ADA).

(8) Documentation requirements:

(a) Documentation is required for all MCM services in accordance with Division General Rule 410-120-1360; and

(b) A correctly completed Division form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for MCM services.

(9) G9001 — Initial Assessment must be performed by a licensed maternity case manager as defined under (6)(a)(A-G) in this rule:

(a) Services include:

(A) Client assessment as outlined in the "Definitions" section of this rule;

(B) Development of a CSP that addresses identified needs;

(C) Making and assisting with referrals as needed to:

(i) A prenatal care provider;

(ii) A dental health provider;

(D) Forwarding the Initial Assessment and the CSP to the prenatal care provider;

(E) Communicating pertinent information to the prenatal care provider and others participating in the client's medical and social care;

(b) Data sources relied upon may include:

(A) Initial Assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client;

(c) The client's record must reflect the date and to whom the Initial Assessment was sent;

(d) The Initial Assessment (G9001) is billable once per pregnancy per provider and must be performed before providing any other MCM services. Only a Home/Environmental Assessment (G9006) and a Case Management Home Visit (G9012) or Case Management Visit Outside the Home (G9011) may be performed and billed on the same day as an Initial Assessment.

(10) G9002 — Case Management includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

(A) The client's records must include a CSP and written updates to the plan;

(B) The CSP includes determining the client's strengths and needs, setting specific goals and utilizing appropriate resources in a cooperative effort between the client and the maternity case manager;

(c) Care coordination as follows:

(A) Contact with Department of Human Services (Department) case worker, if assigned;

(B) Maintain contact with prenatal care provider to ensure service delivery, share information, and assist with coordination;

(C) Contact with other community resources/agencies to address needs;

(d) Linkage to client services indicated in the CSP:

(A) Make linkages, provide information and assist the client in self-referral;

(B) Provide linkage to labor and delivery services;

(C) Provide linkage to family planning services as needed;

(e) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;

(f) Utilization and documentation of the "5 A's" brief intervention protocol for addressing tobacco use (US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008). Routinely:

(A) Ask all clients about smoking status;

(B) Advise all smoking clients to quit;

(C) Assess for readiness to try to quit;

(D) Assist all those wanting to quit by referring them to the Quitline and/or other appropriate tobacco cessation counseling and provide motivational information for those not ready to quit;

(E) Arrange follow-up for interventions;

(g) Provide training and education on all mandatory topics - Refer to Table 130-0595-2 in this rule;

(h) Provide client advocacy as necessary to facilitate access to benefits or services;

(i) Assist client in achieving the goals in the CSP;

(j) G9002 is billable when three months or more of services were provided. Services must be initiated during the prenatal period and carried through the date of delivery;

(k) G9002 is billable once per pregnancy.

(11) G9005 — High Risk Case Management:

(a) Enhanced level of services that are more intensive and are provided in addition to G9002;

(b) A client can be identified as high risk at any time when case management services are provided, therefore G9005 can be billed after 3 months of case management services.

(c) G9005 is billable only once per pregnancy per provider.

(d) G9002 can not be billed in addition to G9005.

(12) S9470 — Nutritional counseling:

(a) Is available for clients who have at least one of the following conditions:

(A) Chronic disease such as diabetes or renal disease;

(B) Hematocrit (Hct) less than 34 or hemoglobin (Hb) less than 11 during the first trimester, or Hct less than 32 or Hb less than 10 during the second or third trimester;

(C) Pre-gravida weight under 100 pounds or over 200 pounds;

(D) Pregnancy weight gain outside the appropriate Women, Infants and Children (WIC) guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

(H) Pregnancy induced hypertension (pre-eclampsia); or

(I) Other identified conditions;

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up;

(c) Can be billed in addition to other MCM services;

(d) S9470 is billable only once per pregnancy.

(13) G9006 — Home/Environmental Assessment:

(a) Includes an assessment of the health and safety of the client's living conditions with training and education of all topics as indicated in Table 130-0595-1 in this rule;

(b) G9006 may be billed only once per pregnancy, except an additional Home/Environmental Assessments may be billed with documentation of problems which necessitate follow-up assessments or when a client moves. Documentation must be submitted with the claim to support the additional Home/Environment Assessment.

(14) G9011 — Case Management Visit Outside the Home:

(a) A face-to-face encounter between a maternity case manager and the client in a place other than the home which meets all requirements of a Case Management Home Visit (G9012) or a telephone encounter when a face-to-face Case Management Visit is not possible or practical;

(b) G9011 is billable in lieu of a Case Management Home Visit and counted towards the total number of Case Management Home Visits (see G9012 for limitations).

(15) G9012 – Case Management Home Visit:

(a) Each Case Management Home Visit must be performed in the client's home and must include:

(A) An evaluation and/or revision of objectives and activities addressed in the CSP: and

(B) At least two training and education topics listed in Table 130-0595-2 in this rule;

(b) Four Case Management Home Visits (G9012) may be billed per pregnancy. Case Management Visits Outside the Home (G9011) are included in this limitation;

(c) Six additional Case Management Home Visits may be billed if the client is identified as high risk and services were provided for three months or longer;

(d) These additional six visits may only be billed with or after High Risk Case Management (G9005) has been billed. Case Management Visits Outside the Home (G9011) are included in this limitation.

(16) Table 130-0595-1

(17) Table 130-0595-2

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 57-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0200 & 461-014-0201; AFS 54-1989(Temp), f. 9-28-89, cert. ef. 10-1-89; AFS 71-1989, f. & cert. ef. 12-1-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0580; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 34-1998, f. & cert. ef. 10-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0100, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 8-2010(Temp), f. 4-13-10, cert. ef. 4-15-10 thru 10-1-10; DMAP 24-2010, f. & cert. ef. 9-1-10; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12

410-130-0610
Telemedicine

(1) For the purposes of this rule, telemedicine is defined as the use of telephonic or electronic communications to medical information from one site to another to improve a patient's health status.

(2) Unless authorized in OAR 410-120-1200 Exclusions, other types of telecommunications are not covered, such as telephone calls, images transmitted via facsimile machines and electronic mail:

(a) When those types are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access, or

(b) When those types and specific services are not specifically allowed in this rule per the Oregon Health Services Commission's Prioritized List of Health Services and Practice Guideline.

(3) Provider Requirements:

(a) The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider.

(b) For Addiction and Mental Health Division (AMH) providers, in addition to being enrolled as a Division provider under (3)(a). AMH providers must have an AMH agency letter of approval, certification of Approval or license issued by AMH. Individuals must also be providing covered services and be authorized to submit claims for covered telemedicine services under this rule.

(c) Providers billing for covered telemedicine services are responsible for the following:

(A) Complying with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA)

Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records. Examples of applicable OHA rules are Confidentiality and Privacy Rules include: OAR 943-120-0170, 410-120-1360 and 410-120-1380, and OAR 943 division 14. Examples of federal and state privacy and security laws that may apply include, if applicable, HIPAA (45 CFR Parts 160, 162, and 164), and 42 CFR Part 2, and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act);

(B) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and Department Privacy and Confidentiality Rules described in subsection (3)(A);

(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized persons;

(D) Complying with the relevant Health Evidence Review Commission (HERC) practice guideline for telephone and email consultation. Refer to the current prioritized list and practice guidelines at www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(E) Maintaining clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(4) Coverage for telemedicine services:

(a) The telemedicine definition encompasses different types of programs, services and delivery mechanisms for medically appropriate covered services within the patient's benefit package;

(b) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC) and the applicable HSC-approved code requirements, delivered consistent with the HSC practice guideline;

(c) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated in below;

(d) Telephonic codes may be used in lieu of videoconferencing codes, if videoconferencing equipment is not available.

(5) Telephone and E-mail billing requirements: Use the Evaluation and Management (E/M) code authorized in the HSC practice guideline, unless otherwise authorized in OAR 410-120-1200.

(6) Videoconferencing billing requirements:

(a) Only the transmission site (where the patient is located) may bill for the transmission:

(A) Bill the transmission with code Q3014;

(B) The referring practitioner may bill an E/M code only if a separately identifiable visit is performed. The visit must meet all of the criteria of the E/M code billed;

(C) The referring provider is not required to be present with the client at the originating site.

(b) The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission (code Q3014):

(A) Bill the most appropriate E/M code for the evaluation;

(B) Add modifier GT to the E/M code to designate that the evaluation was made by a synchronous (live and interactive) transmission.

(c) In addition, for AMH services specifically identified as allowable for telephonic delivery when appropriate, refer to the procedure code and reimbursement rates published by AMH.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 10-2008(Temp), f. & cert. ef. 4-1-08 thru 9-15-08; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08

410-130-0670
Death With Dignity

(1) All Death with Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a managed care plan.

(2) Death with Dignity is a covered service, incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(3) The following physician visits and medical encounters are billable when performed by a licensed physician or psychologist:

(a) The medical confirmation of the terminal condition;

(b) The two visits in which the client makes the oral request;

(c) The visit in which the written request is made;

(d) The visit in which the prescription is written;

(e) Counseling consultation(s); and

(f) Medication and dispensing.

(4) More than one of the services listed in sections (3)(a) through (3)(f) may be provided during the same visit. Additional visits for discussion or counseling are also covered for payment.

(5) Billing:

(a) All claims for Death with Dignity services must be made on a paper CMS-1500 billing form;

(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;

(c) Claims must be submitted using appropriate CPT or HCPCS codes;

(d) The Division unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;

(e) Claims must be submitted only on paper to: Division, PO Box 992, Salem, Oregon 97308-0992;

(f) Prescriptions must be billed only with the Division unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS-1500. In addition, the actual NDC number of the drug dispensed and the dosage must be listed below the prescription code;

(g) the Division may be billed for prescription services only when the pharmacy has been properly notified by the physician in accordance with OAR 847-015-0035. This OAR requires the physician to have the client's written consent to contact and inform the pharmacist of the purpose of the prescription.

[ED. NOTE: Forms referenced available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 46-1998, f. & cert. ef.12-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 2-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0680
Laboratory and Radiology

(1) The following tables list the medical and surgical services that:

(a) Require prior authorization (PA) — OAR 410-130-0200 Table 130-0200-1 (PET scans require PA and are included in the table), and;

(b) Are not covered/bundled — OAR 410-130-0220 Table 130-0220-1.

(2) Newborn screening (NBS) kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) are considered bundled into the delivery fee and, therefore, must not be billed separately. Replacement of lost NBS kits may be billed with code S3620 with modifier –TC. The loss must be documented in the client's medical record. NBS confirmation tests performed by reference laboratories at the request of the OSPHL will be reimbursed only to the OSPHL.

(3) The Division of Medical Assistance Programs (Division) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the Division Transplant Services administrative rules (chapter 410, division 124).

(4) All lab tests must be specifically ordered by, or at the direction of a licensed medical practitioner within the scope of their license.

(5) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests performed by the referring lab.

(6) When billing for lab tests, use the date that the specimen was collected as the date of service (DOS) even if the tests were not performed on that date.

(7) Reimbursement for drawing/collecting or handling samples:

(a) The Division will reimburse providers once per day regardless of the frequency performed for drawing/collecting the following samples:

(A) Blood — by venipuncture or capillary puncture, and;

(B) Urine — only by catheterization.

(b) The Division will not reimburse for the collection and/or handling of other specimens, such as PAP or other smears, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to the Division.

(9) Only the provider who performs the test(s) may bill the Division.

(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:

(a) The Division will only reimburse laboratory services to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS);

(b) CLIA requires all entities that perform even one test, including waived tests on... "materials derived 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" to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory;

(c) Providers must notify the Division of the assigned ten-digit CLIA number;

(d) Payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.

(11) Organ Panels:

(a) The Division will only reimburse panels as defined by the CPT codes for the year the laboratory service was provided. Tests within a panel may not be billed individually even when ordered separately. The same panel may be billed only once per day per client;

(b) The Division will pay at the panel maximum allowable rate if two or more tests within the panel are billed separately and the total reimbursement rate of the combined codes exceeds the panel rate, even if all the tests listed in the panel are not ordered or performed.

(12) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, are payable only when given in conjunction with radiation oncology and nuclear medicine codes 77401-79999;

(b) HCPCS codes R0070 through R0076 are covered.

(13) Reimbursement of contrast and diagnostic-imaging agents is bundled in the radiology procedure except for low osmolar contrast materials (LOCM).

(14) Supply of LOCM may be billed in addition to the radiology procedure only when the following criteria are met:

(a) Prior adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting;

(b) History of asthma or significant allergies;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension;

(d) Decrease in renal function;

(e) Diabetes;

(f) Dysproteinemia;

(g) Severe dehydration;

(h) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage);

(i) Sickle cell disease, or;

(j) Generalized severe debilitation.

(15) X-ray and EKG interpretations in the emergency room:

(a) The Division reimburses only for one interpretation of an emergency room patient's x-ray or EKG. The interpretation and report must have directly contributed to the diagnosis and treatment of the patient;

(b) The Division considers a second interpretation of an x-ray or EKG to be for quality control purposes only and will not be reimbursed;

(c) Payment may be made for a second interpretation only under unusual circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0800; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08

410-130-0700
HCPCS Supplies and DME

(1) Use appropriate HCPCS codes to bill all supplies and DME.

(2) For items that do not have specific HCPCS codes:

(a) Use unlisted HCPCS code;

(b) Bill at acquisition cost, purchase price plus postage.

(3) CPT code 99070 is no longer billable for supplies and materials. Use HCPCS codes.

(4) Use S3620 with modifier TC for lost newborn screening (NBS) kits.

(5) The Division of Medical Assistance Programs (Division) bundles reimbursement for office surgical suites and office equipment in the reimbursement of surgical procedures.

(6) Contraceptive Supplies — Refer to OAR 410-130-0585.

(7) A4000–A9999:

(a) All "A" codes listed in Table 130-0700-1 are covered under this program;

(b) All "A" codes not listed in Table 130-0700-1 must be referred to a Durable Medical Equipment (DME) provider;

(c) Do not use A4570, A4580 and A4590 for splint and cast materials. Use codes Q4001–Q4051;

(d) A9150-A9999 (administrative, investigational, and miscellaneous) are not covered, except for A9500-A9699. Refer to OAR 410-130-0680.

(8) B4000–B9999:

(a) HCPCS codes B4034–B4036 and B4150–B9999 are not covered for medical-surgical providers;

(b) Refer these services to home enteral/parenteral providers.

(9) C1000–C9999 are not covered.

(10) E0100–E1799: Division covers only the following DME HCPCS codes for medical-surgical providers when provided in an office setting:

(a) E0100–E0116;

(b) E0602;

(c) E0191;

(d) E1399;

(e) Refer all other items with "E" series HCPCS codes to DME providers.

(11) J0000–J9999 HCPCS codes — Refer to OAR 410-130-0180 for coverage of drugs.

(12) K0000–K9999 HCPCS codes — Refer all items with "K" series to DME providers.

(13) L0000–L9999:

(a) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies program Administrative rules for coverage criteria for orthotics and prosthetics;

(b) Refer to Table 130-0220-1 for a list of "L" codes that are not covered;

(c) Reimbursement for orthotics is a global package, which includes:

(A) Measurements;

(B) Moldings;

(C) Orthotic items;

(D) Adjustments;

(E) Fittings;

(F) Casting and impression materials.

(d) Evaluation and Management codes are covered only for the diagnostic visit where the medical appropriateness for the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.

(14) Refer to Table 130-0700-1 for supplies and DME covered in the office setting.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-3084, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0810; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

DIVISION 131

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

410-131-0040
Foreword for Physical and Occupation Therapy

(1) The Division Physical and Occupational Therapy (PT/OT) Services program rules are designed to assist licensed physical and occupational therapists deliver health care services and prepare health claims for clients with medical assistance program coverage.

(2) Oregon Administrative Rules (OAR) 410-131-0040 through 410-131-0160:

(a) Apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments are to be in accordance with the rules in their respective provider guides; and

(b) Do not apply to services provided to hospital inpatients.

(3) The Division enrolls only the following types of providers as performing providers under the PT/OT program:

(a) An individual licensed by the relevant state licensing authority to practice physical therapy; and

(b) An individual licensed by the relevant state licensing authority to practice occupational therapy.

(4) The PT/OT program rules contain information on policy, prior authorization, and service coverage and limitations for some procedures. All Division rules are intended to be used in addition to the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Oregon Health Services Commission's Prioritized List of Health Services is found in OAR 410-141-0520 and defines the services covered under the Division.

(6) The PT/OT provider shall understand and follow all Division rules that are in effect on the date services are provided.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-131-0080
Therapy Plan of Care and Record Requirements

(1) A therapy plan of care is required for PA for payment.

(2) The therapy plan of care shall include:

(a) Client's name, diagnosis, and type, amount, frequency and duration of the proposed therapy;

(b) Individualized, measurably objective functional goals;

(c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;

(d) Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;

(e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and

(f) For home health clients, any additional requirements included in OAR chapter 410 division 127.

(3) The therapy treatment plan and regimen shall be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments shall be authorized for teaching.

(4) A therapy plan of care shall comply with the relevant state licensing authority's standards.

(5) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care shall include:

(a) The need for continuing therapy clearly stated;

(b) Changes to the therapy plan of care, including changes to duration and frequency of intervention, and

(c) Any changes or modifications to the plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.

(6) Therapy records shall include:

(a) A written referral, including:

(A) The client's name;

(B) The ICD-10-CM diagnosis code; and

(C) Shall specify the type of services, amount, and duration required.

(b) A copy of the signed therapy plan of care shall be on file in the provider's therapy record prior to billing for services;

(c) Documents, evaluations, re-evaluations, and progress notes to support the therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;

(d) Modalities used on each date of service;

(e) Procedures performed and amount of time spent performing the procedures is documented and signed by the therapist; and

(f) Documentation of splint fabrication and time spent fabricating the splint.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 65-2014, f. 10-30-14, cert. ef. 11-4-14; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-131-0100
Maintenance

(1) Determination of when maintenance therapy is reached is made through comparison of written documentation of evaluation of the last several functional evaluations related to initial baseline measurements.

(2) Therapy becomes maintenance when any one of the following occur:

(a) The therapy plan of care goals and objectives are reached; or

(b) The therapy plan of care does not require the skills of a therapist; or

(c) The client, family, foster parents, or caregiver have been taught the therapy regimen and can carry out the maintenance therapy.

(3) Maintenance therapy is not a reimbursable service.

(4) Re-evaluation to change the therapy plan of care and up to two treatments for brief retraining of the client, family, foster parents or caregiver are not considered maintenance therapy and are reimbursable.

(5) Providers shall maintain adequate documentation as outlined in OAR 410-120-1360, (Requirements for Financial, Clinical and Other Records).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 & 688.135

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-131-0120
Limitations of Coverage and Payment

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

(2) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services shall be supported by a therapy plan of care signed and dated by the prescribing practitioner.

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

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

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

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

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

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

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

(b) Modalities:

(A) Require PA;

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

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

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

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

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

(8) The following services are not covered:

(a) Services not medically appropriate;

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

(c) Work hardening;

(d) Back school and back education classes;

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

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

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

(h) Maintenance therapy (see OAR 410-131-0100). [Table not included. See ED. NOTE.]

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

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 688.135, 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; HR 28-1993, f. & cert. ef. 10-1-93; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 64-2003, f. 9-8-03, cert. ef. 10-1-03; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 15-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

410-131-0160
Prior Authorization for Payment

(1) Most OHP clients have prepaid health services, contracted for by the Authority through enrollment in a Prepaid Health Plan (PHP). Clients who are not enrolled in a PHP receive services on an "open card" or "fee-for-service" (FFS) basis.

(2) The provider shall verify whether a PHP or the Division is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. Providers shall comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP client enrolled in a PHP. The physical or occupational therapy (PT/OT) provider shall contact the client's PHP for specific instructions.

(4) If a client receives services on a FFS basis, the Division or their contractor may require a PA for certain covered services or items before the service may be provided or before payment may be made. A PT/OT provider assumes full financial risk in providing services to a FFS client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules. See also OAR 410-120-1320 (Authorization of Payment), and Table 131-0160-1 (Services Require Payment Authorization):

(a) PT/OT initial evaluations and re-evaluations do not require a PA;

(b) To ensure reimbursement for continuation of PT/OT services and procedures beyond the initial evaluation, the PT/OT provider shall request a PA within five working days following initiation of services:

(A) PA requests dated within five working days of initiation of services may be approved retroactively to include services provided within five days prior to the date of the PA request;

(B) PA requests dated beyond five working days of initiating services may not be authorized retroactive, and if authorized shall be effective the date of the PA request. The Division recognizes the facsimile or postmark as the PA date of request;

(c) All PA's shall include a therapy plan of care; and

(d) A PA is not required for Medicare-covered PT/OT services provided to dual-eligible clients, Medicare clients who are also Medicaid-eligible.

(5) If the service or item is subject to PA, the PT/OT provider shall follow and comply with PA requirements in these rules, and the General Rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360 Requirements for Financial, Clinical and Other Records). Providers shall maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided;

(d) The services are provided within the timeframe specified on the authorization of payment document; and

(e) Includes the PA number on all claims for occupational and physical therapy services that require PA, or the Division shall deny the claim.

(6) Table 131-0160-1

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: PWC 706, f. 1-2-75, ef. 2-1-75; PWC 760, f. 9-5-75, ef. 10-1-75; AFS 46-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 98-1982, f. 10-25-82, ef. 11-1-82; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 63-1987, f. 12-30-87, ef. 4-1-88; HR 8-1991, f. 1-25-91, cert. ef. 2-1-91, Renumbered from 461-023-0015; HR 19-1992, f. & cert. ef. 7-1-92; HR 28-1993, f. & cert. ef. 10-1-93; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 92-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16

DIVISION 132

PRIVATE DUTY NURSING SERVICES

410-132-0020
Private Duty Nursing Services

(1) The practice of nursing is governed by the following: Oregon State Board of Nursing, ORS 678.010 to 678.410, and Oregon State Board of Nursing, chapter 851, divisions 031, 045, and 047.

(2) Private duty nursing is considered supportive to the care provided to a client by the client's family, foster parents, and delegated caregivers, as applicable. Nursing services shall be medically appropriate. Medically appropriate for private duty nursing shift care is determined by qualifying for services based on the Private Duty Nursing Acuity Grid (DMAP 591). Increases or decreases in the level of care and number of hours or visits authorized shall be based on a change in the client's condition, program limitations, and the family, foster parents, or delegated caregiver's ability to provide care.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 6-1997, f. & cert. ef. 2-19-97; OMAP 6-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 54-2002, f. & cert. ef. 10-1-02; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0030
Definitions

(1) "Activities of daily living or 'ADL'" means activities usually performed in the course of a normal day in an individual's life including:

(a) Eating: Assisting the individual in feeding or fluid intake by any means from a receptacle into the body, including monitoring to prevent choking or aspiration;

(b) Bathing: Assisting the individual with cleansing the body, washing hair, shaving, nail care, and using assistive devices when necessary to get in and out of the bathtub or shower;

(c) Dressing: Assisting the individual with putting on, fastening, and taking off all items of clothing, braces, and artificial limbs, including obtaining and replacing items from their storage area in the immediate environment;

(d) Toileting: Assisting the individual in getting to and from, on and off, the toilet, commode, or bedpan for elimination of feces and urine. This includes cleansing after elimination and adjusting clothing as necessary;

(e) Maintaining Continence: Including external cleansing of Foley catheter, emptying catheter drainage bag, maintenance bowel care, changing and replacing incontinence products, including colostomy or ileostomy bags;

(f) Transferring: Assisting the individual with mobility, transfers, and repositioning by any means including use of an assistive device and includes turning or adjusting padding for physical comfort or pressure relief and encouraging or assisting with range of motion exercises.

(2) "Admission" means acceptance of the client into the private duty nursing program contingent upon meeting the criteria as stated in rule.

(3) "Basic tasks of client/nursing care" means procedures that do not require the education or training of a registered nurse or licensed practical nurse that cannot be performed by the client independently. Basic tasks of client/nursing care also means procedures that may be directed by the client. These basic tasks include, but are not limited to, activities of daily living. Basic tasks may vary from setting to setting depending on the client population served in that setting and the acuity and complexity of the client's care needs. Basic tasks may require the assignment and supervision of a licensed nurse. The need for supervision is at the discretion of the registered nurse. See State Board of Nursing rules that govern the practice of nursing.

(4) "Critical/fluctuating condition" means a situation where the client's clinical and behavioral state is of a serious nature expected to rapidly change and be in need of continuous reassessment and evaluation.

(5) "Delegation" means that a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed persons, and re-evaluating the task at regular intervals. For the purpose of these rules, the unlicensed person, caregiver, or certified nursing assistant performs tasks of nursing care under the Registered Nurse's delegated authority.

(6) "Discharge" means the client no longer meets the Division rules and criteria of the private duty nursing program.

(7) "Habilitation" means services that are provided in order to assist an individual to acquire a variety of skills including self-help, socialization, and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual. Habilitation is contrasted to rehabilitation, which involves the restoration of function an individual lost.

(8) "Home" means a place of temporary or permanent residence, not including a hospital, intermediate care facility for individuals with intellectual disabilities (ICF/ID), nursing facility, or licensed residential care facility.

(9) "Instrumental activities of daily living or 'IADL'" means activities usually performed in the course of a normal day in an individual's life and include:

(a) Personal Hygiene: Perform or assist with activities required to keep one's appearance neat, secure clothing, comb/brush hair, nail care, foot care, skin care, mouth care, and oral hygiene, etc.;

(b) Light Housework: Perform or assist with housekeeping tasks necessary to maintain the individual in a healthy and safe living environment;

(c) Laundry: Perform or assist with laundering or cleaning of clothing, bedding, and other linens;

(d) Meal Preparation: Perform or assist with healthy meal planning and preparation, insuring special diets are followed;

(e) Transportation: Assist the individual in getting to and from necessary appointments and community activities through available means of transportation;

(f) Grocery Shopping: Perform or assist the individual in planning for and purchasing basic needs and household items;

(g) Using the Telephone: Perform or assist the individual in arranging necessary appointments and making desired phone calls;

(h) Medication Management: Assist with medications that are ordinarily self-administered, including administering medication and observing to insure the individual is taking medication as

ordered, documenting and monitoring any notable side effects, and refilling prescriptions in a timely manner. Assist with use, maintenance, and cleaning of in-home equipment, monitoring client's condition, and ordering and maintaining necessary supplies;

(i) Money Management: Perform or assist with budgeting, making payments for monthly expenses, and use of personal funds for desired items and activities.

(10) "Maintenance care" means the level of care needed when the goals and objectives of the care plan are reached, the condition of the client is stable or predictable, the plan of care does not require the skills of a licensed nurse in continuous attendance, or the client, family, foster parents, or caregivers have been taught and have demonstrated the skills and abilities to carry out the plan of care.

(11) "Medically Fragile Children's (MFC) program" means a Department of Human Services (Department) organizational unit that coordinates and funds appropriate services for children ages 0 to 18 years with intensive medical needs that require in-home and technological supports and meet MFC clinical criteria.

(12) "Member of the household" means any individual sharing a common home as part of a single family unit, including domestic employees and others who live together as part of a family unit, but not including a roomer or boarder.

(13) "Plan of care" means written instructions detailing how the client is to be cared for. The plan is initiated by the private duty nurse or nursing agency with input from the prescribing physician. See the "Documentation Requirements" section of the Private Duty Nursing Services administrative rules.

(14) "Private duty nursing shift care" means an RN or LPN nursing service for the client's critical/fluctuating conditions requiring the need for reassessment and evaluation with a high probability that complications would arise without skilled nursing management of the treatment program supplied in a specified block of time.

(15) "Practice of nursing" means using the nursing process under doctor's orders to diagnose and treat human response to actual or potential health care problems, health teaching and health counseling, the provision of direct client care, and the teaching, delegation, and supervision of others who provide tasks of nursing care to clients. See State Board of Nursing rules that govern the practice of nursing.

(16) "Private duty nursing visit" means RN or LPN skilled nursing services for non-critical/stable conditions requiring reassessment and evaluation with a moderate probability that complications would arise without skilled nursing management of the treatment program supplied on an intermittent per visit basis.

(17) "Respite" means short-term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

(18) "Responsible unit" means the agency responsible for approving or denying prior authorization.

(19) "Shift" means four to twelve hours of private duty nursing.

(20) "Skilled nursing services" means client care services pertaining to the curative, restorative, or preventive aspects of nursing performed by or under the supervision of a registered nurse pursuant to the plan of care established by the physician in consultation with the registered nurse. Skilled nursing emphasizes a high level of nursing direction, observation, and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct care and the teaching, delegation, and supervision of others who provide tasks of nursing care to clients. These services shall comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing.

(21) "Special tasks of client/nursing care" means tasks that require the education and training of a registered nurse or licensed practical nurse to perform. Special tasks may vary from setting to setting depending on the client population served in that setting and the acuity/complexity of the client's care needs. Examples of special tasks include, but are not limited to, administration of injectable medications, suctioning, and complex wound care.

(22) "Stable/predictable condition" means a situation in which the client's clinical and behavioral status is known and does not require the regularly scheduled presence and evaluation of a licensed nurse. See State Board of Nursing rules that govern the practice of nursing.

(23) "Teaching" means the registered nurse instructs an unlicensed person in the correct method of performing a selected task of client/nursing care. See State Board of Nursing rules that govern the practice of nursing.

(24) "Unlicensed Person" means an individual who is not licensed to practice nursing, medicine, or any other health occupation requiring a license in Oregon, but who provides tasks of nursing care or is taught to administer non-injectable medications. A certified nursing assistant, as defined by these rules, is an unlicensed person. For the purpose of these delegation rules, unlicensed persons do not include members of the client's immediate family. Family members may perform tasks of nursing care without specific delegation from a Registered Nurse. The terms "unlicensed person" and "caregiver" may be used interchangeably.

(25) "Visit" means nursing service supplied on an intermittent basis in the home.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 6-1997, f. & cert. ef. 2-19-97; OMAP 6-1999, f. 3-4-99, cert. ef. 4-1-99; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0060
Private Duty Nursing Transition into Maintenance

(1) Private duty nursing services become maintenance care when any one of the following situations occurs:

(a) Medical and nursing documentation supports that the condition of the client is stable/predictable;

(b) The plan of care does not require a licensed nurse to be in continuous attendance;

(c) The client, family, foster parents, or caregivers have been taught the nursing services and have demonstrated the skills and ability to carry out the plan of care;

(d) The combined score on the Acuity Grid and Psychosocial Grid is less than 54.

(2) This rule does not apply to individuals in the MFC program.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 6-1997, f. & cert. ef. 2-19-97; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0070
Documentation Requirements

(1) Documentation of services provided shall be maintained in the client's place of residence by the private duty nurse until discharged from service. Payment may not be made for services where the documentation does not support the definition of skilled nursing. Documentation shall meet the standards of the Oregon State Board of Nursing.

(2) The private duty nurse shall ensure completion and documentation of a comprehensive assessment of the client's capabilities and needs for nursing services within seven days of admission. Comprehensive assessments shall be updated and submitted to the responsible unit by the next work day after any significant change of condition and reviewed by the responsible unit within the Oregon Health Authority at least every 60 days. Some examples of significant change in condition are hospital admission, emergency room visit, and change in status, death, or discharge from care.

(3) The nursing care plan shall document that the private duty nurse, through case management and coordination with all interdisciplinary staff and agencies, provides services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each client in accordance with a written, dated, nursing care plan. The nursing care plan shall:

(a) Be completed within seven days after admission for children and adolescents with short-term needs who are served

through the Division. The nursing care plan shall be reviewed, updated, and submitted whenever the client's needs change, but at least every 60 days;

(b) Describe the medical, nursing, and psychosocial needs of the client and how the private duty nurse will actively coordinate and facilitate meeting those needs. This description of needs shall include interventions, measurable objectives, goals, and time frames in which the goals and objectives will be met and by whom;

(c) Include the rehabilitation potential including functional limitations related to Activities of Daily Living (ADL), types and frequency of therapies, and activity limitations per physician order;

(d) Include services related to school-based care according to the IEP and the Individualized Family Service Plan, if applicable;

(e) Show coordination of all services being provided including, but not limited to, the client or representative, registered nurse (RN) case manager, Department case worker, physician, other disciplines involved, and all other care providers involved in the client's treatment plan;

(f) Include a statement of the client's potential toward discharge. Timelines shall be included in the plan outline;

(g) Be available to and followed by all caregivers involved with the client's care.

(4) Documentation of private duty shift care and responses to care shall be written in an accurate, timely, thorough, and clear manner on the narrative or flow sheet. Documentation shall comply with the requirements of the Oregon State Board of Nursing in OAR chapter 851 and shall include:

(a) The name of the client on each page of documentation;

(b) The date of service;

(c) Time of start and end of service delivery by each caregiver;

(d) Anything unusual from the standard plan of care shall be expanded on the narrative;

(e) Interventions;

(f) Outcomes including the client's response to services delivered;

(g) Nursing assessment of the client's status and any changes in that status per each working shift; and

(h) Full signature of provider.

(5) Documentation of delegation, teaching, and assignment shall be in accordance with the Oregon State Board of Nursing Rules.

(6) For documentation to be submitted with prior authorization, see OAR 410-132-0100.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 6-1997, f. & cert. ef. 2-19-97; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0080
Limitations

(1) General pertains to both shift care and visits:

(a) Private duty nursing is not covered if the client is:

(A) Twenty-one years of age or older;

(B) A resident of a nursing facility;

(C) A resident of a licensed intermediate care facility for individuals with intellectual disabilities (ICF/ID);

(D) In a hospital;

(E) In a licensed residential care facility;

(b) Private duty nursing is not covered solely to allow the client's family or caregiver to work or go to school;

(c) Private duty nursing is not covered solely to allow respite for caregivers or the client's family;

(d) Payment for private duty nursing may not be authorized for parents, siblings, grandparents, foster care parents, significant others, members of the client's household, or individuals paid by other agencies to provide caregiving services;

(e) Costs of private duty nursing services are not reimbursable if they are provided concurrently with care being provided under home health or hospice program rules;

(f) Home nursing visits as defined in the Home Enteral/Parenteral Nutrition and IV Services rules are not covered in conjunction with private duty nursing services;

(g) These services are provided for individuals aged 0 to 21 who need PDN or the same or similar nursing services during school hours. These services are provided through the school-based health services program in conjunction with the individual's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA;

(h) Holidays are paid at the same rate as non-holidays;

(i) Hours nurses spend in training are not reimbursable;

(j) Travel time to reach the job site is not reimbursable;

(k) Maintenance care is not reimbursable, except for those individuals in the MFC program.

(2) Private duty nursing visit:

(a) The nursing care plan and documentation supporting the medical appropriateness for private duty nursing shall be reviewed every 60 days to continue the service for children and adolescents with short-term needs who are served by the Division. Reviews shall be conducted by the responsible unit;

(b) Private duty nursing visits are limited to two per day.

(3) Private duty nursing shift care:

(a) Medically appropriate private duty nursing shift care for clients up to 21years old may be covered for acute episodes of illness, injury, or medical condition up to 60 continuous days in cases where it has been determined that skilled management by a licensed nurse is required;

(b) A client may be referred to the MFC program to determine if they meet the criteria for program admission at the time of the initial request for services if any of the following are determined to exist:

(A) The client's medical needs are for habilitation or maintenance; or

(B) The client's medical needs are long term.

(c) Individuals who no longer qualify for private duty nursing shift care shall be referred to the Department for determination of their long-term care needs;

(d) The number of hours of private duty nursing services that a client may receive is determined by the score on the Private Duty Nursing Acuity Grid (DMAP 591):

(A) The client shall score greater than 60 points on the Acuity Grid to receive up to 24 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition; or

(B) The client shall score 50 to 60 points on the Acuity Grid to receive up to 16 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition; or

(C) The client shall score 40 to 49 points on the Acuity Grid to receive up to 84 hours per week immediately after discharge from a hospital or if there is a significant worsening or decline of condition; or

(D) If the score is 30 to 39 on the Acuity Grid, then the Private Duty Nursing Psychosocial Grid (DMAP 590) shall be used to determine eligibility. If the score is 24 or above, the client may receive up to 84 hours per week of shift care.

(e) The banking, saving, or accumulating unused prior authorized hours used for the convenience of the family or caregiver is not covered.

Stat. Auth.: 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 25-1992(Temp), f. & cert. ef. 8-18-92; HR 13-1995, f. 6-2-95, cert. ef. 6-15-95; HR 5-1996, f. & cert. ef. 5-1-96; HR 6-1997, f. & cert. ef. 2-19-97; OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 54-2002, f. & cert. ef. 10-1-02; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0100
Prior Authorization

(1) Private duty nursing providers shall obtain prior authorization (PA) for all services.

(2) Providers shall request PA as follows (see the Private Duty Nursing Services Supplemental Information booklet for contact information):

(a) For individuals served by the MFC), from the Department's MFC Program;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For members enrolled in a coordinated care organization (CCO) or prepaid health plan (PHP), from the CCO or the PHP;

(d) For all other clients, from the Division.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: PWC 681, f. & ef. 7-17-74; PWC 759, f. 9-5-75, ef. 10-1-75; PWC 799, f. & ef. 6-1-76; AFS 43-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 9-1983, f. 2-17-83, ef. 3-2-83; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; HR 9-1991, f. 1-28-91, cert. ef. 3-1-91, Renumbered from 461-019-0210; HR 6-1997, f. & cert. ef. 2-19-97; OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 93-2003, f. 12-30-03 cert. ef. 1-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0120
Billing Information

(1) If the client has not enrolled in a CCO or PHP, bill with the appropriate Division unique procedure codes and follow the instructions on how to complete the CMS-1500.

(2) Client copayments may be required for certain services. See OAR 410-120-1230 for specific details.

(3) Claims shall be submitted on a CMS-1500, electronically or on paper. Paper claims shall be sent to the Division.

(4) Contact the Division's Electronic Billing Representative for information about electronic billing.

(5) Bill on a CMS-1500 and enter the appropriate TPR Explanation Code in Field 9 when billing for clients with Medicare.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 6-1997, f. & cert. ef. 2-19-97; OMAP 54-2002, f. & cert. ef. 10-1-02; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0180
Procedure Codes

(1) All private duty nursing services require prior authorization.

(2) Private duty nursing visit:

(a) T1030 — Nursing care in the home by registered nurse per diem;

(b) T1031 — Nursing care in the home by licensed practical nurse per diem.

(3) Private duty nursing shift care:

(a) S9123 — Nursing care in the home by registered nurse per hour -- 1 unit equals one hour;

(b) S9124 — Nursing care in the home by licensed practical nurse per hour — 1 unit equals one hour.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 6-1997, f. & cert. ef. 2-19-97; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 54-2002, f. & cert. ef. 10-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; DMAP 45-2015, f. & cert. ef. 8-25-15

410-132-0200
Provider Enrollment

(1) Registered nurses and licensed practical nurses shall submit a copy of licensure every two years upon renewal by the Oregon State Board of Nursing to be enrolled or continue enrollment as a Division provider.

(2) If the Division provider is a nursing employment/staffing agency, the agency shall:

(a) Be licensed in the State of Oregon as an in-home care agency with a comprehensive licensure as defined in OAR 333-536 or Home Health Agency OAR 333-027;

(b) Conduct a background check through the Department CRIMS;

(c) Provide a copy of the state licensure to the Authority upon request.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; DMAP 45-2015, f. & cert. ef. 8-25-15

DIVISION 133

SCHOOL-BASED HEALTH SERVICES

410-133-0000
Purpose

(1) School-Based Health Services (SBHS) rules describe the Medicaid covered services available to Medicaid-eligible students receiving health services on a fee-for-service basis when "Necessary and Appropriate" and within the limitations established by the Medical Assistance Program and these rules, consistent with the requirements of the Individuals with Disabilities Education Act (IDEA). These rules are to be used in conjunction with the General Rules governing the Health Systems Division, Medical Assistance Programs (Division) (OAR 410 division 120) and the Oregon

Health Plan (OHP) rules (OAR 410 division 141). The School-Based Health Services rules are also a user's manual designed to assist the Educational Agency (EA) in matching state and federal funds for Oregon's Medicaid-eligible students with disabilities.

(2) The Oregon Administrative Rules (OARs) in Chapter 581, division 15 for the Oregon Department of Education (ODE) outline Oregon's program to meet the federal provisions of the IDEA. These SBHS rules define Oregon's fee-for-service program to reimburse publicly funded education agencies for the health services provided under the IDEA to Oregon's Medicaid-eligible children.

(3) The Department of Human Services (Department), The Oregon Health Authority (Authority), and ODE recognize the unique intent of health services provided for Medicaid-eligible students with disabilities in the special education setting. The School-Based Health Services rules address the health aspects of special education services that are covered by Medicaid or the Children's Health Insurance Program (CHIP).

(4) The Authority endeavors to furnish School Medical (SM) providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements. The Authority does so by providing information on its website.

(5) Enrolled School-Based Health Services providers are responsible to maintain current publications provided by the Authority and the Division and to comply with the OARs in effect on the date of service the health service is provided.

(6) In order for the Authority to reimburse for health services provided in the school, the health services must be included as a covered service under the Oregon Health Plan (OHP). There is no benefit category in the Medicaid statute titled "school health services" or "early intervention services." These rules do not create a new category of health benefits for this fee-for-service program.

(7) These rules describe health services that are covered services for Medicaid-eligible students, which are authorized and provided consistent with these rules.

(8) Medicaid-eligible students retain the ability to obtain services from any qualified Medicaid provider that undertakes to provide services to them. These rules do not require a Medicaid-eligible student to receive their health services solely from school medical providers.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0040
Definitions

In addition to the definitions in OAR 410-120-0000, the following definitions apply to these rules:

(1) "Adapted vehicle" means a vehicle specifically designed or modified to transport passengers with disabilities.

(2) "Adequate recordkeeping" means in addition to General Rules OAR 410-120-0000, Definitions and 410-120-1360, Requirements for Financial, Clinical, and Other Records, documentation in the student's educational record and on the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) showing the necessary and appropriate health services provided to the student detailed in the School-Based Health Services (SBHS) administrative rules (410-133-0000 and 410-133-0320).

(3) "Agent" means a third party or organization that contracts with a provider, allied agency, or Prepaid Health Plan (PHP) to perform designated services in order to facilitate a transaction or conduct other business functions on its behalf. Agents include billing agents, claims clearinghouses, vendors, billing services, service bureaus, and accounts receivable management firms. Agents may also be clinics, group practices, and facilities that submit billings on behalf of providers but the payment is made to a provider, including the following: an employer of a provider, if a provider is required as a condition of employment to turn over his fees to the employer; the facility in which the service is provided, if a provider has a contract under which the facility submits the claim; or a foundation, plan, or similar organization operating an organized health care delivery system, if a provider has a contract under which the organization submits the claim. Agents may also include electronic data transmission submitters.

(4) "Assessment" means a process of obtaining information to determine if a student qualifies for or continues to qualify for the Division covered school-based health services.

(5) "Assistive technology service" means services provided by medically qualified staff within the scope of practice under state law with training and expertise in the use of assistive technology (see 410-133-0080 Coverage and 410-133-0200 Not Covered Services in these rules).

(6) "Audiologist" means a licensed audiologist within the scope of practice as defined by state or federal law who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 Medically Qualified Staff.

(7) "Audiology" means assessment of children with hearing loss; determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services.

(8) "Authority" means the Oregon Health Authority. (Please see General Rules 410-120-0000 Acronyms and Definitions.)

(9) "Billing agent or billing service" means a third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider. Also see definition for Electronic Data Interchange (EDI) Submitter.

(10) "Billing Provider (BP)" means a person, agent, business, corporation, clinic, group, institution, or other entity that submits claims to and receives payment from the Division on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider. (See the Department-wide Support Services (DWSS) administrative rules in, chapter 407, division 120 Provider Rules, and the Division's General Rules OAR 410-120-1260 and SBHS OAR 410-133-0140.)

(11) "Billing time limit" means the period of time allowed to bill services to the Division See General Rules OAR 410-120-1300, Timely Submission of Claims. In general, those rules require initial submission within 12 months of the date of service or 18 months for resubmission.

(12) "Centers for Medicare and Medicaid Services (CMS)" means the federal regulatory agency for Medicaid programs.

(13) "Certification." See "licensure."

(14) "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 in Oregon by the Authority and the Division.

(15) "Clinical Social Work Associate (CSWA)" means a person working toward Licensed Clinical Social Worker (LCSW) licensure in compliance with Division 20, Procedure for Certification of Clinical Social Work Associates and Licensing of Licensed Clinical Social Workers, OAR Chapter 877 division 020.

(16) "Coordinated care" means services directly related to covered school-based health services (SBHS) specified in the individualized education program (IEP) or individualized family service plan (IFSP), performed by medically qualified staff, and allowed under OAR 410-133-0080 Coverage to manage integration of those health services in an education setting. Coordinated care includes the following activities:

(a) Conference. The portion of a conference in a scheduled meeting between medically qualified staff and interested parties to develop, review, or revise components of school-based health ser-

vices provided to a Medicaid-eligible student to establish, re-establish, or terminate a Medicaid covered health service on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP); or to develop, review, or revise components of a health service currently provided to a Medicaid-eligible student to determine whether or not those covered health services continue to meet the student's needs as specified on the student's IEP or IFSP;

(b) Consultation. Performed by medically qualified staff within the scope of practice providing technical assistance to or conferring with special education providers, physicians, and families to assist them in providing a covered health service for Medicaid-eligible students related to a specific health service and health service goals and objectives in the individualized education program (IEP) or individualized family service plan (IFSP);

(c) Physician coordinated care. Meeting or communication with a physician in reference to oversight of care and treatment provided for a health service specified on a Medicaid-eligible student's individualized education program (IEP) or individualized family service plan (IFSP).

(17) "Cost Determination" means the process of establishing an annual discipline fee (cost rate), based on the prior-year actual audited costs, used by an EA for the purpose of billing for covered school-based health services (see 410-133-0245 Cost Determination and Payment in these rules).

(18) "Covered entity" means a health plan, health care clearing house, health care provider, or allied agency that transmits any health information in electronic form in connection with a transaction, including direct data entry (DDE), and that must comply with the National Provider Identifier (NPI) requirements of 45 CFR 162.402 through 162.414. When a school provides covered SBHS services in the normal course of business and bills Medicaid for reimbursed covered transactions electronically in connection with that health care such as electronic claims, it is then a covered entity and must comply with the HIPAA Administrative Simplification Rules for Transactions and Code sets and Identifiers with respect to its transactions.

(19) Data transmission means the transfer or exchange of data between the Department and a web portal or electronic data interchange (EDI) submitter by means of an information system that is compatible for that purpose and includes without limitation web portal, EDI, electronic remittance advice (ERA), or electronic media claims (EMC) transmissions.

(20) "Delegated Health Care Aide" means a non-licensed person trained and supervised by a licensed registered nurse (RN) or nurse practitioner (NP) to perform selected tasks of nursing care specific to the Medicaid-eligible student identified in the nursing plan of care pursuant to the Individualized Education Program/Individualized Family Service Plan (IEP/IFSP).

(21) "Delegation of nursing task" means a selected nursing task that is performed by an unlicensed person, trained and monitored by a licensed RN. Delegation and supervision of selected nursing tasks must comply with Oregon Administrative Rules (OARs), Oregon State Board of Nursing, chapter 851, divisions 45 and 47. A school medical (SM) provider must maintain documentation of the actual delegation, training, supervision, and provision of the nursing service billed to Medicaid.

(22) "Department" means the Department of Human Services established in OAR chapter 407, including any divisions, programs, and offices as may be established therein.

(23) "Diagnosis code" means as identified in the International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM), the primary Diagnosis Code is shown in all billing claims, unless specifically excluded in individual Division provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280 Billing.

(24) "Direct services" means face-to-face delivery of health services by or under the direction of medically qualified staff who is the service provider to a Medicaid-eligible student.

(25) "Early Intervention/Early Childhood Special Education (EI/ECSE)": EI is a program designed to address the unique needs of a child age 0-3 years, and ECSE is a program for preschool children with a disability ages 3-5 years or eligible for Kindergarten.

(26) "Educational Agency (EA)" means for purposes of these rules, any public school, school district, Education Service District (ESD), state institution, or youth care center providing educational services to students, birth to age 21 through grade 12, that receives federal or state funds either directly or by contract or subcontract with the Oregon Department of Education (ODE).

(27) "Education records" means those records, files, documents and other materials that contain information directly related to a student and maintained by an Education Agency (EA) or by a person acting for such EA as set forth in OAR 581-021-0220. (A school-based health services (SBHS) provider is required to keep and maintain supporting documentation for Medicaid reimbursed school-based health services for a period of seven years; this documentation is part of the student's education record but may be filed and kept separately by school health professionals.) See 410-133-0320 Documentation and Recordkeeping Requirements in these rules.

(28) "Education Service District (ESD)" means an education agency established to offer a resource pool of cost-effective, education-related, physical or mental health-related, state-mandated services to multiple local school districts within a geographic area described in ORS 334.010.

(29) "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 Department designates for EDI transactions. For purposes of these rules (OAR 407-120-0100 through 407-120-0200), EDI does not include electronic transmission by web portal.

(30) "EDI submitter" means an individual or an entity authorized to establish an electronic media connection with the Department to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner. Also see definition for billing agent in these rules.

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

(32) "Eligibility for special education services" means a determination by a designated education agency (EA) through a team that a child meets the eligibility criteria for early intervention (EI), early childhood special education (ECSE), or special education as defined in ORS 343 and OAR chapter 581, division 15.

(33) "Evaluation" —means procedures performed by medically qualified staff to determine whether a Medicaid-eligible student is disabled and the nature and extent of the health services the student needs under the Individuals with Disabilities Education Act (IDEA) and in accordance with Oregon Department of Education OAR chapter 581 division 15. The Authority can only reimburse evaluations that establish, re-establish, or terminate a school-based health services (SBHS) covered health service on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA).

(34) "Federal Medical Assistance Percentage (FMAP)" means the percentage of federal matching dollars for qualified state medical assistance program expenditures.

(35) "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. See General Rules (OAR 410-120-1280 Billing).

(36) "Health assessment plan (nursing)" means a systematic collection of data for the purpose of assessing a Medicaid-eligible student's health or illness status and actual or potential health care needs in the educational setting. It includes taking a nursing history and an appraisal of the student's health status through interview

information from the family and information from the student's past health or medical record. A SBHS provider is required to keep and maintain the health assessment plan and supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's individualized education program (IEP) or individualized family service plan (IFSP) for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals. (See 410-133-0320 Documentation and Recordkeeping Requirements.)

(37) "Health care practitioner" means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the health care practitioner's license and certification standards established by their health licensing agency. Medical provider and health care practitioner are interchangeable terms. See Definition for medical provider in these rules.

(38) "Health Evidence Review Commission (HERC)" means a 13-member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important and representing the comparable benefits of each service to the entire population to be served.

(39) "Health services" means medical evaluation services provided by a physician for diagnostic and evaluation purposes for a Medicaid-eligible student that is found eligible under the Individuals with Disabilities Education Act (IDEA) and leads to an established Individualized Education Program (IEP) or Individualized Family service Plan (IFSP), physical or mental health evaluations, and assessment or treatment performed by medically qualified staff to achieve the goals set forth in a Medicaid-eligible student's IEP or IFSP. A covered health service is one that is covered by the medical assistance program and is provided to enable the Medicaid-eligible student to benefit from a special education program (age 3-21) or to achieve developmental milestones in an early intervention program (age 0-3). "Health services" are synonymous with "medical services" in these rules. To determine whether a health service specified on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) is a covered School-Based Health Service (SBHS), see 410-133-0080 Coverage and 410-133-0200 Not Covered Services.

(40) "Health Systems Division, Medical Assistance Programs (Division)" means a division within the Oregon Health Authority (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.

(41) "ID number" means a number issued by the Authority used to identify Medicaid-eligible students. This number may also be referred to as recipient identification number, prime number, client medical ID Number, or medical assistance program ID number.

(42) "Individuals with Disabilities Education Act (IDEA)" means the federal law ensuring the rights of children with disabilities to a "free and appropriate education" (FAPE).

(43) "Individualized Education Plan (IEP)" means a written statement of an educational program for a child with a disability that is developed, reviewed, or revised in a meeting in accordance with Oregon Department of Education OAR chapter 581, division 15. When an IEP is used as a prescription for Medicaid reimbursement for covered School-Based Health Services (SBHS), it must include: type of health service, amount, and duration and frequency for the service provided. In order to bill Medicaid for covered health services, they must be delivered by or under the supervision of medically-qualified staff and must be recommended by a physician or appropriate health care practitioner acting within the scope of practice. See the definition of medically qualified staff in this rule.

(44) "Individualized Family Service Plan (IFSP)" means a written plan of early childhood special education (ECSE) services, early intervention (EI) services, and other services developed in accordance with criteria established by the Oregon Department of Education (ODE) for each child (ages birth to 5 years) eligible for IFSP services. The plan is developed to meet the needs of a child with disabilities in accordance with requirements and definitions in OAR chapter 581, division 15. When an IFSP is used as a prescription for Medicaid reimbursement for SBHS covered services, it must include: type of health service, amount, and duration and frequency for the service provided. In order to bill Medicaid for covered health services, they must be delivered by or under the supervision of medically-qualified staff and must be recommended by a physician or health care practitioner within their scope of practice. See the definition of medically qualified staff in this rule.

(45) "Individualized Education Plan/Individualized Family Service Plan (IEP/IFSP) Team" means a group of teachers, specialists, and parents responsible for determining eligibility, and developing, reviewing, and revising an IEP or IFSP in compliance with the Oregon Department of Education (ODE) OAR chapter 581, division 15.

(46)" Licensed Clinical Social Worker (LCSW)" means a person licensed to practice clinical social work pursuant to state law.

(47) "Licensed Physical Therapist Assistant (LPTA)" means a person licensed to assist in the administration of physical therapy, solely under the supervision and direction of a physical therapist.

(48)" Licensed Practical Nurse (LPN)" means a person licensed to practice under the direction of a licensed professional within the scope of practice as defined by state law.

(49) "Licensure" means documentation from state agencies demonstrating that licensed or certified individuals are qualified to perform specific duties and a scope of services within a legal standard recognized by the licensing agency. In the context of health services, licensure refers to the standards applicable to health service providers by health licensing authorities. For health services provided in the State of Oregon, licensure refers to the standards established by the appropriate State of Oregon licensing agency.

(50) "Medicaid-eligible student" means the child or student who has been determined to be eligible for Medicaid health services by the Authority. For purposes of this rule, Medicaid-eligible student is synonymous with "recipient" or "Oregon Health Plan (OHP) client". For convenience, the term "student" used in these rules applies to both students covered by an Individualized Education Program (IEP) and children covered by an Individualized Family Service Plan (IFSP). Also for purposes of this rule, students or children whose eligibility is based on the Children's Health Insurance Program (CHIP) shall be referred to as Medicaid-eligible students.

(51) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians. Oregon's medical assistance program includes Medicaid services including the Oregon Health Plan (OHP) Medicaid Demonstration, and the Children's Health Insurance Program (CHIP). The Medical Assistance Program is administered by the Health Systems Division, Medical Assistance Programs (Division) of the Oregon Health Authority.

(52) "Medical Management Information System (MMIS)" means a data collection system for processing an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

(53) "Medical provider" means an individual licensed by the state to provide health services within their governing body's definitions and respective scope of practice. Medical provider and health care practitioner are interchangeable terms.

(54) "Medical services" means the care and treatment provided by a licensed health care practitioner to prevent, diagnose, treat, correct, or address a medical problem, whether physical, mental, or emotional. For the purposes of these rules, this term shall be syn-

onymous with health services or health-related services listed on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), as defined in OAR chapter 581, division 15. Not all health-related services listed on an IEP or IFSP are covered as SBHS. See 410-133-0080 Coverage and 410-133-0200 Not Covered Services.

(55) "Medical transportation" means specialized transportation in a vehicle adapted to meet the needs of passengers with disabilities transported to and from a SBHS covered service.

(56) "Medically qualified staff" means:

(a) Staff employed by or through contract with an EA; and

(b) Licensed by the state to provide health services in compliance with state law defining and governing the scope of practice, described further in OAR 410-133-0120.

(57) "Medication management" means a task performed only by medically qualified staff within the scope of practice, pursuant to a student's Individualized Education Program/Individualized Family Service Plan (IEP/IFSP), which involves administering medications, observing for side effects, and monitoring signs and symptoms for medication administration.

(58) "National Provider Identifier (NPI)" means a federally directed provider number mandated for use on Health Insurance Portability Accountability Act (HIPAA) covered transactions. Individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare covered entities are required to apply for an NPI.

(59) "Necessary and appropriate" health services means those health services described in a Medicaid-eligible student's IEP or IFSP that are:

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

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

(c) Not solely for the convenience of the Medicaid-eligible student or provider of the service; and

(d) The most cost-effective of the alternative levels of health services that can safely be provided to a Medicaid-eligible student.

(60) "Nursing Diagnosis and Management Plan" means a written plan that describes a Medicaid-eligible student's actual and anticipated health conditions that are amenable to resolution by nursing intervention.

(61) "Nursing Plan of Care" means written guidelines that are made a part of and attached to the Individualized Education Program (IEP) or individualized Family Service Plan (IFSP) that identify specific health conditions of the Medicaid-eligible student and the nursing regimen that is "necessary and appropriate" for the student. Development and maintenance of this plan includes establishing student and nursing goals and identifying nursing interventions (including location, frequency, duration, and delegation of care) to meet the medical care objective identified in their IEP or IFSP. See Oregon State Board of Nursing Practice Act, Division 47. The SBHS provider is responsible for developing the nursing plan of care and is required to keep and maintain a copy of the nursing plan of care as supporting documentation for Medicaid reimbursed health services. (See definition "Education records.")

(62) "Nurse practitioner" means a person licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.

(63) "Nursing services" means services provided by a nurse practitioner (NP), registered professional nurse (RN), a licensed practical nurse (LPN), or delegated health care aide within the scope of practice as defined by state law. Nursing services include preparation and maintenance of the health assessment plan; nursing diagnosis and management plan; nursing plan of care, consultation, and coordination; and integration of health service activities, as well as direct patient care and supervision.

(64) "Observation" means surveillance or visual monitoring performed by medically-qualified staff as part of an evaluation, assessment, direct service, or care coordination for a necessary and appropriate Medicaid-covered health service specified on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) to better understand the child's medical needs and progress in their natural environment. An observation by itself is not billable.

(65) "Occupational therapist (OT)" means a person licensed by the state's Occupational Therapy Licensing Board.

(66) "Occupational Therapist Assistant" means a person who is licensed as an occupational therapy assistant assisting in the practice of occupational therapy under the supervision of a licensed occupational therapist.

(67) "Occupational therapy" means assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation to improve the ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention initial or further impairment or loss of function. It also means obtaining and interpreting information, coordinating care, and integrating necessary and appropriate occupational therapy services relative to the Medicaid-eligible student.

(68) "Oregon Department of Education (ODE)" means the state agency that provides oversight to public educational agencies for ensuring compliance with federal and state laws relating to the provision of services required by the individuals with disabilities education act (IDEA).

(69) "Orientation and mobility training" means services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in school, home, and community. These services are not covered under School-Based Health Services (SBHS). (See OAR 410-133-0200 Not Covered Services.)

(70) "Performing provider" means a person, agent, business, corporation, clinic, group, institution, or other entity that is the provider of a service or item with the authority to delegate fiduciary responsibilities to a billing provider, also termed billing agent, to obligate or act on the behalf of the performing provider regarding claim submissions, receivables, and payments relative to the Medical Assistance Program. For the purposes of these SBHS rules, the school medical (SM) provider is the performing provider.

(71) "Physical Therapist" means a person licensed by the relevant state licensing authority to practice physical therapy. (See OAR chapter 848, division10 Licensed Physical Therapists and Licensed Physical Therapist Assistants; chapter 848 division 40 Minimum Standards for Physical Therapy Practice and Records.)

(72) "Physical Therapy" means assessing, preventing, or alleviating movement dysfunction and related functional problems, obtaining and interpreting information, and coordinating care and integrating necessary and appropriate physical therapy services relative to the student receiving treatments.

(73) "Prime Number" See definition of ID Number.

(74) "Prioritized List of Health Services" means the Oregon Health Evidence Review Commission's (HERC) prioritized list of health services with "expanded definitions' of ancillary services and preventative services and the HERC practice guidelines, as presented to the Oregon Legislative Assembly for the purpose of administering the Oregon Health Plan (OHP).

(75) "Procedure code." See definition of HCPC healthcare common procedure code.

(76) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health care services or items, also termed a performing provider, or bills, obligates, and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term "Provider" refers to both performing providers and billing providers unless otherwise specified. Payment can only be made to Division-enrolled providers who have by signature on the provider enrollment forms and attachments agreed to provide services and to bill in accordance with General Rules OAR 410-120-1260 and the SBHS OAR 410-133-0140. If a provider submits claims electronically, the provider must become a trading partner with the Authority and

comply with the requirements of the Electronic Data Interchange (EDI) rules pursuant to OAR Chapter 407 division 120.

(77) "Provider enrollment agreement" means an agreement between the provider and the Authority that sets forth the conditions for being enrolled as a provider with the Authority and to receive a provider number in order to submit claims for reimbursement for covered SBHS provided to Medicaid-eligible students. Payment can only be made to Division-enrolled providers who have by signature on the provider enrollment forms and program applicable attachments agreed to provide services and to bill in accordance with Provider Rules chapter 407, division 120 and the Division's General Rules chapter 410, division 120, and these SBHS rules. Also see definitions for Trading Partner and Trading Partner Agreement in these rules.

(78) "Psychiatrist" means a person licensed to practice medicine and surgery in the State of Oregon and possesses a valid license from the Oregon Medical Board.

(79) "Psychologist" means a person with a doctoral degree in psychology and licensed by the State Board of Psychologist Examiners. See 858-010-0010.

(80) "Psychologist Associate" means a person who does not possess a doctoral degree that is licensed by the Board of Psychologists Examiners to perform certain functions within the practice of psychology under the supervision of a psychologist. See 858-010-0037 through 858-010-0038. An exception would be psychologist associate with the authority to function without immediate supervision. See OAR 858-010-0039.

(81) "Record keeping requirements" means An SBHS SM provider is required to keep and maintain the supporting documentation in compliance with the respective medical provider's scope of practice and governing licensure or certification board requirements for Medicaid reimbursed health services described in a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals. (See OAR 410-133-0320.)

(82) "Re-evaluation" means procedures used to measure a Medicaid-eligible student's health status compared to an initial or previous evaluation are focused on evaluation of progress toward current goals, modifying goals or treatment, or making a professional judgment to determine whether or not the student will continue to receive continued care for a covered service pursuant to an IEP or IFSP under the Individuals with Disabilities Education Act (IDEA). Continuous assessment of the student's progress as a component of ongoing therapy services is not billable as a re-evaluation.

(83) "Regional program" means regional program services provided on a multi-county basis under contract from the Oregon Department of Education (ODE) to eligible children (birth to 21) visually impaired, hearing impaired, deaf-blind, autistic, and severely orthopedically impaired. A regional program may be reimbursed for covered health services it provides to Medicaid-eligible students through the school medical (SM) provider (e.g., public school district or ESD) that administers the program.

(84) "Registered Nurse (RN)" means a person licensed and certified by the Oregon Board of Nursing to practice as a registered nurse pursuant to state law.

(85) "Rehabilitative services" means for purposes of the School-Based Health Services (SBHS) program any health service that is covered by the Medical Assistance Program and that is a medical, psychological, or remedial health service recommended by a physician or other licensed health care practitioner within the scope of practice under state law and provided to a Medicaid-eligible student pursuant to an Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) under the Individuals with Disabilities Education Act (IDEA) that help the Medicaid eligible student keep, learn, or improve skills and functioning, including reduction, correction, stabilization, or functioning improvement of physical or mental disability of a Medicaid-eligible student. (See 410-133-0060.)

(86) "Related services" means for purposes of this rule related services as listed on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and may include: transportation and such developmental, corrective, and other supportive services (e.g., speech language, audiology services, psychological services, physical therapy, occupational therapy, social work services in schools, and nursing services) as are required to assist a child or student with a disability to benefit from special education, and includes early identification and assessment of disabling conditions in children.

NOTE: Not all "related services" are covered for payment by Medicaid. To determine whether a particular related service is a covered health service for a Medicaid-eligible student, see OAR 410-133-0080, Coverage and OAR 410-133-0200, Not Covered Services.

(87) "School-Based Health Services (SBHS)" means special education, related services, or early intervention services addressing health-related needs that help the Medicaid eligible student keep, learn, or improve skills and functioning and any services authorized under Oregon's approved Medicaid state plans that are also considered special education, related services, or early intervention that adversely affects the child/student's educational performance. SBHS services reimbursed by Medicaid are recommended by a physician or other licensed health care practitioner within the scope of practice under state law and provided to a Medicaid-eligible student pursuant to an Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) under the Individuals with Disabilities Education Act (IDEA) meeting the requirements of these rules and applicable federal and state laws and rules.

(88) "School medical (SM) provider" means an enrolled provider type established by the Division to designate the provider of school-based health services eligible to receive reimbursement from the Division. See the Authority's general rules chapter 943 division 120, the Division's General Rules OAR 410-120-1260, and School-Based Health Services Program OAR 410-133-0140 (School Medical (SM) Provider Enrollment Provisions).

(89) "Screening" means a limited examination to determine a Medicaid-eligible student's need for a diagnostic medical evaluation.

(90) "Special Education Services" means specially designed instruction to meet the unique needs of a child with a disability, including regular classroom instruction, instruction in physical education, home instruction, and instruction in hospitals, institutions, special schools, and other settings.

(91) "Speech-Language Pathology Assistant (SLPA)" means a person who is licensed by the Oregon State Board of Examiners for Speech-Language Pathology and Audiology and provides speech-language pathology services under the direction and supervision of a speech-language pathologist licensed under ORS 681.250.

(92) "Speech-Language Pathologist" means a licensed speech pathologist within the scope of practice as defined by state or federal law licensed by the Oregon Board of Examiners for Speech-Language Pathology and Audiology or holds a license issued by the Teacher Standards and Practice Commission (TSPC) prior to July 1, 2016, exemption in ORS 681.230(4) pursuant to SB287, and holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA) or has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate. (See Medically Qualified Staff 410-133-0120.)

(93) "Speech-language pathology services" means assessment of children with speech-language disorders, diagnosis, and appraisal of specific speech-language disorders and referral for medical and other professional attention necessary for the rehabilitation of speech-language disorders and the provision of speech-language services for the prevention of communicative disorders. It includes obtaining and interpreting information, coordinating care, and integrating necessary and appropriate speech-language pathology services relative to the student receiving services.

(94) "State Education Agency (SEA)." See "Oregon Department of Education (ODE)."

(95)" State-operated school" means the Oregon School for the Deaf. See "Educational Agency."

(96) "Student health/medical/nursing records" means education records that document for purposes of the Health Systems Division, Medical Assistance Program the Medicaid-eligible student's diagnosis or the results of tests, screens, or treatments, treatment plan, the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), and the record of treatments or health services provided to the child or student in compliance with the respective licensed practitioner's scope of practice and licensure or certification.

(97) "Teacher Standards and Practices Commission (TSPC)" means the commission that governs licensing of teachers, personnel, service specialists, and administrators as set forth in OAR chapter 584. In order for schools or school providers to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the Medicaid provider qualifications. It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered health services provided in an education setting.

(98) "Testing Technician" means a person/technician adequately trained to administer and score specific tests as delegated under the direction and supervision of a licensee and maintains standards for the testing environment and testing administration as set forth in the American Psychological Association Standards for Educational and Psychological Tests (1999) and Ethical Principles for Psychologists (2002). See ORS 675.010(4) and 858-010-0002.

(99) "Trading partner" means a provider, prepaid health plan (PHP), clinic, or allied agency that has entered into a trading partner agreement with the Department in order to satisfy all or part of its obligations under a contract by means of electronic data interchange (EDI), electronic remittance advice (ERA), electronic media claims (EMC), or any other mutually agreed means of electronic exchange or transfer of data. EDI transactions must comply with the requirements of the EDI rules OAR 407-120-0100 through 407-120-0200. For the purposes of these rules EDI does not include electronic transmission by web portal.

(100) "Trading partner agreement (TPA)" means a specific request by a provider, PHP, clinic, or allied agency to conduct EDI transactions that governs the terms and conditions for EDI transactions in the performance of obligations under a contract. A provider, PHP, clinic, or allied agency that has executed a TPA will be referred to as a trading partner in relation to those functions.

(101) "Transportation Aide" means an individual trained for health and safety issues to accompany a Medicaid-eligible student transported to and from a covered Health Service as specified in the Individualized Education Program/individualized Family Service Plan (IEP/IFSP). The School Medical (SM) Provider must maintain documentation of the training, supervision, and provision of the services billed to Medicaid. For the purposes of these rules, individual transportation aides are included in the cost calculation for transportation costs and will not be billed separately. This computation will not include delegated health care aides for whom costs are direct costs.

(102) "Transportation as a related service" means specialized transportation adapted to serve the needs of a Medicaid-eligible student to and from a covered health service that is necessary and appropriate and described in the Individualized Education Program/individualized Family Service Plan (IEP/IFSP) as outlined in OAR 410-133-0080 (Coverage).

(103) "Transportation vehicle trip log" means a record or log kept specifically for tracking each transportation trip a Medicaid-eligible student receives transportation to or from a covered health service. (See SBHS OAR 410-133-0245, Cost Determination and Payment.)

(104) "Treatment Plan" means a written plan of care services, including treatment with proposed location, frequency and duration of treatment as required by the health care practitioner's health licensing agency.

(105) "Unit" means a service measurement of time for billing and reimbursement efficiency. One unit equals 15 minutes unless otherwise stated.

(106) "Visit" means a service measurement of time for billing and reimbursement efficiency. One visit equals the school provider's hourly cost rate for category of service provided (i.e., occupational therapy, physical therapy, speech therapy, etc.) specified in an IEP or IFSP, divided by 60 to yield a cost per minute, and multiplied by amount of service time provided in minutes. For billing purposes, a visit is always presented as one visit.

(107) "Web Portal submitter" means an individual or entity authorized to establish an electronic media connection with the Health Systems Division, Medical Assistance Programs to conduct a direct data entry transaction. A web portal submitter may be a provider or a provider's agent.

Stat. Auth.: ORS 413.042
Stats. Implemented: 413.042, 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 29-1993, f. & cert. ef. 10-1-93; HR 21-1995, f. & cert. ef. 12-1-95;OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0060
Health Services

(1) A School-based Health Service is a health service for a Medicaid-eligible student that meets the coverage requirements in OAR 410-133-0080 and that:

(a) Addresses physical or mental disabilities and health-related service needs and devices that help the child or student keep, learn, or improve skills and functioning that adversely affects the child or student's educational performance; and

(b) Is identified in a student's Individualized Education Program (IEP) or the Individualized Family Service Plan (IFSP); and

(c) Is recommended by a physician or other licensed health care practitioner within the scope of practice under state law.

(2) School-based health services that meet the requirements of section (1) of this rule may include:

(a) Physical Therapy Evaluations and Treatments that include assessing, preventing, or alleviating movement dysfunction and related functional problems, obtaining and interpreting information, and coordinating care and integrating services relative to the student receiving treatments such as:

(A) Neuromotor or neurodevelopmental assessment;

(B) Assessing and treating problems related to musculo-skeletal status;

(C) Gait, balance, and coordination skills;

(D) Oral motor assessment;

(E) Adaptive equipment assessment;

(F) Gross and fine motor development;

(G) Observation of orthotic devices; and

(H) Prosthetic training.

(b) Occupational Therapy Evaluations and Treatments that include assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning when functions are lost or impaired; preventing through early intervention initial or further impairment or loss of function; obtaining and interpreting information; coordinating care; and integrating services relative to the student receiving services such as:

(A) Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);

(B) Gross and fine motor development;

(C) Feeding or oral motor function;

(D) Adaptive equipment assessment;

(E) Prosthetic or orthotic training;

(F) Neuromotor or neurodevelopmental assessment;

(G) Gait, balance, and coordination skills.

(c) Speech Evaluation and Therapy Treatments that include assessment of children with speech and language disorders, diagnosis and appraisal of specific speech or language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech-language disorders, provision of speech-language services for the prevention of communicative disorders, obtaining and interpreting information, coordinating care and integrating services relative to the student receiving services such as:

(A) Expressive language;

(B) Receptive language;

(C) Auditory processing, discrimination, perception and memory;

(D) Vocal quality;

(E) Resonance patterns;

(F) Phonological;

(G) Pragmatic language;

(H) Rhythm or fluency; and

(I) Feeding and swallowing assessment.

(d) Audiological Evaluation and Services that include assessment of children with hearing loss; determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation; and determination of the child's need for individual amplification; obtaining and interpreting information; coordinating care and integrating services relative to the student receiving services such as:

(A) Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;

(B) Auditory discrimination in quiet and noise;

(C) Impedance audiometry, including tympanometry and acoustic reflex;

(D) Central auditory function;

(E) Testing to determine the child's need for individual amplification;

(F) Auditory training; and

(G) Training for the use of augmentative communication devices.

(e) Nurse Evaluation and Treatment Services that include assessments, treatment services, and supervision of delegated health care services provided to prevent disease, disability, other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. This includes any medical or remedial services recommended by a physician or other licensed health care practitioner within the scope of practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. The RN is responsible for periodic supervision for services provided to coordinating care and integrating nursing tasks and services that can be performed in the educational setting such as:

(A) Monitoring patient's seizure activity for breathing patterns, onset/duration of seizure, triggers/auras, level of consciousness, support after seizure, administering medication as ordered;

(B) Monitoring and providing treatment for high and low blood sugar, checking urine keytones, blood glucose testing, carbohydrate calculations, assisting with insulin administration;

(C) Ventilator Care, suctioning, and equipment management;

(D) Tracheotomy care, changing dressings, emergency trach replacement, suctioning, changing "nose", and providing humidification as necessary;

(E) Catheterization, assisting with or performing procedure for catheterization, monitor urinary tract infections, and performing skin integrity checks;

(F) Gastrostomy tube feeding, administering tube feedings per physician order, monitoring skin status around the tube, and emergency treatment for button dislodgement;

(G) Medication pumps, e.g., insulin pump, calculate carbohydrate amounts in food/snacks, provide insulin bolus per physician order, emergency disconnect procedure and monitoring blood sugar; and

(H) Medication management, e.g., monitoring signs and symptoms for medication administration, administering medications, observing for side effects.

(f) Mental Health Evaluation and Treatment Services that include assessment and treatment services provided by or under the supervision and direction of a psychiatrist, psychologist, a mental health nurse practitioner, or by a social worker qualified and licensed to deliver the service and who may provide care coordination and integration for services relative to the student for outpatient mental health services received in the educational setting to prevent disease, disability, other health conditions or their progression, to prolong life and promote physical and mental health and efficiency. This includes any medical or remedial services recommended by a physician or other licensed health care practitioner within the scope of practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level, such as:

(A) Mental health assessment;

(B) Psychological testing (non-educational cognitive and adaptive testing);

(C) Assessment of motor language, social, adaptive, and cognitive functioning by standardized developmental instruments;

(D) Behavioral health counseling and therapy; and

(E) Psychotherapy (group/individual).

(3) Services for physical, occupational, and speech therapy, hearing, nursing, and mental health services must be recommended as set out and provided by medically-qualified individuals as defined in OAR 410-133-0120.

(4) Medicaid covered services and treatments are considered as a covered service in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an IEP/IFSP eligible under Individuals with Disabilities Education Act in the educational setting. The above-listed therapy services and treatments are examples of services that may be provided to eligible recipients in an educational setting under the Oregon Medicaid program. The current Prioritized List of services can be found on the Health Evidence Review Commission's (HERC) web site.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0080
Coverage

The Authority may reimburse school medical (SM) providers for covered health services that meet all of the following criteria:

(1) The health service must be "necessary and appropriate," considered as a covered service under the Oregon Health Plan (OHP) Prioritized List of health services, and the health service may not be excluded under OAR 410-133-0200 Not Covered Services.

(2) The health service must be required by a Medicaid-eligible student's physical or mental condition that adversely affects the child/student's educational performance and that helps the child/student keep, learn, or improve skills and functioning as specified on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and further described in the treatment plan and the evaluation of the student.

(3) The health service, individual, or group may include corrective health services treatments and Medicaid-covered related services as described in a student's IEP or IFSP:

(a) The payment rate for health services includes case management and necessary supplies for these services. Additional reimbursement for such services are not paid separately from the health service;

(b) These services must be provided by medically-qualified staff that meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120 and comply with the respective medical provider's governing definitions, scope of practice, documentation requirements, and licensure or certification.

(4) Evaluation and assessment for SBHS are reimbursed for the part of the evaluation or assessment regarding a Medicaid-eligible student's "necessary and appropriate" SBHS needs for the purpose of establishing, re-establishing, or terminating a Medicaid-covered service on a Medicaid-eligible student's IEP or IFSP or to develop, review, or revise components of a covered health service currently provided to a Medicaid-eligible student for continuation of those covered services pursuant to an IEP or IFSP under the Individuals with Disabilities Education Act (IDEA):

(a) Evaluation services are procedures used to determine an SBHS covered health-related need, diagnosis, or eligibility under IDEA;

(b) Re-evaluation services are procedures used to measure a Medicaid-eligible student's health status compared to an initial or previous evaluation and is focused on evaluation of progress toward current goals, modifying goals or treatment, or making a professional judgment to determine whether or not a Medicaid-eligible student will continue to receive continued care for a SBHS covered service pursuant to the IEP or IFSP under IDEA. Continuous assessment of the student's progress as a component of ongoing therapy services is not billable as a re-evaluation.

(5) Assistive technology services directly assist a Medicaid-eligible student with a disability eligible under IDEA to receive assistive technology-covered SBHS as specified on the IEP or IFSP in the selection, acquisition, or use of an assistive technology device, including:

(a) The assistive technology assessment with one-to-one student contact time by medically-qualified staff within the scope of practice performing the assessment of the need, suitability, and benefits of the use of an assistive technology device or adaptive equipment that will help restore, augment, or compensate for existing functional ability in the Medicaid-eligible student or that will optimize functional tasks for the Medicaid-eligible student's environmental accessibility. This requires and includes the preparation of a written report;

(b) Care coordination with the Medicaid-eligible student's physician, parent/guardian, and the Division) for the parent/guardian's acquisition of a personal assistive technology device for their Medicaid-eligible student through the student's Medicaid plan for the benefit of the Medicaid-eligible student to maximize her functional ability and environmental accessibility; and

(c) Training or technical assistance provided to or demonstrated with the Medicaid-eligible student by medically-qualified staff, instructing the use of an assistive technology device or adaptive equipment in the educational setting with professionals (including individuals providing education and rehabilitation services) or where appropriate the family members, guardians, advocates, or authorized representative of the Medicaid-eligible student. In order to bill Medicaid for this service, the student must be present.

(6) The Authority may reimburse physical therapy services provided by:

(a) A physical therapist authorized to administer physical therapy to an individual when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, and is being seen pursuant to the Medicaid-eligible student's individual education plan or individual family service plan (see Oregon administrative rules chapter 848, division 10, Licensed Physical therapist and Licensed Physical Therapist Assistants; Division 15 Physical Therapist Assistants; and Division 40 Minimum Standards For Physical Therapy Practice and Records);

(b) A physical therapist assistant providing treatment under the supervision of a physical therapist that is available and readily accessible for consultation with the assistant at all times either in person or by means of telecommunications (see OAR chapter 848, division 15, Physical Therapist Assistants). Physical therapy services must be provided by medically-qualified staff that meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120;

(c) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report to establish necessary and appropriate physical therapy services on a Medicaid-eligible student's IEP or IFSP;

(B) Obtaining and interpreting medical information for the part of an evaluation or assessment performed by the physical therapist to establish necessary and appropriate physical therapy services on a Medicaid-eligible student's IEP or IFSP or to determine whether or not necessary and appropriate physical therapy services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA (cannot be delegated);

(C) Care coordination and integrating services within the scope of practice for providing necessary and appropriate physical therapy services relative to the Medicaid-eligible student pursuant to an IEP or IFSP;

(D) Direct treatment and supervision of services provided to a Medicaid-eligible student by the physical therapist and defined in the individual plan; when

(E) Documentation by the supervising physical therapist supporting the appropriate supervision of the assistant is maintained and kept by the School Medical Provider for a period of seven years (see OAR chapter 848, division 40, Minimum Standards for Physical Therapy Practice and Records);

(F) Individual or group physical therapy services provided to a Medicaid-eligible student by or under the supervision and direction of a licensed physical therapist pursuant to the Medicaid-eligible student's IEP or IFSP; when the documentation describing physical therapy services provided are signed by the therapist providing the service in accordance with their board licensing requirements, and documentation for supervision of services performed by or under the supervision and direction of the supervising physical therapist supporting the services provided is maintained and kept by the school medical provider for seven years (see Minimum Standards for Physical Therapy Practice and Records OARs 848-040-0100 through 848-040-0170);

(G) Other covered physical therapy services within the scope of practice and sections (1) and (2) of this rule.

(7) The Authority may reimburse occupational therapy services provided by:

(a) A licensed Occupational Therapist (OT) authorized to administer occupational therapy to an individual when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, and is being seen pursuant to the Medicaid-eligible student's individual education plan or individual family service plan; and

(b) A licensed occupational therapy assistant assisting in the practice of occupational therapy under the general supervision of a licensed occupational therapist. General supervision requires the supervisor to have at least monthly direct contact in person with the supervisee at the work site with supervision available as needed by other methods; and

(c) Before an occupational therapy assistant assists in the practice of occupational therapy, he must file with the Board a signed, current statement of supervision of the licensed occupational therapist that will supervise the occupational therapy assistant (see OAR 339-010-0035 Statement of Supervision for Occupational Therapy Assistant). Occupational therapy services must be provided by medically-qualified staff that meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120;

(d) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment reports that establish necessary and appropriate occupational therapy services on a Medicaid-eligible student's IEP or IFSP;

(B) Obtaining and interpreting medical information for the part of the evaluation or assessment performed by the occupational

therapist to establish necessary and appropriate occupational therapy services on a Medicaid-eligible student's IEP or IFSP or to determine whether or not necessary and appropriate occupational therapy services will continue to be specified on the Medicaid eligible student's IEP or IFSP under IDEA (cannot be delegated);

(C) Development of the initial occupational therapy treatment plan by the OT (cannot be delegated);

(D) Coordinating care and integrating services within the scope of practice relative to the Medicaid-eligible student receiving necessary and appropriate occupational therapy services as specified on the IEP or IFSP;

(E) Individual or group occupational therapy services provided to a Medicaid-eligible student by or under the supervision and direction of a licensed occupational therapist as specified on Medicaid-eligible student's IEP or IFSP;

(F) Direct treatment and supervision of services provided to a Medicaid-eligible student by the occupational therapist and defined in the individual plan when documentation supporting the appropriate supervision of the assistant is kept and maintained by the school medical provider for a period of seven years;

(G) The occupational therapy services provided are consistent with OAR 339-010-0050 Occupational Therapy Services for Children and Youth in Education and Early Childhood Programs Regulated by Federal Laws; and

(H) Documentation describing occupational therapy treatment provided must be signed including credentials by the occupational therapist providing the service. Where appropriate, services provided by an occupational therapist assistant shall be reviewed and co-signed by the supervising occupational therapist. All documentation describing treatment provided by an occupational therapy assistant must name the assistant therapist and the supervising therapist including credentials as reflected on the current statement of supervision filed with the Occupational Therapist Licensing Board. Supervision and documentation of supervision by the supervising therapist for therapy provided by the occupational therapy assistant must meet general supervision requirements or closer supervision where professionally appropriate. See OAR 339-010-0005, 339-010-0035, and 339-010-0050. Also, see 410-133-0320 Documentation and Record Keeping Requirements in these rules;

(I) Other covered occupational therapy services within the scope of practice and sections (1) and (2) of this rule.

(8) The Authority may reimburse speech therapy services provided by:

(a) A licensed speech pathologist licensed by the Oregon Board of Examiners for Speech-Language Pathology and Audiology or holds a license issued by the Teacher Standards and Practice Commission (TSPC) prior to July 1, 2016, exemption in ORS 681.230(4) pursuant to SB287, and holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA), or has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate, or is authorized to administer speech therapy to an individual when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, receiving speech therapy services pursuant to an individual education plan or individual family service plan; or

(b) A graduate speech pathologist in their Clinical Fellowship Year (CFY) practicing under the supervision of al licensed speech pathologist with CCC meeting the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 medically-qualified staff; and when:

(A) A standardized system for reviewing the clinical work of the clinical fellow is performed at regularly scheduled intervals, using the Skills Inventory Rating (CFSI) form addressing the fellow's attainment of skills for independent practice;

(B) The clinical fellow supervisor maintains and documents the supervision of the clinical fellow to be kept by the school medical provider for a period of seven years;

(C) Documentation describing the treatment provided is signed and initialed by the clinical fellow for review and co-signed by the supervising clinical fellow.

(c) Speech-language pathology assistants (SLPA), licensed by the Oregon State Board of Examiners for Speech-Language Pathology and Audiology, under the supervision of a supervising speech-language pathologist and who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 Medically Qualified Staff, when the following conditions are met:

(A) The supervising speech-language pathologist must have at least two years of full-time professional speech-language pathology experience (see OAR 335-095-0040 and 335-095-0050, Requirements for Supervising Licensed Speech-Language Pathology Assistants);

(B) The supervising speech therapist does not supervise more than the equivalent of two full-time speech-language pathology assistants;

(C) The supervising speech-language pathologist maintains documentation supporting the appropriate supervision of the assistant to be kept by the school medical provider for a period of seven years;

(D) The caseload of the supervising clinician allows for administration, including assistant supervision, evaluation of students and meeting times. All students assigned to an assistant are considered part of the caseload of the supervising clinician;

(E) The supervising speech-language pathologist must be able to be reached at all times. A temporary supervisor may be designated as necessary;

(F) The services provided by the assistants are consistent with the Scope of Duties for the Speech-Language Pathology Assistant (SLPA) pursuant to OAR 335-095-0060;

(G) Documentation describing the treatment provided is signed and initialed by the SLPA for review and co-signature by the supervising speech-language pathologist to be kept by the school medical provider for a period of seven years from date of payment.

(d) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the speech pathologist to establish necessary and appropriate speech therapy services on a Medicaid-eligible student's IEP or IFSP or determine whether or not necessary and appropriate speech therapy services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA (cannot be delegated);

(B) Development of the initial speech therapy treatment plan by the speech pathologist (cannot be delegated);

(C) Care coordination and integrating services within the scope of practice relative to the Medicaid-eligible student receiving necessary and appropriate speech therapy services specified on the IEP or IFSP;

(D) Direct individual or group speech therapy services provided to a Medicaid-eligible student for speech services specified on the IEP or IFSP delivered by or under the supervision and direction of a speech pathologist who is medically qualified to deliver the service, see 410-133-0120 Medically Qualified Staff;

(E) Direct training and supervision of services provided to a Medicaid-eligible student by the medically qualified supervising speech pathologist to be kept by the school medical provider for a period of seven years; and

(F) Other covered speech therapy services within the scope of practice and sections (1) and (2) of this rule.

(9) The Authority may reimburse audiology services provided by:

(a) A licensed audiologist within the scope of practice as defined by state or federal law who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120, Medically Qualified Staff;

(b) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report, including obtaining and interpreting medical

information for the part of the evaluation or assessment performed by the audiologist within the scope of practice to establish necessary and appropriate hearing services on a Medicaid-eligible student's IEP or IFSP or determine whether or not necessary and appropriate hearing impairment services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA;

(B) Periodic hearing evaluations and assessments of a Medicaid-eligible student with hearing loss found eligible under IDEA pursuant to services as specified on the IEP or IFSP for determination of the range, nature, and degree of hearing loss;

(C) Care coordination and integration of services for medical or other professional attention relative to a Medicaid-eligible student receiving services for restoration or rehabilitation due to hearing and communication disorders as specified on the IEP or IFSP;

(D) Provision of rehabilitative activities such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the Medicaid-eligible-student's need for individual amplification in accordance with the student's IEP or IFSP.

(10) The Authority may reimburse nurse services provided by:

(a) A nurse practitioner (NP), registered nurse (RN), licensed practical nurse (LPN), or delegated health care aid under the supervision of an RN or NP who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 Medically Qualified Staff;

(b) Nursing services under this program are not intended to reimburse nursing activities of a private duty RN or LPN that is otherwise billing Medicaid directly for those services;

(c) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report to establish nursing services including obtaining and interpreting medical information for the part of the evaluation or assessment performed to establish necessary and appropriate nursing services on the Medicaid-eligible student's IEP or IFSP or determine whether or not necessary and appropriate nursing services will continue to be specified on the Medicaid-eligible students IEP or IFSP under IDEA;

(B) Coordinated care for other specified care management for a chronic medical condition that is not addressed on the current IEP or IFSP that will result in amending nursing services specified in the IEP or IFSP and requires an updated nursing plan of care. This may result in an increase in supervision, monitoring, and training of DHC staff to provide new nursing tasks related to the change in condition, i.e., a child with seizure disorder that develops diabetes;

(C) Care coordination and integration of necessary and appropriate nursing services relative to the Medicaid–eligible student's covered health service specified on the IEP or IFSP;

(D) Nurse to student interactive services that are covered health services provided to a Medicaid-eligible student with a chronic medical condition receiving nursing services pursuant to an IEP or IFSP;

(E) Oversight of delegated health care aides performing delegated nursing services directly with the student as specified on the IEP or IFSP;

(F) Student observation by medically qualified staff for medical reasons of a Medicaid-eligible student with a chronic medical condition as part of an evaluation, assessment, or care coordination. An observation by itself is not a billable activity;

(G) Other covered nursing care services within the scope of practice and sections (1) and (2) of this rule.

(11) The Authority may reimburse mental health services provided by:

(a) A psychiatrist who meets the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(A), or a psychologist who meets the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(B), or a mental health nurse practitioner who meets the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(e)(A); or

(b) A psychologist associate with authority to function without immediate supervision, performing functions that may include but are not restricted to administering tests of mental abilities, conducting personality assessments and counseling (see OAR 858-010-0039 Application for Independent Status). These services must be provided by medically-qualified staff who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(C); or

(c) A psychologist associate under the supervision of a psychologist as specified by the Board of Psychologist Examiners, OAR chapter 858, division 010. These services must be provided by medically-qualified staff who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(D); or

(d) A technician under the supervision of a psychologist as specified by the Board of Psychologist Examiners, chapter 858, division 10, OAR 858-010-0002, Guidelines for Supervising Technicians, and who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(f)(E); or

(e) An LCSW qualified and licensed to deliver the service, or a Clinical Social Work Associate (CSWA) under the supervision of an LCSW specified by the Board of Licensed Social Workers, chapter 877 division 20 and who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(f)(F);

(f) Reimbursable time may include:

(A) Preparation of the written initial evaluation or initial assessment report for a suspected disability per the referral process for determining IDEA eligibility, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the mental health care practitioner within the scope of practice to establish necessary and appropriate mental health services on the Medicaid-eligible student's IEP or IFSP or to determine whether or not necessary and appropriate mental health services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA;

(B) Care coordination and integrating services within the scope of practice relative to the Medicaid-eligible student receiving mental health services as specified on the IEP or IFSP;

(C) Direct individual therapy services provided within the scope of practice under state law and covered under sections (1) and (2) of this rule to a Medicaid-eligible student by or under the supervision and direction of a psychologist, a psychiatrist, or mental health nurse practitioner, or a Licensed Clinical Social Worker qualified and licensed to deliver the service pursuant to the Medicaid-eligible student's IEP or IFSP.

(12) Medicaid reimbursed transportation:

(a) Transportation to a covered health service as documented in the child's IEP/IFSP and defined in these rules (see 410-133-0245, Cost Determination and Payment);

(b) Ongoing transportation specified as a related service on the Medicaid-eligible student's IEP or IFSP may be claimed as a Medicaid service on the days a Medicaid-eligible student receives a covered health service that is also specified on the IEP or IFSP and the transportation is supported by a transportation vehicle trip log;

(c) The Authority may only reimburse for transportation as a related service to and from a Medicaid-covered service for a Medicaid-eligible student when the transportation is supported by a transportation vehicle trip log; and the student receives a Medicaid-covered health service other than transportation on that day when either of the following situations exist:

(A) The Medicaid-eligible student requires specialized transportation adapted to serve the needs of the disabled student; there is documentation to support specialized transportation is "necessary and appropriate;" and transportation is listed as a related service on the student's IEP or IFSP; or

(B) The Medicaid-eligible student has a medical need for transportation that is documented in the IEP or IFSP and resides in an area that does not have regular school bus transportation such as those areas in close proximity to a school.

(d) If a Medicaid-eligible student is able to ride on a regular school bus, but requires the assistance of a delegated health care aide trained by an RN to provide a delegated nursing task specific to the student and cannot be transported safely without the delegated health care aide, the service provided by the delegated healthcare aide is reimbursed under the delegated healthcare code. See the Standards for Community-Based Care Registered Nurse Delegation of a nursing care task as outlined in the Nurse Practice Act, OAR chapter 851 division 47;

(e) If a Medicaid-eligible student requires the assistance of a delegated health care aide and transportation adapted to serve the needs of the disabled student, both the necessary and appropriate transportation and the service provided by the delegated healthcare aide may be reimbursed when both are specified on the Medicaid-eligible student's current IEP or IFSP;

(f) If an education agency provides special transportation to a Medicaid-eligible student to a covered service outside the district or the Medicaid-eligible student's resident school and the student cannot be transported safely without a transportation aide as specified on the IEP or IFSP, the transportation is billable. However, a transportation aide who is not a delegated healthcare aide trained by an RN cannot be billed as a separate cost because the cost of the transportation aide is included in the cost of the transportation;

(g) Transportation is not reimbursable by the Division when provided by the parent or relative of the child;

(h) Transportation to an "evaluation" service is covered as long as:

(A) Medically necessary transportation is listed and included in the Medicaid-eligible student's current IEP or IFSP and the evaluation is to establish, re-establish, or terminate a SBHS covered service under IDEA;

(B) The evaluation is a SBHS covered health service;

(C) The medical provider conducting the evaluation, if not employed or contracted by the school medical provider, is an enrolled provider with the Division and meets applicable medical licensing standards necessary to conduct the evaluation.

(13) Medicaid may reimburse for contracted consultation health services for furnishing consultations regarding a Medicaid-eligible student's covered health service specified on the IEP or IFSP for an evaluation or assessment to establish, re-establish, or terminate a covered SBHS on an IEP or IFSP. Contracted consultation services must be provided by a licensed medical professional other than school medical provider staff:

(a) This service may be on a contracted basis for a number of students;

(b) Allowable services must be furnished through a personal service contract between the school medical provider and the licensed health care practitioner;

(c) This service would only be an SBHS covered health service by the school medical provider when the licensed health care practitioner did not bill Medicaid directly under other programs for the same services.

(14) Reimbursed coordinated care performed by medically qualified staff as described in OAR 410-133-0120 directly related to health services required by a Medicaid-eligible student's physical or mental condition as described in the IEP or IFSP must be one of the following:

(a) Managing integration of those Medicaid covered health services for treatment provided in the education setting;

(b) The portion of a conference between interested parties and medically-qualified staff for developing, reviewing, or revising a Medicaid-covered health service or therapy treatment plan for services provided pursuant to a Medicaid-eligible student's IEP or IFSP or to establish, re-establish, or terminate a covered health service under IDEA for eligibility purposes;

(c) Consultation from medically qualified staff providing technical assistance to or conferring with special education providers, physicians, or families to assist them in providing covered health services to Medicaid-eligible students for treatment provided in the educational setting related to specific health services and the goals and objectives in the student's IEP or IFSP. Consultation services must be completed by a licensed health care practitioner within the scope of practice under their licensure.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 31-2003, f. & cert ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0090

Public Education Agency School Medical Provider Payment Requirements

These rules are designed to assist the public Education Agency (EA) School Medical (SM) provider in matching state and federal funds for services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g) and are to be used in conjunction with the Division of Medical Assistance Programs (Division) General Rules (OAR 410 division 120).

(1) Payment will be made in accordance with Authority Provider Rules chapter 943 division 120 and Division General Rules chapter 410 division 120 to the enrolled School Medical (SM) provider with the Oregon Health authority (Authority), also termed Authority, meeting the requirements set forth in the provider enrollment agreement for those covered health services provided by medically qualified staff working within the scope of their practice. Medically qualified staff must meet the qualifications as outlined in OAR 410-133-0120 Medically Qualified Staff.

(2) Signing the school medical provider enrollment agreement sets forth the relationship between the State of Oregon, the Authority, and the SM provider and constitutes agreement by the SM provider to comply with all applicable rules of the Authority, the Division, and federal and state laws or regulations. (See OARs chapter 943 division 120 and Division General Rules chapter 410 division 120).

(3) The school medical (SM) provider will bill for covered services provided to Medicaid-eligible students in accordance with Authority chapter 943 division 120 Provider rules, the Division rules chapter 410 division 120 and these School-Based Health Services (SBHS) rules. Payments will be made through the Medicaid Management Information System (MMIS) and the SM provider must retain the full payment for the covered services provided. The SM provider must have a Trading Partner Agreement (TPA) with the Department prior to submission of electronic transactions.

(4) School-based health services (SBHS) authorized under these rules is a cost-sharing Federal Financial Participation (FFP) matching program in which the Education Agency (EA) SM provider that is a public entity unit of government, is responsible for paying the non-federal matching share of the amount of the SBHS claims, calculated using the Federal Medical Assistance Percentage (FMAP) rates in effect during the quarter when the SBHS claims will be paid:

(a) The unit of government public education agency SM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42 CFR 433.51, public funds may be considered as the State's share in claiming federal financial participation (FFP) if the public funds meet the following conditions:

(A) The public funds are transferred to the Authority from public entities that are units of government;

(B) The public funds are not federal funds or they are federal funds authorized by federal law to be used to match other federal funds;

(C) All sources of funds must be allowable under 42 CFR 433 Subpart B;

(b) The unit of government EA SM provider must pay its non-federal matching share portion for claims submitted to the Authority in accordance with OAR 410-120-0035.

(5) Before the Authority pays for SBHS claims, the Authority must receive the SM provider's corresponding local match payment as described in this rule. Failure to timely pay the non-federal matching funds to the Authority will delay reimbursement of claims and may require the SM provider to resubmit the claims.

(6) The Authority will not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If the Authority has previously paid the SM provider for any claim which the CMS disallows, the SM provider must reimburse the Authority the amount of the claim that the Authority has paid to the SM provider, less any amount previously paid by the unit of government EA SM Provider to the Authority for purposes of reimbursing the Department for the non-federal match portion of that claim.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 41-1992, f. 12-31-92, cert. ef. 1-1-93; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 88-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 4-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 28-2008(Temp), f. 6-30-08, cert. ef. 7-1-08 thru 12-28-08; DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09

410-133-0100
School Medical Provider Requirements

The School Medical (SM) provider is responsible to:

(1) Enroll with the Authority's Division, Medical Assistance Programs to provide health services and comply with all the requirements in the Authority's provider rules OAR chapter 943 division 120, General Rules OAR chapter 410 division 120, and SBHS 410-133-0140 in these rules, applicable to enrollment as a provider.

(2) Provide health services pursuant to the Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) for special education under OAR chapter 581, division 15.

(3) Provide health services using medically qualified staff (see 410-133-0120 Medically Qualified Staff in these rules).

(4) Provide appropriate medical supervision by licensed medically qualified staff consistent with their licensing board requirements.

(5) Document health services in writing as required in OAR 410-133-0320.

(6) Maintain adequate medical and financial records as part of the Medicaid-eligible student's education record necessary to fully disclose the extent of the covered health services provided.

(7) Make the records required by these rules and specifically OAR 410-133-0320 available for a period of seven years from the date of payment.

(8) Document costs and establish a schedule of cost rates per discipline in accordance with OAR 410-133-0245.

(9) Provide access for on-site review of IDEA Medicaid-eligible students' education records directly related to payments for claims to the SM provider for Medicaid covered health related services specified on an IEP or IFSP and furnish such information to any state or federal agency responsible for administration or oversight of the medical assistance program as the state or federal agency may from time to time request in compliance with OAR 943-120-0310.

(10) Document any changes in the Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) related to the provision of Medicaid covered health services under School-Based Health Services (SBHS).

(11) Assure that SBHS services billed are billed in accordance with OAR 410-120-0035, reflect covered health services, and do not reimburse for non-covered education services or administrative activities.

(12) Retain the full payment amount for Medicaid-covered services provided.

(13) Utilize procedures to confirm that all individuals providing health services to Medicaid-eligible students, whether as employees or under contract with the SM provider, are eligible to provide Medicaid services and are not excluded from providing Medicaid services. Exclusion means the Authority will not reimburse an SM provider (allied agency) who employs a medically licensed individual who has defrauded or abused the Authority for items or services furnished by that individual. (See OAR 410-120-1400 Provider Sanctions, OAR 410-133-0120 Medically Qualified Staff, and 410-133-0200 Not Covered Services.).

(14) Comply with all applicable provisions of the Authority's rules chapter 943 division 120 and the Division General Rules Chapter 410 division 120, including rules related to the use of billing providers. If the SM provider seeks to submit claims to the Authority electronically, it must comply with the applicable provisions of the Department's Electronic Data Interchange (EDI) rules for EDI transactions OAR Chapter 943 Divsion120. EDI does not include electronic transmission by web portal.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 28-2008(Temp), f. 6-30-08, cert. ef. 7-1-08 thru 12-28-08; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0120
Medically Qualified Staff

(1) The school medical (SM) provider shall furnish covered health services through the medically qualified staff who provide health services within the scope of their licensure. The SM provider shall document the credentials and qualifications, updated periodically, of all medically qualified staff. The SM provider credential file shall document the manner in which the provider checked, and periodically re-checked, the Medicaid provider exclusion list to confirm that the medically qualified staff is eligible to provide health services to Medicaid-eligible students in compliance with provider enrollment agreement attachment OHP 3120. Special education teachers are not recognized as medically qualified staff for these services. See http://oig.hhs.gov/exclusions/index.asp.

(2) School-based health services are delivered by providers who meet the federal requirements listed below and who operate within the scope of their health care practitioner's license or certification pursuant to state law as follows:

(a) Evaluation and physical therapy treatments shall be provided by licensed physical therapists that meet the federal requirements of 42 CFR 440.110 and are licensed by the state Physical Therapist Licensing Board. Licensed physical therapists assistants whose function is to assist the physical therapist in patient-related activities and to perform delegated procedures that are commensurate with the licensed therapist assistant's education and training may provide therapy treatments under the supervision and direction of a state licensed physical therapist within the scope of the health care practitioner's license and accreditation pursuant to state law;

(b) Occupational therapy evaluation and treatments shall be provided by licensed occupational therapists that meet the federal requirements of 42 CFR 440.110 and are licensed by the state Occupational Therapy Licensing Board. Licensed occupational therapist assistants whose function is to assist the occupational therapist in patient-related activities and to perform delegated procedures that are commensurate with the licensed therapist assistant's education and training may provide therapy treatments under the supervision and direction of a state licensed occupational therapist within the scope of the health care practitioner's license and accreditation pursuant to state law;

(c) Speech therapy evaluation and treatments shall be provided by speech pathologists that meet the federal requirements at 42 CFR 440.110 and are licensed by the state Board of Examiners for Speech-Language Pathology and Audiology or hold a license

issued by the Teacher Standards and Practice Commission (TSPC) prior July 1, 2016, exemption in ORS 681.230(4) pursuant to SB287 and hold a Certificate of Clinical Competency from the American Speech-Language-Hearing Association or has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate:

(A) Speech therapy services may be provided by a graduate speech pathologist being supervised in the Clinical Fellowship Year (CFY) and shall be provided in compliance with supervision requirements of the state licensing board and the American Speech-Language-Hearing Association (ASHA);

(B) A Certified Speech-Language Pathology Assistant (SLPA) performing within the scope of practice may provide therapy under the supervision of a state licensed speech-language pathologist within the scope of the health care practitioner's license and accreditation pursuant to state law meeting the requirements for speech pathologist as above described in (c). Excludes services described in OAR 335-095-0040, Qualifications for Supervising Speech-Language Pathology Assistants; see OAR 410-133-0200 Not Covered Services.

(d) Audiology evaluation and services shall be provided by audiologists that meet the federal requirements at 42 CFR 440.110;

(e) Nurse evaluation and treatments shall be provided by or under the direction of registered nurses (RN) licensed to practice in Oregon by the Oregon State Board of Nursing or nurse practitioners that meet the federal requirements at 42 CFR 440.166 and are licensed by the Oregon State Board of Nursing to practice in Oregon as a Nurse Practitioner (See Oregon State Board of Nursing Nurse Practice Act, OAR chapter 851 divisions 4547 and Nurse Practitioners, OAR chapter 851 division 050:

(A) Licensed practical nurses (LPN) may participate in the implementation of the plan of care for providing care to clients under the supervision of a licensed registered nurse, nurse practitioner, or physician pursuant to the Oregon State Board of Nursing Nurse Practice Act, OAR divisions 045 and 047;

(B) Treatment may also be provided by a delegated health care aide that is a non-licensed person trained and supervised by a licensed registered nurse (RN) or nurse practitioner (NP) to perform selected tasks of nursing care pursuant to the Oregon State Board of Nursing administrative rules, division 047 of the Nurse Practice Act.

(f) Psychological/mental health evaluations, testing, psychological services and treatments shall be provided by individuals who meet the relevant requirements of their respective professional state licensure as follows:

(A) Psychiatrists must be licensed to practice medicine and surgery in the State of Oregon and possess a valid license from the Oregon Medical Board;

(B) Psychologists must have one of the following: A doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA), a doctoral degree in psychology from a program at a college or university that is regionally accredited at the doctoral level that meets the requirements approved by the state Board of Psychologist Examiners (Board) by rule (see OAR Chapter 858 Division 10), and have two years of supervised employment under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the board to have equivalent supervisory competence;

(C) Psychologists associates granted independent status by the Board for authority to function without immediate and direct supervision in compliance with OAR 858-010-0039. Until the psychologist associate successfully obtains independent status, the "psychologist associate resident" must not practice without immediate supervision, but must at all times be under the periodic direct supervision of a licensed psychologist or under the direction of a person considered by the board to have equivalent supervisory competency who shall continue to be responsible for the practice of the associate, see OAR 858-010-0037-through 858-010-0039;

(D) Psychologists associates who do not possess a doctoral degree and are deemed competent to perform certain functions within the practice of psychology under the periodic direct supervision of a psychologist licensed by the Board:

(i) Complied with all the applicable provisions of ORS 675.010 to 675.150;

(ii) Received a master's degree in psychology from a psychology program approved by the Board by rule;

(iii) Completed an internship in an approved educational institution or one year of other training experience acceptable to the Board, such as supervised professional experience under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the Board to have equivalent supervisory competence; and

(iv) Furnishes proof acceptable to the Board of at least 36 months, exclusive of internship, of full-time experience satisfactory to the board under the direct supervision of a licensed psychologist in Oregon or under the direct supervision of a person considered by the Board to have equivalent supervisory competence.

(E) Testing technicians under the supervision of a licensed psychologist. A licensee may delegate administration and scoring of tests to technicians as provided in ORS 675.010(4) and OAR 858-010-0002;

(F) Services provided by Clinical Social Work Associate (CSWA) or Licensed Clinical Social Workers (LCSW): Must possess a master's degree from an accredited college or university accredited by the Council on Social Work Education and have completed the equivalent of two years of full-time experience in the field of clinical social work in accordance with rules of the Oregon State Board of Social Workers for a LCSW or whose plan of practice and supervision has been approved by the board for a CSWA working toward LCSW licensure under the supervision of a LCSW for two years of postmasters clinical experience and is licensed by the Board of Licensed Social Workers to practice in Oregon. See Board of Licensed Social Workers, chapter 877, division 20, Rules Applicable to Certification and Licensing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 49-1991(Temp), f. & cert. ef. 10-24-91; HR 3-1992, f. & cert. ef. 1-2-92; HR 29-1993, f. & cert. ef. 10-1-93; HR 19-1994, f. & cert. ef. 4-1-94; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 31-2003, f. & cert ef. 4-1-03 ; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0140
School Medical Provider Enrollment Provisions

(1) This rule applies only to providers seeking reimbursement from the Division, except as otherwise provided in OAR 410-120-1295.

(2) Only Educational Agency (EA) providers of SBHS that meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2005 will be enrolled with the Division as school medical (SM) providers allowed to seek reimbursement for the provision of covered health services pursuant to a Medicaid eligible child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

(3) The provider enrollment process will consist of: The completion and submission of the School Medical (SM) provider enrollment application and the required attachments, disclosure documents, and provider agreement with the Division of Medical Assistance Programs.

(4) An approved enrollment application by the Division or the Authority unit responsible for enrolling the SM provider is a contractual agreement that binds the SM provider to comply with the Authority administrative rules OAR 943-120-0300 through 943-120-0380, the Division General Rules 410-120-1260 and School-Based Health Services (SBHS) rules.

(5) Signing the SM provider agreement enclosed in the application package constitutes agreement by performing, and billing providers for provision of SBHS to comply with all applicable rules of the Medical Assistance Program and federal and state laws and regulations.

(6) An SM provider is a performing provider. A performing provider is the provider of a service or item. A billing provider is an individual, agent, business, corporation, clinic, group, institution, or other entity who in connection with the submission of claims to the Authority, receives or directs the payment (either in the name of the performing provider or the name of the billing provider) from the Authority, on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider (See OAR 410-120-1260):

(a) A billing provider is responsible for identifying to the Division and keeping current the identification of all performing providers for whom they bill, or receive or direct payments. This identification must include the providers' names, Authority provider numbers, NPIs, and either the performing provider's Social Security Number (SSN) or Employer Identification Number (EIN). The SSN or EIN of the performing provider cannot be the same as the Tax Identification Number (TIN) of the billing provider. In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements, the Authority requires billing providers to be enrolled consistent with the provider enrollment process described in OAR 410-120-1260(7);

(b) If the SM performing provider uses electronic media to conduct transactions with the Authority, or authorizes a billing provider to conduct such electronic transactions, the SM performing provider must comply with the Electronic Data Interchange (EDI). Enrollment as a SM performing provider or billing provider is a necessary requirement for submitting electronic claims, but the provider must also register as a trading partner and identify the EDI Submitter;

(c) A school medical (SM) performing provider that uses electronic media to conduct transaction with the Authority or authorizes a billing provider to conduct such electronic transactions, must comply with the electronic data interchange (EDI). Enrollment as an SM performing provider or billing provider is a necessary requirement for submitting electronic claims. If the SM provider intends to use an electronic data interchange (EDI) submitter, the SM performing provider must register with the Authority as a trading partner and shall complete the "Trading Partner Authorization of EDI Submitter" and the EDI submitter information required in the application in compliance with the trading partner requirements of identifying the authority of the EDI submitter to submit claims on its behalf. The EDI submitter must sign the EDI certification and meet other Authority EDI submission requirements pursuant to the EDI rules, before the Authority may accept an electronic submission from the EDI submitter on behalf of the performing provider. Information about the EDI transaction requirements is available on the Authority's web site.

(7) To be enrolled and able to bill as an SM provider, an EA, must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules and must comply with all Oregon statutes and regulations for provision of Medicaid and State Children's Health Insurance program (SCHIP) services. In addition, all providers of services within the State of Oregon must 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.

(8) An EA, individual, or organization that is currently subject to sanction by the Medical Assistance Program or Federal government is not eligible for enrollment.

(9) The Authority requires compliance with the National Provider Identification (NPI) requirements in 45 CFR Part 142. Providers that obtain an NPI should update their records with the Division Provider Enrollment. Provider applicants that have been issued an NPI must include that NPI number with the Division provider enrollment application.

(10) A performing provider number will be issued to an EA providing covered health care services or items upon:

(a) Completion of the application and submission of the required School-Based Health Services SM Provider Attachment, disclosure documents, and provider agreement;

(b) The signing of the SM provider application by the authorized representative for the EA to bind the EA SM provider to compliance with these rules;

(c) Verification of licensing or certification. Loss of the appropriate licensure or certification or failure to meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2005 will result in immediate dis-enrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Approval of the application and required documentation for an SM provider by the Division or the Division responsible for enrolling the provider.

(11) An SM performing provider may be enrolled retroactive to the date services were provided to a medical assistance client/child if:

(a) The SM provider met the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2005, was appropriately licensed, certified, and otherwise met all Medical Assistance Program requirements at the time services were provided; and

(b) Services were provided less than 12 months prior to the date of application for medical assistance provider status as evidenced by the first date stamped on the paper claims(s) submitted with application materials for those services either manually or electronically; or

(c) Extenuating circumstances existed outside the control of the EA SM provider consistent with federal Medicaid regulations, with approval of the Division's Provider Services Unit Manager.

(12) Issuance of an Authority-assigned SM provider number establishes enrollment of an EA as a provider for limited categories of services for the Medical Assistance Program applicable to the provision of Medicaid covered School-Based Health Services (SBHS).

(13) An SM provider is required for providing and continuing to provide to the Authority accurate, complete and truthful information regarding their qualification for enrollment. The SM provider is responsible for notifying the Division in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide SBHS including but not limited to change in any of the following information: changes address, business affiliation, licensure, ownership, certification, NPI, billing agents or Federal Tax Identification Number (TIN), change in status for meeting the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying the EA's programs for state reimbursement under OAR 581-015-2005, if the SM provider or a person with an ownership or control interest, or an agent or managing employee of the SM provider has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program, the SM provider must notify the Division in writing within 30 calendar days of the change:

(a) Failure to notify the Division of a change of federal tax identification number (TIN) may result in the imposing of a $50 fine;

(b) Changes in business affiliation, ownership and control of information, criminal convictions, NPI, or federal tax identification number may require the submission of a new application;

(c) Payments made to providers who have not furnished such notification as required by this rule or to a provider that has failed to submit a new application as required by this rule and OAR 410-120-1260 may be denied or recovered.

(14) For information regarding enrollment of Billing Providers (BP) and issuance of an Authority assigned BP Provider ID in compliance with Provider Rules see OAR 943-120-0300 through 943-

120-1505, 410-120-1260 and 943-120-0100 through 943-120-0200.

(15) Provider termination:

(a) The SM provider may terminate enrollment at any time. The request must be in writing, via certified mail, return receipt requested. The notice shall specify the provider number to be terminated and the effective date of termination. Termination of the SM provider enrollment does not terminate any obligations of the SM provider for dates of services during which the enrollment was in effect;

(b) The Division provider terminations or suspensions may be for, but are not limited to the following:

(A) Breaches of provider agreement;

(B) Failure to comply with the statutes, regulations and policies of the Authority, Federal and State regulations that are applicable to the provider;

(C) When no claims have been submitted in an 18-month period. The provider must reapply for enrollment.

(16) When one or more of the requirements governing a provider's participation in the medical assistance program are no longer met, the provider's medical assistance program provider number may be immediately suspended. The provider is entitled to a contested case hearing as outlined in 410-120-1600 to determine whether the provider's medical assistance program number will be revoked.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0160
Licensed Practitioner Recommendation

Requests for payment for covered health services required by a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) must be supported by written recommendation from a physician or a licensed health care practitioner acting within the scope of their practice for the treatment provided. The recommendation must be current for the treatment provided as specified on the IEP or IFSP.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09

410-133-0180
Duplication of Service

(1) The School Medical (SM) provider that utilizes a contractor to provide health services may only bill The Oregon Health Authority (Authority) or the Division of Medical Assistance Programs (Division) for health services when the school medical (SM) provider and the contracted provider have previously agreed that the contractor will not also bill for the same service.

(2) Duplicate billings are not allowed and payments will be recovered. Billings for health services to Medicaid-eligible students will be considered as duplicate if the same services are billed by more than one Educational Agency (EA) to address the same need. For example: an Education Service District (ESD) and a local school district cannot both bill the same services provided to the student.

(3) A unit of service can only be billed once; under one procedure code, under one provider number.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09

410-133-0200
Not Covered Services

(1) Education-based costs normally incurred to operate a school and provide an education are not covered for payment by the Authority.

(2) Health services and treatment not documented on the Medicaid-eligible student's IEP or IFSP is not covered for payment by the Authority under the School-Based Health Services (SBHS) rules.

(3) Reviewing records (exception: reviewing records as part of an evaluation to establish, re-establish, or terminate a SBHS covered health service on a Medicaid-eligible student's IEP or IFSP).

(4) Meeting preparation.

(5) Health services preparation including materials preparation.

(6) Report writing (exception: report writing as part of preparation of initial evaluation and initial treatment plan to establish a covered health service on a Medicaid-eligible student's IEP or IFSP).

(7) Correspondence.

(8) Treatment and care coordination for an acute medical condition.

(9) Medication management not specific to mental health related services listed in the IEP/IFSP.

(10) Purchase of an assistive technology device is not covered through SBHS.

(11) Activities related to researching student names, determining Medical Assistance Program eligibility status, administrative activities such as data entry of billing claim forms, and travel time by service providers.

(12) Family therapy where the focus of treatment is the family.

(13) Routine health nursing services provided to all students by school nurses and nursing intervention for acute medical issues in the school setting, e.g., students who become ill or are injured.

(14) Educational workshops, training classes, and parent training workshops.

(15) Regular transportation services to and from school.

(16) Vocational services.

(17) Screening services.

(18) Evaluation services that are not performed by medically qualified staff within the scope of practice to establish, re-establish, or terminate a covered SBHS under IDEA.

(19) Service provided to non-Medicaid students in a group, class, or school free of charge. If only Medicaid-eligible students are charged for the service, the care is free, and Medicaid will not reimburse for the service. The free care limitation does not apply to health services provided as a result of an educational agency's obligation to provide FAPE services, and the health service is identified on the Medicaid-eligible student's IEP/IFSP. This means that school medical providers may bill for covered health services provided to Medicaid-eligible students under IDEA even though they may be provided to non-Medicaid-eligible students for free as a part of FAPE.

(20) Any non-medical unit of time spent on evaluations.

(21) Recreational services.

(22) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) comprehensive examinations described in OAR 410-130-0245 are not authorized to be provided by school medical providers.

(23) Services provided by an entity that employs an excluded provider. It is the obligation of the education agency to utilize the excluded provider web site to check for providers who have been excluded from receiving any monies affiliated with Medicaid and Medicare service reimbursements.

(24) Covered health services listed on an IEP or IFSP for those dates of service when the IEP/IFSP has lapsed.

(25) Covered health services that do not have a current recommendation by medically qualified staff within the scope of practice for the treatment provided as specified on the IEP or IFSP.

(26) Orientation and Mobility Training. Services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community.

(27) Using a rubber stamp to authenticate any entry for documentation of therapy provided to a student and billed to Medicaid for reimbursement for SBHS.

(28) Services provided by staff in an education setting licensed solely by the Teacher Standards and Practices Commission (TSPC). It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered health services provided in an education setting.

(29) Services provided by speech-language pathology assistants in schools under the supervision of a speech-language pathologist who do not meet the requirements for a speech pathologist described in 410-133-0120 Medically Qualified Staff but instead holds either a basic, initial, standard, or continuing license in speech impaired issued by the Teacher Standards and Practices Commission and has obtained a permit from the Oregon Board of Examiners for Speech-Language Pathology and Audiology to supervise SLPA's in education settings under OAR 335-095-0055.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0220
Billing and Payment

(1) The School Medical (SM) provider must bill the Oregon Health Authority (Authority), also termed Department, in accordance with OAR 410-120-0035; and must bill at a cost rate no greater than the education agency's cost rate for the applicable discipline reviewed and accepted by the Authority based on the cost determination process described in OAR 410-133-0245.

(2) Services must be billed on a CMS-1500 or by electronic media claims (EMC) submission using only those procedure codes specified for the School-Based Health Services (SBHS) program. If the SM provider submits their claims electronically, the SM provider must become a trading partner with the Authority and comply with the requirements for Electronic Data Interchange (EDI) pursuant to Chapter 943 Division 120 rules and Chapter 410 Division 120 rules.

(3) The Authority will accept a claim up to 12 months from the date of service. See Department Provider Rules 943-120-0340 Claim and PHP Encounter Submission and General Rules 410-120-1300 Timely Submission of Claims.

(4) Third party liability. In general, the Medicaid program is the payor of last resort and a provider is required to bill other resources before submitting the claim to Medicaid. This requirement means that other payment sources, including other federal or state funding sources, must be used first before the Authority can be billed for covered health services. However, the following exceptions apply to the requirement to pursue third party resources:

(a) For health services provided under the Individuals with Disabilities Education Act (IDEA), Medicaid pays before Oregon Department of Education (ODE) or the Educational Agency (EA), to the extent the health service is a covered service provided to a Medicaid-eligible student documented as required under these rules, and subject to the applicable reimbursement rate;

(b) If School-Based Health Services (SBHS) are provided under Title V of the Social Security Act (Maternal and Child Health Services Block Grant), Medicaid-covered Health Services provided by a Title V grantee are paid by Medicaid before the Title V funds;

(c) The Centers for Medicare and Medicaid Services (CMS) recognize that while schools are legally liable to provide IDEA-related health services at no cost to the eligible students, Medicaid reimbursement is available for these services because section 1903(c) of the ACT requires Medicaid to be primary to the U.S. Department of Education for payment of the health-related services provided under IDEA.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 28-2008(Temp), f. 6-30-08, cert. ef. 7-1-08 thru 12-28-08; DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09

410-133-0245
Cost Determination and Payment

(1) The Oregon Health Authority (Authority) will make rate determinations for the purposes of payment under OAR 410-133-0220 based on annual cost determinations submitted by local education agencies (EA's).

(2) Cost determinations will:

(a) Be based on the EA's prior year's annual audited costs;

(b) Establish an hourly and 15-minute increment rate for the current year billed;

(c) Use the current year Oregon Department of Education (ODE)-approved indirect rate for the EA;

(3) An EA shall not bill for more than its prior year's annual audited cost incurred during the previous year. There will be no required annual cost settlement for each EA, although the Authority may conduct reviews or audits of cost reports.

(4) Data for cost determinations shall be submitted in a format prescribed by the Authority and in accordance with Oregon's State Plan approved by the Centers for Medicare and Medicaid Services (CMS).

(5) Cost determinations shall be completed for each service discipline eligible for Medicaid billing. If an EA does not receive a confirmation from the Authority indicating costs have been received and accepted, the EA may not submit payment requests for those services. Costs for services include: Nursing, Occupational Therapy, Physical Therapy, Speech Language Pathology, Audiology, Psychological, Delegated Health Care, and Clinical Social Work. The Authority's acceptance of the cost calculations submitted by the SBHS provider for rates per discipline based upon the School-Based Health Services' (SBHS) provider's previous year's audited costs and, if applicable, the current years indirect rates does not imply or validate the accuracy of the data submitted.

(6) Transportation costs for Medicaid-eligible children will be reimbursed when the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) for the Medicaid eligible child documents the need for necessary and appropriate transportation. Transportation cost reimbursement rates are based on the EA's prior year's audited costs for special education transportation and will be submitted in a format prescribed by the Department and in accordance to Oregon's State Plan approved by the Centers for Medicare and Medicaid Services (CMS).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09

410-133-0280
Rebilling

In order to correct a claim reimbursed for services provided to a Medicaid-eligible student, the School Medical (SM) provider must request an adjustment. The paid claim must be corrected on the Individual Adjustment Request Form (Division 1036) to allow revision of the original claim. Providers may perform online claim submissions and adjustments using the Authority's web portal. The link can be found at: http://www.oregon.gov/oha/healthplan/pages/providers.aspx. Rebilling additional units of service on a CMS-1500 for the same timeframe would be denied as duplicate services. See 410-120-1300 Timely Submission of Claims and 410-120-1397 Recovery of Overpayments to Providers — Recoupments and Refunds.

[ED. NOTE: Forms referenced available from the agency.]
Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09

410-133-0300
Procedure Codes

(1) The provider must use the procedure code from the School-Based Health Services table that best describes the specific service provided and a modifier that describes the discipline providing the service. Refer to 410-133-0080 Coverage for service requirements and limitations.

(2) Unit values equal 15 minutes of service unless otherwise stated. These time units must be documented in the Medicaid-eligible student's records under the services billed and accounted for under one code only.

(3) Visit. A service measurement of time for billing and reimbursement efficiency. One visit equals the school provider's hourly cost rate for category of service provided (i.e., occupational therapy, physical therapy, speech therapy, etc.) specified in an IEP or IFSP, divided by 60 to yield a cost per minute; per minute cost is then multiplied by amount of service time provided in minutes. For billing purposes, a visit is always presented as one visit.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 29-1993, f. & cert. ef. 10-1-93; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 1-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0320
Documentation and Record keeping Requirements

(1) Record keeping must conform and adhere to federal, state, and local laws and regulations.

(2) Records must record history taken, procedures performed, tests administered, results obtained, and conclusions and recommendations made. Documentation may be in the form of a "SOAP" (subjective objective assessment plan) note, or equivalent.

(3) Providers will retain information necessary to support claims submitted to the Authority including: documentation and supervision of the specific health services provided, the extent of the health service provided, the dates and the name and credentials of medically qualified staff who provided the service to the Medicaid-eligible student for seven years from date of payment. This documentation must meet the requirements of and must be made available pursuant to the requirements in the General Rules, OAR 410-120-1360 Requirements for Financial, Clinical and Other Records. These requirements may be met if the information is included in the IEP or IFSP and the school medical provider maintains adequate supporting documentation at the time the service is rendered, consistent with the requirements of OAR 410-120-1360:

(a) Supporting documentation should:

(A) Be accurate, complete, and legible;

(B) Be typed or recorded using ink;

(C) Be signed by the individual performing the service including their credentials or position;

(D) Be signed and initialed in accordance with licensing board requirements for each clinical entry by the individual performing the service;

(E) Be reviewed and authenticated by the supervising therapist in compliance with their licensing board requirements (Also see covered services 410-133-0080 and not covered services 410-133-0200.);

(F) Be for covered health services provided as specified for the service period indicated on the Medicaid-eligible student's current IEP or IFSP.

(b) Corrections to entries must be recorded by:

(A) Striking out the entry with a single line that does not obliterate the original entry or amend the electronic record preserving the original entry; and

(B) Dating and initialing the correction.

(c) Late entries or additions to entries shall be documented when the omission is discovered with the following written at the beginning of the entry: "late entry for (date)" or "addendum for (date)."

(4) Supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's IEP or IFSP must be kept for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals and must include:

(a) A copy of the Medicaid-eligible student's IEP or IFSP as well as any addendum to the plan that correlates with the covered health services provided and reimbursed by Medicaid;

(b) A notation of the diagnosis or condition being treated or evaluated, using specific medical or mental health diagnostic codes;

(c) Results of analysis of any mental health or medical analysis, testing, evaluations, or assessments for which reimbursement is requested;

(d) Documentation of the location, duration, and extent of each health service provided, by the date of service, signed and initialed by medically qualified staff in accordance with their licensing board requirements (electronic records can be printed);

(e) The record of who performed the service and their credentials or position;

(f) The medical recommendation to support the service;

(g) Periodic evaluation of therapeutic value and progress of the Medicaid-eligible student to whom a health service is being provided;

(h) Record of medical need for necessary and appropriate transportation to a covered health service is supported by a transportation vehicle trip log including specific date transported, client name, ID number, and point of origin and destination consistent with transportation services specified in the child's IEP or IFSP as part of record-keeping requirements; and

(i) Attendance records for Medicaid-eligible students to support dates for covered services billed to Medicaid;

(j) In supervisory situations, the record documenting therapy provided must name both the assistant providing services and the supervising therapist including credentials. The licensed health care practitioner who supervises and monitors the assessment, care, or treatment rendered by licensed or certified therapy assistants shall meet the minimum standards required by their licensing board and shall co-sign for those services where appropriate with their name and professional titles (documentation may not be delegated except in emergency situations).

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0340
Client Rights and Record Confidentiality

(1) School Medical (SM) providers are required to provide The Oregon Health Authority (Authority), the Division of Medical Assistance Programs (Division), the Department of Justice Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services, or their authorized representatives, access to Medicaid-eligible student medical records when requested as a condition of accepting Medicaid reimbursement from the Authority.

(2) Medicaid client rights of confidentiality must be respected in accordance with the provisions of 42 CFR Part 431, Subpart F and ORS 411.320.

(3) School Medical providers are also subject to the confidentiality laws applicable to student records, including student medical records maintained as part of the education record.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 192.410–192.505
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

DIVISION 136

MEDICAL TRANSPORTATION SERVICES

410-136-3000
Responsibility for Providing Non-emergent Medical Transportation

(1) The Authority shall provide non-emergent medical transportation (NEMT) for eligible clients who receive their OHP covered medical services on a fee-for-service basis or are members enrolled in prepaid health plans (PHP) or coordinated care organizations (CCO). The Authority shall cease providing this service to CCO enrollees when CCOs provide the service to their enrollees pursuant to section (2) of this rule.

(2) When a CCO begins providing NEMT services for its enrollees, the Authority shall provide NEMT services in the CCO's service area only to clients not enrolled in a CCO for health care services:

(a) The Authority may not pay for services covered by a CCO; reimbursement is a matter between the CCO and its transportation subcontractor.

(b) For clients enrolled in a CCO responsible for NEMT, the transportation provider must coordinate all transportation services with the client's transportation brokerage or CCO prior to providing services.

(3) The requirements in OAR 410-136-3000–410-136-3360 apply to NEMT services for which the Authority is responsible pursuant to this rule.

(4) A brokerage may request that the Authority delay responsibility for reimbursement to clients pursuant to OAR 410-136-3240, Client Reimbursed Mileage, Meals and Lodging, until a CCO in the brokerage's service area assumes NEMT services for the CCO's enrollees. The delay of the brokerage's responsibility also includes reimbursing clients in the fee-for-service delivery system.

(5) OAR 410-136-3040,Vehicle Equipment and Subcontractor Standards and 410-136-3120, Secured Transports do not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 69-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 29-2014, f. & cert. ef. 5-20-14

410-136-3010
Coordinated Care Organizations

(1) The Authority contracts with Coordinated Care Organizations (CCOs) to provide medical services for individuals receiving Division of Medical Assistance Programs (Division), Title XIX and Title XXI services for the purpose of providing integrated and coordinated care services across physical health, dental health, and non-emergent medical transportation (NEMT). See also OAR chapter 410, division 120 (General Rules) and division 141 (Oregon Health Plan rules) for definitions and responsibilities and OAR 410-120-1210(4) (Division of Medical Assistance Programs and Delivery Systems) for a description of how individuals receive services through CCOs.

(2) When the Authority provides a CCO with a global budget that includes funds to provide NEMT services for its members, the CCO shall provide NEMT services to its members.

(3) The Authority may not pay for services a CCO covers for its members. Reimbursement is a matter between the CCO and its transportation providers.

(4) For members enrolled in a CCO, all transportation services must be coordinated through the member's CCO or the CCO's designated transportation provider, if any, prior to receiving services.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 39-2014, f. & cert. ef. 7-1-14

410-136-3020
General Requirements for NEMT

(1) The Authority may enroll governmental transportation brokerages (local units of government) or other entities to arrange rides and pay subcontractors for NEMT services. The Authority may limit the enrollment with brokerages to units of local government.

(2) For purposes of the rules (OAR 410-136-3000 through 410-136-3360), "subcontractor" means the individual or entity with which the brokerage subcontracts or employs to drive the client to and from OHP covered medical services.

(3) The brokerage shall:

(a) Prior authorize and pay subcontractors for the least costly but most appropriate mode of transport for the client's medical needs to and from an OHP covered medical service. The most appropriate and least costly ride may include requiring the client to share the ride with other clients;

(b) Verify that the client is obtaining OHP covered medical services in the client's local area. "Local area" means an area within the accepted community standard and includes the client's metropolitan area, city, or town of residence;

(c) Verify the client's OHP eligibility and that the client's benefit package includes NEMT services. The brokerage shall verify this through electronic eligibility information;

(d) Assess the client's access to other means of transportation, such as driving their own car or getting a ride from a family member or neighbor;

(e) Verify the client's attendance for continuing requests for rides if the medical provider could not affirm an appointment for a previous ride;

(f) Schedule a ride with an alternate subcontractor if the subcontractor originally assigned is unable to provide the ride; and

(g) Assign rides based on an evaluation of several factors including, but not limited to:

(A) Cost;

(B) The client's need for appropriate equipment and transportation;

(C) Any factors related to a subcontractor's capabilities, availability, and past performance; and

(D) Any factors related to the brokerage's need to maintain sufficient service capacity to meet client needs.

(4) Pursuant to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System, clients receiving the following benefit packages are not eligible for NEMT:

(a) Citizen Alien Waived Emergency Medical (CWM); and

(b) Qualified Medicare Beneficiary (QMB) only.

(5) The brokerage shall maintain records of the reasons for authorizing a ride:

(a) That is not cost effective or not based on the factors specified in section (3);

(b) With more than two attendants for an ambulance or stretcher car; or

(c) With more than one attendant for a wheelchair van.

(6) The brokerage shall provide a ride to a client to fill prescription medication only in the following situation:

(a) The client needs to stop on the way home to fill or pick up prescribed medication related to the medical service for which the brokerage provided the ride;

(b) It is medically necessary to fill or pick up the medication immediately; and

(c) The pharmacy is located on the return route or is the closest pharmacy to the return route.

(7) The brokerage may provide a ride to a client to fill prescribed medication under the following situations:

(a) The brokerage asks the client if the prescription service is available through the Authority's contracted postal prescription service, and the client responds that it is not available through that source;

(b) The client has an urgent need to fill or pick up prescribed medication because the postal prescription service mailed the

wrong medication, or the client has an unexpected problem caused by the medication; or

(c) The client is transient or without regular access to a mailbox. In this situation, the brokerage may evaluate the need on a case-by-case basis.

(8) The brokerage shall provide rides outside the brokerage's service area, as described in Table 136-3380, under the following circumstances:

(a) The client is receiving an OHP covered medical service that is not available in the service or local area but is available in another area of the state;

(b) The client is receiving a covered service in California, Idaho, or Washington where the service location is no more than 75 miles from the Oregon border; or

(c) No local medical provider or facility will provide OHP covered medical services for the client.

(9) Brokerages may coordinate to provide a return ride to a client who receives medical services outside the client's local area.

(10) Brokerages shall retroactively authorize and pay for NEMT services that have already occurred only when the brokerage could not prior authorize the service because the brokerage was closed, and the request for authorization is within 30 days of the date of service. The brokerage also must confirm that one of the following circumstances supported the ride:

(a) The eligible client needed urgent medical care;

(b) The eligible client required secured transport pursuant to OAR 410-136-3120, Secured Transports; or

(c) The client was in a hospital, and the hospital discharged or transferred the client.

(11) Notwithstanding section (10), a brokerage shall retroactively authorize NEMT services for ambulance transports when:

(a) An ambulance provider responds to an emergency call, but the client's medical condition does not warrant an emergency transport;

(b) The ambulance provider transports the client as a NEMT service; and

(c) The ambulance provider requests retroactive authorization within 30 days of the NEMT service.

(12) Brokerages shall not authorize or pay for rides outside their service areas based only on client preference or convenience.

(13) Brokerages shall provide toll-free call centers for clients to request rides. The following pertain to the brokerage's call center and scheduling of rides:

(a) The call center shall operate at a minimum Monday through Friday from 9:00 a.m. to 5:00 p.m., but the brokerage may close the call center on New Year's Day, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the brokerage requests the closure at least 30 days in advance.

(b) Brokerages shall make all reasonable efforts for clients to have access to available NEMT services 24 hours a day. When the call center is closed, the brokerages shall provide a recording or answering service to refer the client directly to a subcontractor. If no subcontractor is available, the brokerage must provide clients with recorded information about service hours and how to reach emergency services by calling 911;

(c) The brokerage shall allow a client to schedule rides at least 30 days in advance of the medical service; and

(d) The brokerage shall allow a client to request multiple ride requests at one time.

(e) The brokerage shall develop procedures and make reasonable efforts to arrange a ride requested on the day of the medical service when the medical service is:

(A) For an urgent medical condition; and

(B) Due to the urgency of the medical condition, the client scheduled an immediate medical appointment.

(14) The brokerage is not responsible for providing emergency medical transportation services. However, brokerages shall have procedures for referring clients requesting emergency medical transportation services to the appropriate emergency transportation resources and procedures for subcontractors per OAR 410-136-3040, Vehicle Equipment and Subcontractor Standards.

(15) The Authority shall collaborate with brokerages and CCOs to develop and conduct a statewide client satisfaction survey at least once every two years. The Authority may contract with one or more brokerages to conduct the survey. The Authority shall use the results of the survey to identify and address potential operational deficiencies and to identify and share successes in the NEMT program.

(16) Brokerages shall establish regional advisory groups consisting of representatives from the Authority, DHS, Area Agencies on Aging, consumers, representatives of client advocacy groups from within the service or local area, brokerage subcontractors, and providers of NEMT ambulance services. The role of the group includes, but is not limited to:

(a) Assisting in monitoring and evaluating the NEMT program; and

(b) Recommending potential policy or procedure changes and program improvements to brokerages and the Authority and assisting in prioritizing those changes and improvements.

(17) Brokerages shall have the discretion to use or not use DHS-approved volunteers. DHS shall provide brokerages with a list of approved and trained volunteers. DHS shall supervise the volunteers and assumes all liability for each volunteer as provided by law.

(18) Brokerages or their subcontractors shall not bill eligible clients for any transports to and from OHP covered medical services or any transports where the Authority denied reimbursement.

(19) On a minimum of five percent of the ride requests, brokerages shall contact medical providers to verify appointments and that the appointments are for OHP covered medical services.

(20) Brokerages may purchase tickets for common carrier transportation, such as inter- or intra-city bus, train, or commercial airline when deemed cost effective and safe for the client.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 69-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 29-2014, f. & cert. ef. 5-20-14

410-136-3040
Vehicle Equipment and Subcontractor Standards

(1) Brokerages shall require subcontractors to maintain their vehicles for the comfort and safety of the clients. The vehicles shall meet the following requirements:

(a) The interior of the vehicle shall be clean;

(b) The subcontractor shall not smoke, aerosolize or vaporize an inhalant or permit smoking, aerosolizing or vaporizing of an inhalant in the vehicle at any time; and

(c) The subcontractor shall comply with appropriate local, state, and federal transportation safety standards regarding passenger safety and comfort. The vehicle shall include, but is not limited to, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) A first aid kit;

(C) A fire extinguisher;

(D) Roadside reflective or warning devices;

(E) A flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to transport clients using wheelchairs or stretchers if the subcontractor uses the vehicle for these modes of transport.

(2) The subcontractor shall follow a preventative maintenance schedule that incorporates at least all of the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to:

(a) Side and rear view mirrors;

(b) A horn; and

(c) Working turn signals, headlights, taillights and windshield wipers.

(3) Brokerages shall require the subcontractors' drivers to receive training on their job duties and responsibilities, including:

(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting and the geographic area in which subcontractors will provide service;

(b) Requiring the subcontractors' drivers to complete the National Safety Council Defensive Driving course or an equivalent course within six months of the date of hire and at least every three years thereafter;

(c) Requiring the subcontractors' drivers to complete Red Cross-approved First Aid, Cardiopulmonary Resuscitation and blood spill procedures courses or equivalent courses within six months of the date of hire and to maintain the certification as a condition of employment;

(d) Requiring the subcontractors' drivers to complete the Passenger Service and Safety course or an equivalent course within six months of the date of hire and at least every three years thereafter;

(e) Understanding established procedures for subcontractors and the subcontractors' drivers in the event that the client needs emergency care during the ride; and

(f) If providing ground or air ambulance services, verifying that the Authority has licensed the subcontractor to operate ground or air ambulance. If the subcontractor is located in a contiguous state and regularly provides rides to OHP eligible clients, the brokerage must ensure that both the Authority and the contiguous state have licensed the subcontractor.

(4) Brokerages shall require the following when hiring a subcontractor:

(a) The subcontractor's driver must have valid driver license. The license must be the class of license, with any required endorsements, that permits the subcontractor's driver to legally operate the vehicle for which they are hired to drive per ORS Chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states; and

(b) The subcontractor's drivers must pass a criminal background check in accordance with ORS 181.534 and 181.537 and OAR chapter 257, division 10, or if the brokerage is a mass transit district formed under ORS Chapter 267, the subcontractor's drivers must pass a criminal background check in accordance with ORS 267.237 and the mass transit district's background check policies. The brokerage may request an exception to this requirement in writing to the Authority, but only the Authority may grant the exception. Approval of the exception is dependent upon when the crime occurred, the nature of the offense, and any other circumstances to ensure that the client is not at risk of harm from the subcontractor. If approved, the Authority shall document the approval within 30 days of the request.

(5) For authorized out-of-state NEMT services in which the subcontractor solely performs work in the other state and for which the brokerage has no oversight authority, the brokerage is not responsible for requiring that the subcontractor's vehicle and the subcontractor's standards meet the requirements set forth in this rule.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 87-2015, f. 12-29-15, cert. ef 1-1-16

410-136-3060
Insurance Requirements

(1) Brokerages must obtain and maintain general and automobile liability coverage for personal injury and death in accordance with ORS 30.271, Limitations on Liability of State for Personal Injury and Death.

(2) Brokerages must obtain and maintain general and automobile liability coverage for property damage and destruction in accordance with ORS 30.273, Limitations on Liability of Public Bodies for Property Damage or Destruction.

(3) The liability coverage required by sections (1) and (2) of this rule shall include the State of Oregon, Oregon Health Authority and its divisions, officers, employees, and agents as additional insureds but only as related to the brokerages' NEMT services.

(4) In lieu of purchasing liability coverage under sections (1) and (2) of this rule, the Authority may authorize a brokerage to establish and maintain a Self-Insurance Reserve Fund. The following apply to requirements of the fund:

(a) The Authority shall establish the fund at $1 million through the fixed rate for rides established in OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport;

(b) The fund shall comply with OMB Circular 87;

(c) If the brokerage subsequently terminates its enrollment with the state as a Medicaid provider, the brokerage shall refund the Authority the balance of any monies in the fund within two years from the termination of its enrollment or at the conclusion of any claim or litigation related to the brokerage's NEMT services for eligible clients;

(d) Once funded, the fund shall be maintained at an amount not less than $1 million through the fixed rate for rides established in OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport;

(e) The Authority shall reconcile the fund amount during the annual cost settlement process pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport, and shall increase or decrease the fixed rate for rides to maintain the $1 million fund amount; and

(f) The brokerage shall maintain a separate account for the fund.

(5) Brokerages and their subcontractors that employ workers as defined in ORS 656.027 shall comply with 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under 656.126(2). Brokerages shall require each of their subcontractors to comply with this requirement.

(6) In lieu of purchasing workers' compensation insurance coverage as required by section (5), a brokerage may self-insure for all of its subject workers. The Authority shall not fund this reserve and shall only reimburse the brokerage for costs of self-insurance in the event of a claim arising from the brokerage's NEMT services to eligible clients.

(7) Brokerages and their subcontractors shall furnish proof of liability coverage and insurance to the Authority upon request.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 69-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 29-2014, f. & cert. ef. 5-20-14

410-136-3080
Out-of-State Transportation

(1) "Out-of-state transportation" means transportation to or from any location outside Oregon, with the exception of contiguous areas up to 75 miles outside the Oregon border.

(2) The brokerage shall arrange rides and pay for out-of-state transportation, as defined in section (1) of this rule, to and from an out-of-state OHP covered medical service when:

(a) The brokerage confirms that the Authority, the Prepaid Health Plan (PHP) or CCO authorized the out-of-state OHP covered medical service per OAR 410-120-1180, Medical Assistance Benefits: Out-of-State Services; and

(b) The client is eligible for transportation services per OAR 410-136-3020, General Requirements for NEMT.

(3) Brokerages shall not arrange or pay for:

(a) A client's return from any foreign country to any location within the United States for the client to obtain medical care because the care is not available in the foreign country;

(b) A client's return to Oregon from another state when the client was not in the other state to obtain authorized medical services or treatments.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3100
Attendants for Child Transports

(1) This rule applies to NEMT for children under 12 years of age who are eligible for NEMT services to and from OHP covered

medical services. The rule also applies to children and young adults with special physical or developmental needs, regardless of age, hereafter referred to as "child" or "children."

(2) Parents or legal guardians must provide an attendant to accompany the children while traveling to and from medical appointments except when:

(a) The driver is a DHS volunteer, DHS employee or an Authority employee;

(b) The child requires secured transport per OAR 410-136-3120, Secured Transports; or

(c) An ambulance subcontractor transports the child for NEMT services, and the brokerage reimburses the ambulance subcontractor at the ambulance transport rate.

(3) Attendants are required for NEMT ambulance transports when the brokerage uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) DHS shall establish and administer written guidelines for children in the department's custody, including written guidelines for volunteer drivers. If DHS's requirements or administrative rules differ from this rule, DHS's requirements or administrative rules take precedence.

(5) An attendant may be the mother, father, stepmother, stepfather, grandparent or legal guardian of the child. The attendant also may be any adult the parent or legal guardian authorizes to be an attendant. An attendant also may be a brother, sister, stepbrother or stepsister of the child, as long as the attendant is at least 18 years of age, and the parent or legal guardian authorizes it.

(6) Brokerages or their subcontractors may require the child's parent or legal guardian to provide written authorization for an attendant other than themselves to accompany the child.

(7) Brokerages or their subcontractors shall not bill additional charges for a child's attendant.

(8) The attendant must accompany the child from the pick-up location to the destination and on the return trip. The attendant must also remain with the child during their appointment. Another person shall not accompany the attendant unless the parent or legal guardian authorizes it or unless the other person is an eligible child traveling to the same location for a medical appointment.

(9) The parent, guardian or adult caregiver for the child shall provide and install child safety seats as required by state law. The subcontractor shall not transport a child if a parent or legal guardian fails to provide a child safety seat that complies with state law.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3120
Secured Transports

(1) "Secured transport" means NEMT services for the involuntary transport of clients who are in danger of harming themselves or others. Secured transports are allowable when:

(a) The brokerage verified that the subcontractor has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and, therefore, the subcontractor is able to transport the client who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the client in crisis.

(2) One additional attendant may accompany the client at no additional charge when medically appropriate, such as to administer medications, etc. in-route, or to satisfy legal requirements, including, but not limited to when a parent, legal guardian or escort is required during transport.

(3) The brokerage shall authorize transports to and from OHP covered medical services for an eligible client when the court orders the medical service with the following exceptions:

(a) The client is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The client is an inmate of a public institution as defined in OAR 461-135-0950, Eligibility for Inmates; or

(c) The Authority has suspended the client's OHP eligibility pursuant to ORS 414.420 or 414.424.

(4) The brokerage shall assume that a client returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a client to their place of residence, the brokerage shall obtain written documentation, signed by the treating medical professional, stating the circumstances that required secured transport. The brokerage shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The brokerage shall not approve or pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3140
Transports of Clients Changing Hospitals or Other Facilities

(1) Brokerages shall arrange and pay for transporting an eligible client who has had a change in condition, noted in the client's DHS care plan, resulting in a need for a new service setting with a lower or higher level of care. This includes clients who are changing levels of care between their community-based care settings or between institutional and community-based settings. The client's DHS worker must request the ride.

(2) Brokerages shall not arrange or pay for:

(a) The transport or return of an inpatient client from an admitting hospital to another hospital (or facility) for diagnostic or other short-term services when the patient will return to the admitting hospital within the first 24-hours of admission. The subcontractor shall bill the admitting hospital directly for these transports;

(b) The transport of a client receiving long-term care service in their home or residing in a long-term care facility for the sole purpose of shopping for another long-term care facility, even if the client is looking for a new facility to receive a lower or higher level of care;

(c) The transport of a client moving from one type of facility to a facility of the same type, such as from an adult foster home to another adult foster home; and

(d) The transport of a client who is relocating to another state, unless the transport is to receive an OHP covered medical service pursuant to OAR 410-136-3080, Out-of-State Transportation.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 69-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 29-2014, f. & cert. ef. 5-20-14

410-136-3160
Ground and Air Ambulance Transports

(1) Transporting a client via ambulance is required when a medical facility or provider states the client's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the brokerage shall authorize the transport.

(3) Brokerages shall provide ambulance transports with a medical technician when:

(a) A client's medical condition requires a stretcher;

(b) The length of transport would require a personal care attendant; and

(c) The client does not have an attendant who can assist with personal care during the ride.

(4) Emergency ambulance transportation is required when a client's medical condition is an emergency pursuant to OAR 410-120-0000, Acronyms and Definitions. The ambulance must transport the client to the nearest appropriate facility able to meet the client's

medical needs. Brokerages do not arrange emergency transportation.

(5) The following apply to air-ambulance NEMT services:

(a) The brokerage shall approve air-ambulance NEMT only when another mode of transportation would further jeopardize or compromise the client's medical condition due to:

(A) The length of time required to transport the client by ground-ambulance;

(B) Current road conditions preclude the use of ground transportation; or

(C) Ground-ambulance is not available.

(b) Notwithstanding section (4) (a), the brokerage may grant air-ambulance transportation if it determines the transportation is cost effective. The brokerage shall document how air-ambulance is more cost effective than ground transportation.

(c) The brokerage must obtain a written recommendation from the client's medical provider indicating medical appropriateness before authorizing air-ambulance transportation.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3180
Reimbursement for Ground and Air Ambulance Transports

(1) The following applies to how the Authority shall reimburse providers of NEMT ground and air ambulance services that brokerages arrange for eligible clients. This applies to clients receiving services through the fee-for-service delivery system, a PHP or a CCO.

(2) Brokerages shall submit documentation to the Authority stating the brokerage authorized the transportation. The documentation also shall inform the Authority to reimburse at the Authority's base rate or another amount the brokerage specifies. Ambulance providers shall bill the Authority for payment of authorized rides.

(3) If brokerage does not specify another amount, the Authority's reimbursement shall include:

(a) The base rate established in the Authority's fee schedule posted on the OHP Web page at www.oregon.gov/OHA/healthplan/pages/feeschedule.aspx. The base rate for NEMT ground and air ambulances includes:

(A) Any procedures or services provided, all medications, non-reusable supplies or oxygen and all direct or indirect costs. "Indirect costs" include general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance subcontractor, use of reusable equipment and any other miscellaneous medical items or special handling that may be required in the course of transport;

(B) The first ten miles for ground ambulance transports; and

(C) Mileage for air ambulance transports.

(b) A modified base rate for each additional client, according to OAR 410-136-3220, Brokerage Reimbursements to Subcontractors, if applicable;

(c) Payment for an extra attendant, if applicable; and

(d) Compensation for service or care provided at the scene when the client did not require transport, if applicable.

(4) Reimbursement outlined in section (3) also applies to the Authority's reimbursements to providers of emergency ground or air ambulance services for clients who receive services through the fee-for-service delivery system.

(5) A PHP is responsible for reimbursement to providers of emergency ground or air ambulance for clients who are PHP members.

(6) A CCO is responsible for reimbursement to providers of emergency ground or air ambulance for clients who are CCO enrollees.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3200
Reimbursement and Accounting for all Modes of Transports

(1) The following applies to the rate the Authority pays brokerages:

(a) The Authority shall calculate and pay a brokerage a fixed rate for rides based on the following formula: Direct costs plus indirect costs divided by the number of projected monthly rides. "Direct costs" are transportation costs plus administrative costs;

(b) The Authority shall notify the brokerages of their specific ride rates; and

(c) The Authority and the brokerages shall assess any needed modifications to this rate:

(A) Quarterly;

(B) When the Authority changes any program affecting eligibility or scope; or

(C) If other factors impact the cost of delivering service.

(2) Brokerages shall account for NEMT services separate from any other services the brokerage provides.

(3) The Authority shall reimburse brokerages after they submit claims data files to the Authority, using the standardized electronic billing format prescribed by the Authority.

(4) The Authority and brokerages shall conduct an annual cost settlement to determine any overpayment or underpayment for costs the brokerage incurred for NEMT services for eligible clients. The following applies to the cost settlement process:

(a) The Authority shall request cost settlement information from the brokerages 6 months after the end of the fiscal year. The request shall include a file detailing the brokerages claims, a template for the brokerages to submit their cost settlement information and instructions for completing the template;

(b) Brokerages shall submit the requested information, certified by a Certified Public Accountant, within 90 days of receiving the Authority's request;

(c) The Authority shall verify the reported expenses and notify the brokerages in writing of the Authority's determination;

(d) If the Authority's determination results in an adjustment to the cost settlement information the brokerages submitted, the brokerages may request an appeal pursuant to OAR 410-120-1560 through 410-120-1700, pertaining to provider appeals.

(5) The Authority shall pay for services the brokerage authorized and provided in good faith, including mailing transit passes to clients. The Authority shall use the rate in effect on the day of the transport or the mailing date of the transit passes. "Good faith" means:

(a) The brokerage verified client eligibility on the date of service or the date of mailing the transit passes, using the Authority's eligibility information; or

(b) The client eligibility information was inconsistent or not available, and the brokerage used the most recent client information available immediately before the time of service or mailing of transit passes.

(6) Each brokerage may establish a working capital reserve with funds the Authority provides. The following applies to any established working capital reserve:

(a) The working capital reserve shall represent 30 days of cash expenses for normal operating purposes. The Authority may base the reserve on a time other than 30 days if circumstances warrant the change;

(b) The Authority shall calculate the reserve amount as part of the annual cost settlement for the most recent past fiscal year;

(c) The Authority shall base the reserve amount on an average of six months of operating expenses that the brokerage reports in its monthly NEMT financial reports. However, the Authority may base the reserve amount on more or less than six months of expenses when a six-month average does not reflect an accurate accounting of expenses;

(d) Brokerages shall maintain a separate account for the reserve funds; and

(e) The Authority may require the brokerage to return any funds in excess of the amount the Authority calculated, or the Authority may decrease the ride rate to reduce the reserves. If the

Authority requires the brokerage to return the excess funds, the brokerage shall do so within 45 days of receipt of the Authority notification.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3220
Brokerage Reimbursements to Subcontractors

(1) Brokerages shall reimburse their NEMT subcontractors for the most cost-effective route from point of origin to point of destination that most benefits the client's condition.

(2) Brokerages shall establish a base rate with its subcontractors. "Base rate" for all modes of transportation except ground and air ambulance means the rate the brokerage and its subcontractors agree on for each mode of transportation.

(3) If a subcontractor uses an ambulance as a stretcher car or van, the brokerage shall reimburse the subcontractor using the base rate for stretcher cars or vans.

(4) Notwithstanding section (3), brokerages shall pay ambulance subcontractors at the ambulance rate instead of the stretcher car or van rate when the transport exceeds two hours, necessitating a health care professional to care for the client during the ride.

(5) Brokerages shall not reimburse their subcontractors for waiting for clients to get to the vehicle or for assisting clients to get in or out of a vehicle.

(6) Brokerages may reimburse their subcontractors for waiting time:

(a) In special situations, such as when the subcontractor has to wait for a client who is using the subcontractor's gurney and cannot transfer to a gurney at a medical facility; or

(b) Because of a medical issue during the ride, such as:

(A) The client is nauseous or is vomiting after dialysis or chemotherapy; or

(B) The client needs to stop to get prescription medication or medical supplies related to the medical service.

(7) Brokerages shall reimburse their subcontractors at the base rate for ambulatory vehicles if the subcontractor provides a ride to an ambulatory client in a non-ambulatory vehicle.

(8) Brokerages may authorize a subcontractor to transport a non-ambulatory client in an ambulatory vehicle if the vehicle can accommodate and transport the client and if allowed by local ordinance. The brokerage shall reimburse its subcontractor at the non-ambulatory vehicle rate.

(9) The wheelchair base rate applies to the transport of a client with a reclining wheelchair; wheelchairs do not qualify as stretchers or gurneys.

(10) The following applies to reimbursement for deceased clients:

(a) If a client dies before the subcontractor arrives at the scene, the brokerage shall not reimburse its subcontractors; or

(b) If a client dies after the transport begins but before reaching the destination, the brokerage's payment is limited to the base rate for the mode of transportation and mileage. For ambulance transports, the payment also would include costs for an extra attendant, if applicable.

(11) Brokerages may authorize shared-ride transports of two or more clients at the same time when the shared-ride transports are allowable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(12) Brokerages shall reimburse subcontractors:

(a) At the full base rate for the first client and one-half the base rate for each additional client when all of these clients need the same mode of transportation, such as by wheelchair van; or

(b) At the full base rate for the client with the need for the highest mode of transportation and one-half the base rate of the appropriate mode of transportation for each additional client. This applies when the additional client needs a less costly mode of transportation than the first client. For example, the first client needs an ambulance, but the additional client needs a less costly wheelchair van.

(13) When transporting two or more clients at the same time, brokerages shall pay subcontractors only from the first pickup point to the final destination under the following circumstances:

(a) The clients have a single pick up point but different destinations;

(b) The clients have different pick up points but a single destination; or

(c) The clients have different pick up points and different destinations.

(14) Brokerages shall reimburse subcontractors only for actual miles traveled, regardless of the number of clients transported.

(15) A brokerage shall not reimburse a subcontractor if:

(a) A county or city ordinance prohibits any charging for services identified in the medical transportation services administrative rules; or

(b) The subcontractor does not charge the public for such services.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 69-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 29-2014, f. & cert. ef. 5-20-14

410-136-3240
Client Reimbursed Mileage, Meals and Lodging

(1) The brokerage must prior authorize a client's mileage, meals, and lodging to an OHP covered medical service in order for the client to qualify for reimbursement. If the brokerage prior authorized the travel costs, a client may request reimbursement up to 45 days after the travel.

(2) The client must return any documentation the brokerage requires before receiving reimbursement. Documentation required shall include a receipt for lodging.

(3) The brokerage may hold reimbursements under the amount of $10 until the client's reimbursement reaches $10.

(4) Brokerages shall reimburse clients for meals when a client, with or without an attendant, travels a minimum of four hours round-trip out of their local area. The travel, however, must span the following meal times:

(a) For a breakfast allowance, the travel must begin before 6 a.m.;

(b) For a lunch allowance, the travel must span the entire period from 11:30 a.m. through 1:30 p.m.; and

(c) For a dinner allowance, the travel must end after 6:30 p.m.

(5) Brokerages shall reimburse for meals at the Authority's allowable rate.

(6) Brokerages shall not reimburse clients for meals that a hospital or other medical facility provides.

(7) Brokerages shall reimburse clients for lodging when:

(a) A client would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The client's health care provider documents a medical need.

(8) Brokerages shall reimburse for lodging at the Authority's allowable rate or the actual cost of the lodging, whichever is less.

(9) Brokerages shall reimburse for meals or lodging for only one attendant, which may be a parent, to accompany the client if medically necessary but only if:

(a) The client is a minor child and unable to travel without an attendant;

(b) The client's attending physician provides a signed statement indicating the reason an attendant must travel with the client;

(c) The client is mentally or physically unable to reach his or her medical appointment without assistance; or

(d) The client is or would be unable to return home without assistance after the treatment or service.

(10) The brokerage shall not reimburse for the attendant's time or services.

(11) If a client's health care provider admits the client for inpatient care, an attendant is no longer medically necessary because the facility provides all necessary services for the client. Therefore, the attendant is no longer eligible for lodging and travel expenses. The brokerage shall reimburse for meals and lodging for the attendant's transportation home. However, the brokerage may pay for the attendant's meals and lodging if it is more cost effective for the attendant to remain near the client to accompany the client on the return trip as allowed by section (12).

(12) Upon the client's release from inpatient care, if the attendant is medically necessary based on one of the conditions or circumstances listed in section (9), the brokerage shall reimburse for the attendant to return to the inpatient facility to accompany the client on the return trip. This only applies if the brokerage prior authorizes the attendant's travel.

(13) Brokerages shall not reimburse for mileage, meals, and lodging for an attendant visiting an inpatient client unless the physician provides a signed statement of the medical need. This exclusion includes, but is not limited to, parents of minors, breastfeeding mothers, and spouses.

(14) The state shall recover overpayments made to a client. Overpayments occur when the brokerage paid the client:

(a) For mileage, meals, and lodging, and another resource also paid:

(A) The client or;

(B) The ride, meal, or lodging provider directly;

(b) Directly to travel to medical appointments, and the client did not use the money for that purpose, did not attend the appointment, or shared the ride with another client whom the brokerage also directly paid;

(c) For common carrier or public transportation tickets or passes, and the client sold or otherwise transferred the tickets or passes to another person.

(15) If a person or entity other than the client or the minor client's parent or legal guardian provides the ride, the brokerage may reimburse the person or entity that provided the ride. However, the client or the minor client's parent or legal guardian must approve in writing of the reimbursement.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 69-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 29-2014, f. & cert. ef. 5-20-14

410-136-3260
Modifications Based on Client Circumstances

(1) Brokerages may impose reasonable modifications on NEMT services when the client:

(a) Is threatening harm to the driver or others in the vehicle;

(b) Has a health condition that creates health or safety concerns to the driver or others in the vehicle;

(c) Has other behaviors or circumstances that place the driver or others in the vehicle at risk of harm;

(d) Frequently does not show up for scheduled rides;

(e) Frequently cancels the ride on the day of the scheduled ride time;

(f) Has behaviors that cause local medical providers or facilities to refuse to provide further services without imposing modifications; or

(g) Has special needs that require special accommodations.

(2) Reasonable modifications include, but are not limited to requiring the client to:

(a) Use a specific transportation subcontractor;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive themselves or locate someone to drive them and receive mileage reimbursement; or

(e) Confirm the ride with the brokerage on the day of or the day before the scheduled ride.

(3) Before requiring any modifications, the brokerage shall talk with the client about the reason for imposing a modification, explore modifications that are appropriate to the needs of the client and that address the health and safety concerns of the brokerages. The brokerage or client may include the client's worker, PHP or CCO in the discussion. The client may include other individuals in the discussion.

(4) Brokerages may not make a reasonable modification based on the criteria in section (1)(a)-(g) above that results in a denial of NEMT services to a client and must make all reasonable efforts to offer an appropriate alternative to meet the client's needs under the circumstances.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13; DMAP 58-2013(Temp), f. & cert. ef. 10-30-13 thru 4-28-14; DMAP 11-2014, f. & cert. ef. 3-11-14

410-136-3280
Client Rights and Confidentiality

(1) Brokerages shall treat all information gathered on the client as privileged and confidential communications. The brokerage shall apply confidentiality policies to all requests for information from outside sources. Nothing prohibits the disclosure of information in summaries, statistical reports or other forms as long as the document does not identify particular individuals and cannot lead to the identification of individuals. Brokerages and any subcontractors may share information as necessary to serve the client effectively. The brokerage shall not divulge the information without the written consent of the client, the responsible parent of a minor child or the client's legal guardian. The use or disclosure of information is limited to persons directly connected to the administration of NEMT services.

(2) Brokerages or their subcontractors shall comply with OAR 943-014-0300 through 943-014-0320 pertaining to access control if the Authority grants them access to any secure computer system or information asset.

(3) The brokerage shall not deny or allow subcontractors to deny any client NEMT services based on race, color, sex, sexual orientation, religion, national origin, creed, marital status, age, health status or the presence of any sensory, mental or physical disability.

(4) Brokerages must treat clients and require subcontractors to treat clients in accordance with OAR 410-120-1855, Client Rights and Responsibilities.

(5) The brokerages shall have educational materials available for clients on its NEMT services. The Authority must first approve the materials and document the approval in writing.

(6) As required by 42 CFR 431, a brokerage shall follow OAR 410-120-1860 and 410-120-1865 pertaining to contested case hearings when it denies a ride, with the following exceptions:

(a) The brokerage must immediately provide a secondary review by another employee when the initial screener denies a ride; and

(b) The brokerage must mail a notice of action to a client denied a ride within 72 hours of denying a ride.

(7) Upon the Authority's request, brokerages shall provide documentation pertaining to discovery for or investigation of contested case hearings pursuant to OAR 410-120-1360.

(8) Brokerages shall provide documentation pertaining to discovery for or investigation of contested case hearings when the client, the responsible parent of a minor child or the client's legal guardian requests the documentation. The brokerage shall provide the documentation to the client's legal representative upon written consent from the client, the responsible parent of a minor child or the client's legal guardian.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3300
Reports and Documentation

(1) Brokerages shall maintain documentation of rides denied and rides provided to clients. This documentation shall include, but is not limited, to:

(a) The name of the client and the person requesting the ride on behalf of the client, if applicable;

(b) The client's OHP medical care identification number;

(c) The date and time of the request for transportation;

(d) The mode of transport authorized for the client and a justification for authorizing a mode of transport that is not reasonably understandable;

(e) The location for picking-up the client and the destination;

(f) The medical reason for the appointment;

(g) The availability of other transportation resources and the justification for authorizing a ride when the client has other resources;

(h) The subcontractor assigned to give the ride and the date and time the brokerage notified the subcontractor of the assignment;

(i) The name of the employee who approved a ride; and

(j) In the case of a denial of a ride:

(A) The name of the employee who denied a ride;

(B) The name of the employee who performed the secondary review before denying the ride;

(C) The reason for the denial and the applicable Oregon administrative rule that supports the denial;

(D) The date on the notice of action the brokerage mailed to the client;

(E) Documentation on the brokerage's review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and

(F) Notations of oral and written communications with the client.

(2) The brokerage shall retain the documentation on denials of rides for three calendar years, even if the brokerage is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(3) The brokerage shall maintain billing files organized by subcontractor that justify the number of transports and with cross references to actual rides and specific clients.

(4) The brokerages shall report monthly on estimated revenue and expenses that affect the balance of the working capital reserve amount. The report must contain the following costs as they pertain to providing NEMT services:

(a) Sub-totals of administrative expenses, including:

(A) Salaries and wages of the brokerage's employees;

(B) Payroll related expenses for the brokerage's employees;

(C) Other employee related expenses, such as recruitment and advertising;

(D) Computer hardware and software purchased, leased or licensed;

(E) Office supplies such as stamps, paper or printing;

(F) Non-computer related equipment purchased, leased or licensed;

(G) Telephone;

(H) Administrative support and other indirect charges;

(I) Education and training;

(J) Building expenses such as leases, rents, security, janitorial services and repairs that retain the property's operating condition but do not add to the permanent value of the property;

(K) Subcontractor identification and drug testing, such as fingerprinting and drug analysis;

(L) Legal expense not related to the Authority, such as attorney fees; fines or penalties;

(M) Indirect expenses, such as accounting, human resources, risk management or insurance;

(N) Sub-contracts for operations or temporary employees;

(O) Required driver training, if applicable;

(P) The client satisfaction survey, if applicable;

(Q) Software maintenance, if applicable; and

(R) Details of other administrative expenses not specified above.

(b) The number and costs of the following:

(A) Stretcher car rides;

(B) Wheelchair rides;

(C) Ambulatory rides;

(D) Secured transports;

(E) Bus tickets;

(F) Bus passes;

(G) NEMT ambulance transports;

(H) Reimbursements to clients; and

(I) Commercial transports.

(c) The amount of credits to subcontractors.

(d) Information on the brokerage's working capital reserve, including:

(A) The Authority-calculated working capital reserve;

(B) The estimated working capital reserve as of the beginning of the fiscal year;

(C) The estimated working capital reserve as of this report; and

(D) The difference between sub-sections (B) and (C).

(5) The financial reports must show the number of rides that volunteer drivers provide.

(6) Brokerages must submit the financial report required in Section (4) of this rule within 45 days of the end of the reporting month.

(7) Brokerages shall submit a cost allocation plan that includes anticipated expenses, certified by the brokerage's Chief Financial Officer, to the Authority no later than April 1 of each year for the upcoming fiscal year.

(8) The Authority may request, and the brokerage shall provide, other reports or information not specified in sections (1), (3), (4) and (6) of this rule.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3320
Audits

(1) The Authority, the Oregon Secretary of State Audits Division, the Oregon Department of Justice and the federal government may audit the brokerage's or its subcontractor's records at least annually. The audit shall include, but is not limited to, the following areas:

(a) Financial status;

(b) Performance and quality of the service;

(c) Efficiency and effectiveness of the program's operation; and

(d) The relationship between the funds provided by the Authority and the amounts expended by brokerages or billed by subcontractors and that the use of funds is reasonable and necessary to provide quality service.

(2) The Authority, the Oregon Secretary of State Audits Division, the Oregon Department of Justice, and the federal government may review the brokerage's or subcontractor's records whenever necessary to verify delivery of service, financial and operational status, and compliance with Oregon administrative rules or to investigate unresolved questions of fact.

(3) As specified by 42 CFR 455.17, brokerages and subcontractors shall report to the Authority any suspected fraud or abuse of NEMT services. If the suspected fraud or abuse is subcontractor-related, and the brokerage or the Authority determines the subcontractor has committed fraud, the brokerage shall immediately terminate its subcontract.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3340
Brokerage Service Areas

(1) Brokerages enrolled with the Authority shall arrange and pay for NEMT services to all eligible clients in the counties shown in Table 136-3340.

(2) OHP clients shall use only the brokerages available in their county of residence unless they have permission from their local brokerage to use another brokerage.

(3) Nothing in this rule precludes brokerages from coordinating to provide rides to clients in another brokerage if it would be more cost effective or provide better service for the client.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3360
Discontinuation of Brokerage as Enrolled Provider

(1) A brokerage may discontinue being an enrolled provider for NEMT services only with notice to the Authority. The following establishes the requirements for notice:

(a) If the reason is for the brokerage's convenience: The effective date must be at least 90 days after the brokerage sends written notice; and (ii) the effective date must be on the first calendar date of the month ;

(b) The brokerage must provide 45 days advance written notice if the brokerage does not obtain funding, appropriations and other expenditure authorizations from its governing body, federal, state or other sources sufficient to permit the brokerage to satisfy its requirements pursuant to these rules (OAR 410-136-3000 through 410-136-3360);

(c) Immediately upon written notice if the Oregon Legislative Assembly, the federal government or a court interprets, modifies or changes Oregon statutes or federal laws, regulations or guidelines in such a way that the brokerage immediately has no authority to satisfy the requirements of these rules.

(2) The Authority may discontinue allowing a brokerage to provide NEMT services as an enrolled provider only with notice to the brokerage. The following establishes the requirements for notice:

(a) If the reason is for the Authority's convenience:

(A) The effective date must be at least 90 days after the Authority sends written notice; and

(B) the effective date must be on the first calendar date of a month.

(b) The Authority must provide 45 days advance written notice if the Authority does not obtain funding, appropriations and other expenditure authorizations from its governing body, federal, state or other sources sufficient to meet its payment obligations pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transportation.

(c) Immediately upon written notice if the Oregon Legislative Assembly, the federal government or a court interprets, modifies or changes Oregon statutes or federal laws, regulations or guidelines in such a way that the Authority immediately has no authority to provide NEMT services pursuant to these rules.

(d) Immediately upon written notice to the brokerage if the Oregon Legislative Assembly or Emergency Board reduces the Authority's expenditure authorization, resulting in the following:

(A) The Authority cannot meet its payment obligations pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transportation; and

(B) The effective date for the reduction in expenditure authorization is less than 45 days from the date the Legislative Assembly or Emergency Board takes the action.

(e) Immediately upon written notice to the brokerage if a law or regulation requires a brokerage to have any license or certificate, and the license or certificate is denied, revoked, suspended, not renewed or changed in such a way that brokerage no longer meets requirements to deliver NEMT services. The Authority may only exercise this right with respect to the particular service impacted by the loss of the licensure or certification.

(f) Immediately upon written notice to the brokerage, if the Authority determines the brokerage any of its subcontractors have endangered or are endangering the health or safety of a client or others.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

DIVISION 138

TARGETED CASE MANAGEMENT

410-138-0000
Targeted Case Management Definitions

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

(1) Assessment means the act of gathering information and reviewing historical and existing records of an eligible client in a target group to determine the need for medical, educational, social, or other services. To perform a complete assessment, the case man-

ager shall gather information from family members, medical providers, social workers, and educators, if necessary.

(2) Care Plan means a Targeted Case Management (TCM) Care Plan that is a multidisciplinary plan that contains a set of goals and actions required to address the medical, social, educational, and other service needs of the eligible client based on the information collected through an assessment or periodic reassessment.

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

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

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

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

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

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

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

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

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

(12) EI/ECSE TCM Program means a service under the State plan and includes case management services furnished to eligible EI/ECSE preschool children age 0-5 with disabilities, assisting them to gain access to needed medical, social, educational, developmental and other appropriate services (such as housing or transportation) in coordination with their IFSP. EI/ECSE TCM providers must meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for State reimbursement under OAR 581-015-2710 EI/ECSE and must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be sub-contractors with such a contractor. Medicaid reimbursement for EI/ECSE TCM services is available only to eligible clients in the target group and does not restrict an eligible client's free choice of providers.

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

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

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

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

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

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

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

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

(19) Oregon Health Plan (OHP) means the Medicaid program in Oregon that is known as the OHP and governed by a series of laws passed by the Oregon Legislature with the intention of providing universal access to healthcare to Oregonians. OHP is also governed by many federal laws.

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

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

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

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 20-1992, f. & cert. ef. 7-1-92; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-138-0005
Payment for Targeted Case Management Services Eligible for Federal Financial Participation

(1) This rule is to be used in conjunction with Targeted Case Management (TCM) rules 410-138-0000 through 410-138-0009 and 410-138-0390, and the Division of Medical Assistance Programs' (Division) General Rules (chapter 410, division 120).

(2) The TCM services rules are designed to assist the TCM provider organization in matching state and federal funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(3) Payment will be made to the TCM provider enrolled with the Oregon Health Authority (Authority) as a unit of government provider meeting the requirements set forth in the provider enrollment agreement.

(4) Signing the provider enrollment agreement sets forth the relationship between the State of Oregon, the Authority and the TCM provider and constitutes agreement by the TCM provider to comply with all applicable Authority rules, and federal and state laws and regulations.

(5) The TCM provider will bill according to administrative rules in chapter 410, division 138 and the TCM supplemental information. Payments will be made using the Medicaid Management Information System (MMIS) and the TCM provider will retain the full payment for covered services provided. The TCM provider must have a Trading Partner Agreement with the Authority prior to submission of electronic transactions.

(6) TCM authorized under these rules is a cost-sharing (Federal Financial Participation (FFP) matching) program in which the TCM provider as a public entity, unit of government, is responsible for paying the non-federal matching share of the amount of the TCM claims, calculated using the Federal Medical Assistance Percentage (FMAP) rates in effect during the quarter when the TCM claims will be paid:

(a) The TCM provider's non-federal matching share means the public funds share of the Medicaid payment amount. Pursuant to the Social Security Act, 42 CFR 433.51, public funds may be considered as the state's share in claiming federal financial participation, if the public funds meet the following conditions:

(A) The public funds are transferred to the Authority from public entities that are units of government;

(B) The public funds are not federal funds or they are federal funds authorized by federal law to be used to match other federal funds; and

(C) All sources of funds must be allowable under the Social Security Act 42 CFR 433 Subpart B;

(b) The unit of government TCM provider must pay the non-federal matching share to the Authority in accordance with OAR 410-120-0035.

(7) Before the Authority pays for TCM claims, the Authority must receive the corresponding local match payment as described in this rule. Failure to timely pay the non-federal matching funds to the Authority will delay payment and may require the TCM provider to resubmit the claims.

(8) The Authority will not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If the Authority has previously paid the TCM provider for any claim, which CMS disallows, the TCM provider must reimburse the Authority the amount of the claim that the Authority has paid to the TCM provider, less any amount previously paid by the unit of government TCM provider to the Authority for the non-federal match portion for that claim.

(9) Providers can only bill Medicaid for allowable activities in the TCM program, that assist individuals eligible under the Medicaid State plan to gain access to needed medical, social, educational, and other services. One or more of the following allowable activities must occur before billing:

(a) Assessment;

(b) Development of a care plan;

(c) Referral (including follow up); and

(d) Monitoring (including follow up).

(10) TCM claims must not duplicate payments made to:

(a) Public agencies or private entities for any other case management activities or direct services provided under the State Plan or the Oregon Health Plan (OHP), through fee for service, managed care, or other contractual arrangement, that meet the same need for the same client at the same point in time;

(b) A TCM provider by program authorities under different funding authority than the Oregon Health Plan, including but not limited to other public health funding;

(c) A TCM provider for administrative expenditures reimbursed under agreement with the Authority or any other program or funding source.

(11) Medicaid is only liable for the cost of otherwise allowable case management services if there are no other third parties liable to pay. However, while schools are legally liable to provide IDEA-related health services at no cost to eligible children, Medicaid reimbursement is available for these services because section 1903(c) of the Act requires Medicaid to be primary to the U.S. Department of Education for payment for covered Medicaid services furnished to a child with a disability. These services may include health services included in a child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) under the IDEA. Payment for those services that are included in the IEP or IFSP would not be available when those services are not covered Medicaid services.

(12) The Authority's acceptance of cost data provided by provider organizations for the purpose of establishing rates paid for TCM services does not imply or validate the accuracy of the cost data provided.

(13) Reimbursement is subject to all rules and laws pertaining to federal financial participation.

Stat. Auth.: ORS 409.050 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11

410-138-0007
Targeted Case Management — Covered Services

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

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

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

(A) Taking client history;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Monitoring activities may include contacts with:

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

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

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

(a) The name of the individual;

(b) The dates of the case management services;

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

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

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

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

(g) A timeline for obtaining needed services;

(h) A timeline for reevaluation of the plan.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-138-0009

Targeted Case Management — Services Not Covered

Targeted Case Management (TCM) services do not cover:

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

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

(3) Escorting an eligible client to a service;

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

(5) Contacts with individuals who are not categorically eligible for Medicaid or who are categorically eligible for Medicaid but not included in the eligible target population when those contacts relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care;

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

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

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 43-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-138-0020

Targeted Case Management Programs

(1) This rule is in effect for services rendered retroactive to July 1, 2009, except for the Asthma/Healthy Homes Program, which is retroactive to July 1, 2010.

(2) TCM programs include the following:

(a) Asthma/Healthy Homes;

(b) Babies First/CaCoon;

(c) Early Intervention/Early Childhood Special Education (EI/ECSE);

(d) Human Immunodeficiency Virus (HIV);

(e) Substance Abusing Pregnant Women and Substance Abusing Parents with Children Under Age 18; and

(f) Federally Recognized Tribal Governments.

(3) The TCM Programs are medical assistance programs operated by public health authorities, unit of government providers, or Federally Recognized Tribal Governments in Oregon who are enrolled as TCM providers with the Authority. Participation by providers is voluntary and subject to approval by the Authority and the Centers for Medicare and Medicaid Services (CMS). With the exception of the Federally Recognized Tribal Governments TCM programs, the TCM programs authorized under these rules are cost-sharing (Federal Financial Participation (FFP) matching) programs in which the TCM provider as a public entity, unit of government, must pay the non-federal matching share of the amount of the TCM claims. (See Oregon Administrative Rule (OAR) 410-138-0005, Payment for Targeted Case Management Services Eligible for Federal Financial Participation.)

(4) Federally Recognized Tribal Governments TCM services authorized under these rules provided to Tribal members at an Indian Health Service facility operated by the Indian Health Service, by an Indian tribe or tribal organization are reimbursed at 100 percent by Title XIX (Medicaid) and Title XXI Children's Health Insurance Program (CHIP).

(5) The Authority may not authorize services or reimbursement for direct care as part of any targeted case management activity. The following are targeted case management programs and services:

(a) The TCM Asthma/Healthy Homes program improves access to needed services for eligible clients with poorly controlled asthma or a history of environmentally induced respiratory distress. The TCM Asthma/Health Homes program services include management of medical and non-medical services, which address medical, social, nutritional, educational, housing, environmental, and other needs. Home visits constitute an integral part of the delivery of TCM services, provided by a TCM Asthma/Healthy Homes case manager consistent with these rules;

(b) The TCM Babies First program improves access to needed medical and non-medical services, which address medical, social, educational, and other services for at risk infants and children through four years of age. The TCM CaCoon program improves access to needed medical, psychosocial, educational, and other services for infants, children, and youth through age twenty with specific diagnoses or very high risk factors. These clients are categorical eligibles covered by Medicaid and are at risk of poor health outcomes as outlined in OAR 410-138-0040, (Risk Criteria – Babies First/CaCoon). Home visits constitute a significant part of the delivery of targeted case management services, provided by a Babies First/CaCoon case manager consistent with these rules;

(c) The TCM Early Intervention/Early Childhood Special Education (EI/ECSE) program is a medical assistance program provided by enrolled EI/ECSE providers that meet the criteria approved by the State Superintendent of Public Instruction to administer the provision of EI and ECSE. The TCM EI/ECSE program provides services to categorically eligible children with dis-

abilities, receiving EI/ECSE services from birth until they are eligible for public school. These TCM services are available on a fee-for-service basis, within the limitations established by the Medical Assistance Program and chapter 410, division 138 rules, consistent with the requirements of the Individuals with Disabilities Education Act (IDEA). This qualifies such programs for state reimbursement under EI/ECSE programs OAR 581-015-2700 through 581-015-2910. An enrolled TCM EI/ECSE provider must be a contractor/agency designated by the Oregon Department of Education (ODE) to administer the provision of EI and ECSE within selected service areas or be a sub-contractor with such a contractor. TCM EI/ECSE program services include management of medical and non-medical services, to assist children with disabilities in gaining access to needed medical, social, educational, developmental and other appropriate services in coordination with a child's Individualized Family Service Plan (IFSP) developed and implemented pursuant to IDEA and based on information collected through the TCM assessment or periodic reassessment process;

(d) The TCM HIV program improves access to needed medical and non-medical services, which address physical, psychosocial, nutritional, educational, and other services for Medicaid categorically eligible clients with symptomatic or asymptomatic HIV disease. Home visits constitute an integral part of the delivery of targeted case management services, provided by a TCM HIV case manager consistent with these rules. Without targeted case management services, an eligible client's ability to remain safely in their home may be at risk;

(e) The TCM Substance Abusing Pregnant Women and Substance Abusing Parents with Children under age 18 program improves access to needed medical and non-medical services, which address physical, psychosocial, educational, nutritional and other services to Medicaid categorically eligible pregnant women or custodial parents with children under the age of 18 who have alcohol and/or drug addiction issues. Targeted clients are those who are not yet ready to actively engage in addiction treatment services. TCM services are provided by an enrolled TCM Substance Abusing Pregnant Women and Substance Abusing Parents with Children under age 18 provider consistent with these rules. Participation by all TCM providers is voluntary and subject to approval by the Division CMS;

(f) The TCM Federally Recognized Tribal Government program improves access to needed medical and non-medical services, which address health, psychosocial, economic, educational, nutritional and other services for Medicaid categorically eligible tribal members served by tribal programs, provided by an enrolled tribal TCM provider consistent with these rules. The target group includes those members receiving elder care; individuals with diabetes; children and adults with health and social service care needs, and pregnant women.

(6) Refer to the State Plan Amendments for participating counties for each TCM program. The State Plan Amendments are located at http://www.oregon.gov/oha/healthplan/Pages/stateplan.aspx.

(7) Provision of any TCM Program services may not restrict an eligible client's choice of providers, in accordance with 42 CFR 441.18 (a):

(a) Eligible clients must have free choice of available TCM Program service providers or other TCM service providers available to the eligible client, subject to the Social Security Act, 42 USC 1396n and 42 CFR 441.18(b);

(b) Eligible clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist: HR 20-1992, f. & cert. ef. 7-1-92; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04; DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 43-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11

410-138-0040
Targeted Case Management Babies First/CaCoon Program Risk Criteria

(1) This rule is in effect for services rendered retroactive to July 1, 2009.

(2) This rule sets the medical risk factors for the TCM Babies First programs for infants and preschool children (birth through age four):

(a) Drug exposed infant;
(b) Alcohol exposed infant;
(c) Infant Human Immunodeficiency Virus (HIV) Positive;
(d) Maternal Phenylketonuria (PKU) or HIV Positive;
(e) Intracranial hemorrhage grade I or II;
(f) Seizures or maternal history of seizures;
(g) Perinatal asphyxia;
(h) Small for gestational age;
(i) Very low birth weight (1500 grams or less);
(j) Mechanical ventilation for 72 hours or more prior to discharge;
(k) Neonatal hyperbilirubinemia;
(l) Congenital infection (e.g., Toxoplasmosis, Rubella, Cytomegalovirus, Herpes Simplex Virus, Other Infections);
(m) Central Nervous System (CNS) infection;
(n) Head trauma or near drowning;
(o) Failure to grow;
(p) Suspect vision impairment;
(q) Family history of childhood onset hearing loss;
(r) Prematurity;
(s) Lead exposure;
(t) Suspect hearing loss;

(3) This rule sets the social risk factors for the TCM Babies First program from birth through 4 years:

(a) Maternal age 16 years or less;
(b) Parents with developmental disabilities or intellectual impairment;
(c) Parental alcohol or substance abuse;
(d) At-risk caregiver;
(e) Concern of parent/provider;
(f) Parent with limited financial resources;
(g) Parent with history of mental illness;
(h) Parent with child welfare history;
(i) Parent with domestic violence history;
(j) Parent with sensory impairment or physical disability;
(k) Other evidence-based social risk factors.

(4) The rule sets the very high risk medical factors for the TCM CaCoon program for birth through age 20:

(a) Intraventricular hemorrhage (grade III, IV);
(b) Periventricular leukomalacia (PVL) or chronic subdurals;
(c) Perinatal asphyxia and seizures;
(d) Seizure disorder;
(e) Oral-motor dysfunction requiring specialized feeding program (including gastrostomy);
(f) Chronic lung disorder;
(g) Suspect neuromuscular disorder.

(5) This rule sets the diagnosis for the TCM CaCoon progam from birth through 20 years:

(a) Heart disease;
(b) Chronic orthopedic disorders;
(c) Neuromotor disorders including cerebral palsy and brachial nerve palsy;
(d) Cleft lip and palate and other congenital defects of the head and face;
(e) Genetic disorders, e.g., cystic fibrosis, neurofibromatosis;
(f) Multiple minor physical anomalies;
(g) Metabolic disorders, e.g., PKU;
(h) Spina bifida;
(i) Hydrocephalus or persistent ventriculomegaly;
(j) Microcephaly and other congenital or acquired defects of the CNS;
(k) Hemophilia;
(l) Organic speech disorders;

(m) Hearing loss;
(n) Traumatic brain injury;
(o) Fetal alcohol spectrum disorder;
(p) Autism, autism spectrum disorder;
(q) Behavioral or metal health disorder with developmental delay;
(r) Chromosome disorders;
(s) Positive newborn blood screen;
(t) HIV, seroconversion;
(u) Visual Impairment;
(v) Developmental delay; or
(w) Other chronic conditions not listed.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 20-1992, f. & cert. ef. 7-1-92; HR 37-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11

410-138-0060
Targeted Case Management Program — Provider Requirements

(1) This rule is in effect for services rendered retroactive to July 1, 2009, except for the TCM Asthma/Heathy Homes Program, that is retroactive to July 1, 2010.

(2) TCM Babies First/CaCoon providers must be public health authorities with the ability to link with the Title V Statewide Maternal and Child Health Data System or provide another statewide-computerized tracking and monitoring system.

(3) TCM Asthma/Healthy Homes, Early Intervention/Early Childhood Special Education (EI/ECSE), and Human Immunodeficiency Virus (HIV) provider organizations must be unit of government providers. TCM EI/ECSE providers may also be a subcontractor of a government entity.

(4) TCM Substance Abusing Pregnant Women and Substance Abusing Parents with Children Under Age 18 provider organizations must be locally based agencies.

(5) TCM Federally Recognized Tribal Governments providers must be Indian Health Services/638 facilities.

(6) All providers must demonstrate the ability to provide all core elements of case management services including:

(a) Comprehensive assessment, which may include triage and environmental assessment, of client needs. All providers for the TCM BabiesFirst/CaCoon program must provide comprehensive nursing assessment of client needs;

(b) Reassessment of the client's status and needs annually or more frequently with a significant change in client's condition;

(c) Development and periodic revision of a comprehensive care and service plan;

(d) Referral and linking/coordination of services;

(e) Ongoing monitoring and follow-up of referral and related services;

(f) A financial management capacity and system that provides documentation of services and costs, and provides computerized tracking and monitoring to assure adequate follow-up and avoid duplication.

(7) Except for Federally Recognized Tribal Governments providers, the TCM provider shall provide the non-federal matching share from public funds in compliance with OAR 410-138-0005.

(8) If the provider is a subcontractor of a governmental entity, the governmental entity shall make the non-federal matching share with public fund payments in compliance with OAR 410-138-0005.

(9) All program providers must demonstrate the following TCM experience and capacity:

(a) Understanding and knowledge of local and state resources and services available to the target population;

(b) Demonstrated case management experience in coordinating and linking community resources as required by the target population;

(c) Demonstrated and documented experience providing services for the target population;

(d) An administrative capacity to ensure quality of services in accordance with state and federal requirements;

(e) A financial management capacity and system that provides documentation of services and costs;

(f) Capacity to document and maintain client case records in accordance with state and federal requirements, including requirement for recordkeeping on OAR 410-138-0007 and 410-120-1360; confidentiality requirements in ORS 192.518–192.524,179.505 and 411.320; and HIPAA Privacy requirements applicable to case management services;

(g) A sufficient number of staff to meet the case management service needs of the target population;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program; and

(i) Enrolled as a TCM provider with the Authority and meeting the requirements set forth in the provider enrollment agreement.

(10) TCM Asthma/Healthy Homes Program case managers must possess the following additional qualifications:

(a) A current active Oregon registered nurse (RN) license; or

(b) A registered environmental health specialist; or

(c) An asthma educator certified by the National Asthma Education and Prevention Program; or

(d) A community health worker certified by the Standford Chronic Disease Self-Management Program; or

(e) A case manager working under the supervision of a licensed registered nurse or a registered environmental specialist.

(11) The TCM case managers for the Babies First/CaCoon program must be:

(a) An employee of a local county health department, or other public or private agency contracted by a local county health department;

(b) A licensed registered nurse with one year of experience in community health, public health, or child health nursing, or be a community health worker, family advocate, or promotora working under the direction of the above; and

(c) Working under the policies, procedures, and protocols of the State Title V Maternal and Child Health Program and Medicaid.

(12) Additional qualifications for TCM EI/ECSE provider organizations include the following:

(a) TCM EI/ECSE providers must meet the criteria to administer the provision of EI and ECSE within selected service areas designated by the Oregon Department of Education, qualifying such programs for state reimbursement under EI/ECSE Programs (OAR 581-015-2700 through 581-015-2910);

(b) Must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or sub-contractors with such a contractor, and must meet the following qualifications;

(c) Demonstrated case management experience in conjunction with service coordination under OAR 581-015-2840 specified on a child's Individualized Family Service Plan (IFSP) for coordinating and linking such community resources as required by the target population; and

(d) Capacity to document and maintain individual case records in accordance with confidentiality requirements in the Individuals with Disabilities Education Act, ORS 192.518–192.524, 179.505, and 411.320 and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable.

(13) Qualifications for TCM EI/ECSE Supervisors of EI/ECSE service coordinators of targeted case management services must:

(a) Possess a minimum of a master's degree in early childhood special education or a related field, and have three years of experience with infants, toddlers, young children, and families;

(b) Hold a Teacher Standard and Practices Commission (TSPC) administrative endorsement or within 12 months of employment, complete authorization as an Early Childhood Supervisor under OAR 581-015-2910; and

(c) Have a professional development plan based on the content of the EI/ECSE competencies.

(14) Qualifications of EI and ECSE Specialists performing case management/Targeted Case Management services must:

(a) Possess a minimum of a baccalaureate degree in early childhood, special education or a related field;

(b) Have a professional development plan based on the content of the EI/ECSE competencies; and

(c) Hold one of the following credentials:

(A) TSPC licensure or endorsement in EI/ECSE;

(B) TSPC licensure or endorsement in related field; or

(C) Within 12 months of employment, authorization as an Early Childhood Specialist under OAR 581-15-2905.

(15) Qualifications of EI and ECSE Related services personnel must possess a minimum of a baccalaureate degree and a valid license necessary to practice in Oregon. Related services personnel who also provide service coordination as outlined in OAR 581-015-2840 must have:

(a) TSPC licensure in their area of discipline; or

(b) State licensure in their area of discipline; and

(c) A professional development plan based on the content of the EI/ECSE competencies;

(d) The Individuals with Disabilities Education Act (IDEA);

(e) The nature and scope of services available under the Oregon EI/ECSE programs.

(16) In addition to the above, all must be employees of the Oregon Department of Education (ODE), its contractors or subcontractors; and must have demonstrated knowledge and understanding about:

(a) The Oregon Department of Education EI/ECSE programs OAR 581-015-2700 through 581-015-2910, including these rules and the applicable State Medicaid Plan Amendment;

(b) Case Management experience in conjunction with service coordination under OAR 581-015-2840 for coordinating and linking such community resources as required by the target population to assist clients in gaining access to needed medical, social, educational, developmental and other appropriate services in coordination with the eligible child's IFSP;

(c) The Individuals with Disabilities Education Act (IDEA);

(d) The nature and scope of services available under the Oregon EI/ECSE program, including the TCM services, and the system of payments for services and other pertinent information.

(17) TCM HIV providers must have the financial management capacity and system that provides documentation of services and costs and is able to generate quarterly service utilization reports that can be used to monitor services rendered against claims submitted and paid. The service utilization reporting requirements are as follows:

(a) Report on the number of unduplicated clients receiving services during the reporting period;

(b) Report on the number of full time equivalent (FTE) case managers providing services during the reporting period; and

(c) Report on the number of distinct case management activities performed during the reporting period (Triage Assessments, Comprehensive Assessments, Re-Assessments, Care Plan Development, Referral and Related Services, and Monitoring Follow-Up) along with the total number of 15-minute increments associated with each activity category.

(18) TCM HIV case managers must possess the following education and qualifications:

(a) A current active Oregon registered nurse (RN) license or Bachelor of Social Work, or other related health or human services degree from an accredited college or university; and

(b) Documented evidence of completing the Authority's HIV Care and Treatment designated HIV Case Manager training, and must participate in the Authority's on-going training for HIV case managers. The training must either be provided by the Authority, or be approved by the Authority and provided by the TCM provider organization.

(19) The TCM Substance Abusing Pregnant Women and Substance Abusing Parents with Children Under Age 18 case manager must;

(a) Possess a combination of education and experience necessary to support case planning and monitoring. The case manager must be able to demonstrate an understanding of issues relating to substance abuse and community supports;

(b) Demonstrate continuous sobriety under a nonresidential or independent living condition for the immediate past two years;

(c) Meet at least one of the following qualifications:

(A) Be a licensed Medical Provider, Qualified Mental Health Professional, or Qualified Mental Health Associate; or

(B) Possess certification as an Alcohol and Drug Counselor (CADC) level I, II, or III; or

(C) Complete a Peer Services Training Program following a curriculum approved by the Authority's Addictions and Mental Health Division and be:

(i) A self-identified person currently or formerly receiving mental health services; or

(ii) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or

(iii) A family member of an individual who is a current or former recipient of addictions or mental health services;

(d) Work under the supervision of a Clinical Supervisor. The Clinical Supervisor must:

(A) Meet the requirements in Oregon administrative rule for alcohol and other drug treatment programs;

(B) Be certified or licensed by a health or allied provider agency to provide addiction treatment; and

(C) Possess one of the following qualifications:

(i) Five years of paid full-time experience in the field of alcohol and other drug counseling; or

(ii) A Bachelor's degree and four years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience; or

(iii) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience;

(e) Satisfy continuing education requirements as specified by the agency providing clinical supervision specific to alcohol and other drug treatment; and

(f) Work in compliance with Medicaid policies, procedures, and protocols.

(20) A Federally Recognized Tribal Governments TCM provider must be an organization certified as meeting the following criteria:

(a) A minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including: assessment, case planning, case plan implementation, case plan coordination, and case plan reassessment;

(b) A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population;

(c) Administrative capacity to ensure quality of services in accordance with tribal, state, and federal requirements; and

(d) Evidence that the TCM organization is a federally recognized tribe located in the State of Oregon.

(21) The following are qualifications of Tribal Case Managers within provider organizations:

(a) Completion of training in a case management curriculum;

(b) Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, and issues around aging;

(c) Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication;

(d) Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources;

(e) Knowledge and understanding of these rules and the applicable State Medicaid Plan Amendment.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 409.010, 409.110 & 414.065

Hist.: HR 20-1992, f. & cert. ef. 7-1-92; HR 37-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11

410-138-0080
Targeted Case Management Program Billing Policy

(1) This rule is in effect for services rendered retroactive to July 1, 2009, except for the Targeted Case Management (TCM) Asthma Healthy/Homes Program, which is effective July 1, 2010.

(2) Reimbursement is based on cost-based rate methodology and subject to all rules and laws pertaining to federal financial participation. The Authority's acceptance of cost data provided by provider organizations for the purpose of establishing rates paid for TCM services does not imply or validate the accuracy of the cost data provided.

(3) The cost-based rate will be derived by considering the following expenditures directly attributable to TCM staff:

(a) TCM staff salaries and other personnel expenses;

(b) Supervisory salaries and other personnel expenses;

(c) Administrative support salaries and other personnel expenses;

(d) Services and supply expenses;

(e) Various overhead expenditures, if not already considered in the indirect rate.

(4) The Division will accept a claim up to 12 months from the date of service. See provider rules 943-120-0340, (Claim and PHP Encounter Submission), and OAR 410-120-1300, (Timely Submission of Claims).

(5) Providers shall only bill for allowable activities in the TCM programs that assist individuals eligible under the Medicaid State Plan to gain access to needed medical, social, educational, housing, environmental, and other services.

(6) The Division may not allow duplicate payments to other public agencies or private entities under other program authorities for TCM services under the eligible client's care plan. Medical services must be provided and billed separately from case management services. The Authority shall recover duplicate payments.

(7) The Division may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, federal or state funded parole and probation, or juvenile justice programs. These services must be billed separately.

(8) In general, the Medicaid program is the payer of last resort and a provider is required to bill other resources before submitting the claim to Medicaid. This requirement means that other payment sources, including other federal or state funding sources, must be used before the Authority may be billed for covered TCM services. However, the following exceptions apply to the requirement to pursue third party resources:

(a) For TCM Early Intervention /Early Childhood School Education (EI/ECSE) services provided under the Individuals with Disabilities Education Act (IDEA), 1903(c) of the Social Security Act and 34CFR300.154 Methods of Ensuring Services make Medicaid/Children's Health Insurance Program (CHIP) primary payer before Oregon Department of Education (ODE) or the Educational Agency (EA), for a covered TCM EI/ECSE service provided to a Medicaid-eligible child receiving Service Coordination/Case Management pursuant to the Medicaid-eligible child's Individualized Family Service Plan (IFSP), the services are documented as required under the TCM rules, and subject to the applicable reimbursement rate;

(b) If TCM EI/ECSE services are provided under Title V of the Social Security Act Maternal and Child Health Services Block Grant, Medicaid-covered TCM services provided by a Title V grantee are paid by Medicaid before the Title V funds;

(c) CMS recognizes that while public education agencies are required to provide IDEA services at no cost to eligible children, Medicaid reimbursement is available for these services because section 1903 (c) of the Social Security Act requires Medicaid to be primary to the U.S. Department of Education for payment of covered services that may also be considered special education, related services, or early intervention services, or services provided under IDEA.

(9) Any place of service is valid.

(10) Prior authorization is not required.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 20-1992, f. & cert. ef. 7-1-92; HR 37-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 28-2008(Temp), f. 6-30-08, cert. ef. 7-1-08 thru 12-28-08; DMAP 32-2008(Temp), f. & cert. ef. 10-2-08 thru 3-27-09; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11

410-138-0390
Targeted Case Management Retroactive Payments

(1) Providers may submit claims retroactively for services provided to the targeted populations described in OAR 410-138-0020(2)(a)–(f) if the claims meet the following criteria:

(a) Services were provided less than 12 months prior to the date of first claim submission, and were provided on or after the date indicated in the rule listed above, and were allowable services in accordance with OAR 410-138-0007;

(b) The maximum number of units billed does not exceed the maximum allowed under each Targeted Case Management (TCM) program.

(c) The case manager was appropriately licensed or certified, and met all current requirements for case managers at the time the service was provided, as described in the provider requirements rule OAR 410-138-0060 appropriate for the TCM program:

(d) Documentation regarding provider qualifications and the services that the provider retroactively claims must have been available at the time the services were performed;

(2) The Division may not allow duplicate payments to be made to the same or different providers for the same service for the same client, nor will payment be allowed for services for which third parties are liable to pay (see also OAR 410-138-0005).

(3) Reimbursement is subject to all rules and laws pertaining to federal financial participation.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 34-2009(Temp), f. & cert. ef. 11-16-09 thru 5-1-10; DMAP 43-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 48-2012(Temp), f. & cert. ef. 10-31-12 thru 4-28-13; DMAP 21-2013, f. & cert. ef. 4-26-13

410-138-0420
Targeted Case Management Asthma/Healthy Home — Risk Criteria

(1) This administrative rule will be implemented contingent on Centers for Medicare and Medicaid (CMS) approval for the Targeted Case Management (TCM) Asthma/Healthy Home Program. This rule is to be used in conjunction with the Division of Medical Assistance Programs' (Division) General Rules (chapter 410. division 120) and other Targeted Case Management Program rules 410-138-0000 through 410-138-0009.

(2) The target group is Medicaid eligible children with poorly controlled asthma or a history of environmentally induced respiratory distress, which can result in a life threatening asthma exacerbation or exacerbation of respiratory distress.

(3) Risk factors for the target group could include, but are not limited to:

(a) Unscheduled visits for emergency or urgent care;

(b) One or more in-patient stays;

(c) History of intubation or Intensive Care Unit care;

(d) A medication ratio of control medications to rescue medications of less than or equal to .33 indicating less than desirable control of asthma;

(e) Environmental or psychosocial concerns raised by medical home;

(f) School day loss greater than two school days per year;

(g) Inability to participate in sports or other activities due to asthma;

(h) Homelessness;

(i) Inadequate housing, heating or sanitation.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 22-2010, f. 6-30-10, cert. ef. 7-1-10; DMAP 41-2010, f. 12-28-10, cert. ef. 1-1-11

DIVISION 140

VISUAL SERVICES

410-140-0020
Service Delivery

(1) The Division enrolls the following as providers of vision services:

(a) An individual licensed by the relevant state licensing authority to practice optometry; and

(b) A licensed ophthalmologist; and

(c) An optician as defined in ORS 683.510-683.530;

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

(a) Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

(A) Payment for all vision services provided to PHP and CCO members by ophthalmologists, optometrists, and opticians is a matter between the provider and the PHP or CCO;

(B) Providers shall comply with PHP and CCO policies, including PA requirements, for reimbursement. Providers shall inform PHPs and CCOs of the last date of service when inquiring on service limitations. Failure to follow PHP and CCO rules may result in the denial of payment; and

(C) If the provider has been denied payment for failure to follow the rules established by the PHP or CCO, neither the Division, the PHP or CCO, nor the PHP or CCO member are responsible for payment; and

(D) If the PHP or CCO uses the Division's visual materials contractor or another visual materials contractor for visual materials and supplies, all issues shall be resolved between the PHP or CCO and the contractor;

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

(A) FFS clients are not enrolled in a PHP or CCO and may receive vision services from any Division-enrolled provider that accepts FFS clients subject to limitations and restrictions in the visual services program rules; and

(B) All claims shall be billed directly to the Division.

(3) The provider shall verify whether a PHP, CCO, or the Division is responsible for reimbursement.

(4) If a client receives services under section (2)(b) of this rule:

(a) The Division may require a PA for certain covered services or items before the service may be provided and before payment is made; and

(b) Providers needing materials and supplies shall order those directly from SWEEP Optical, except when the OHP client has primary Medicare coverage.

(5) Most OHP clients must pay a co-payment for some services. (See OAR 410-120-1230, Client Co-payment, and Table 120-1230-1 outlining details including client and service exemptions).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065, 414.631 & 414.651
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0160; HR 37-1992, f. & cert. ef. 12-18-92; HR 15-1994, f. & cert. ef. 3-1-94; HR 38-1994, f. 12-30-94, cert. ef. 1-1-95; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0040
Prior Authorization

(1) Prior Authorization (PA) is defined in OAR 410-120-0000. Providers must obtain a PA from the:

(a) Enrolled member's Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO); and

(b) The Division for clients who receive services on a fee-for-services basis and are not enrolled with a PHP or CCO.

(2) A PA does not guarantee eligibility or reimbursement. Providers shall verify the client's eligibility on the date of service and whether a PHP, CCO, or the Division is responsible for reimbursement.

(3) A PA is not required for clients with both Medicare and Division coverage when the service or item is covered by Medicare.

(4) Provider's shall determine if a PA is required and comply with all PA requirements outlined in these rules.

(5) Provider's shall ensure:

(a) That all PA requests are completed and submitted correctly. The Division does not accept PA requests via the phone. See Visual Services Supplemental Information Guide found at www.oregon.gov/OHA/healthplan/pages/vision.aspx;

(b) PA requests shall include:

(A) A statement of medical appropriateness showing the need for the item or service and why other options are inappropriate;

(B) Diopter information and appropriate International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis codes;

(C) All relevant documentation that is needed for Division staff to make a determination for authorization of payment, including clinical data or evidence, medical history, any plan of treatment, or progress notes;

(c) The service is adequately documented. (See OAR 410-120-1360 Requirements for Financial, Clinical and Other Records.) Providers must maintain documentation to adequately determine the type, medical appropriateness, or quantity of services provided;

(d) The services or items provided are consistent with the information submitted when authorization was requested;

(e) The services billed are consistent with the services provided; and

(f) The services are provided within the timeframe specified on the PA document.

(6) Providers shall comply with the Division's PA requirements or other policies necessary for reimbursement before providing services to any OHP client who is not enrolled in a PHP. Services or items denied due to provider error (e.g., required documentation not submitted, PA not obtained, etc.) may not be billed to the client.

(7) The following vision services require PA:

(a) Contact lenses for adults (age 21 and older) and excludes a primary keratoconus diagnosis, which is exempt from the PA requirement. (See OAR 410-140-0160 Contact Lens Services for service and supply coverage and limitations);

(b) Vision therapy greater than six sessions. Six sessions are allowed per calendar year without PA. (See OAR 410-140-0280 Vision Therapy Services); and

(c) Specific vision materials (See OAR 410-140-0260 Purchase of Ophthalmic Materials for more information.):

(A) Frames not included in the Division's contract with contractor, SWEEP Optical; and

(B) Specialty lenses or lenses considered as "not otherwise classified" by Health Care Common Procedure Coding System (HCPCS);

(d) An unlisted ophthalmological service or procedure, or "By Report" (BR) procedures.

(8) The Division shall send notice of all approved PA requests for vision materials to the Division's contractor, SWEEP Optical; who forwards a copy of the PA approval and confirmation number to the requesting provider. (See OAR 410-140-0260 Purchase of Ophthalmic Materials.)

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 343.146, 414.065, 683.010 & 743A.250
Hist.: AFS 9-1978, f. & ef. 2-1-78; AFS 2-1979, f. 2-6-79, ef. 3-1-79; AFS 2-1982(Temp), f. 1-20-82, ef. 2-1-82; AFS 45-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 55-1983, f. 11-15-83, ef. 12-1-83; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 24-1984(Temp), f. & ef. 5-29-84; AFS 31-1984(Temp), f. 7-26-84, ef. 8-1-84; AFS 5-1985, f. & ef. 1-25-85; AFS 22-1987, f. 5-29-87, ef. 7-1-87; AFS 75-1989, f. & cert. ef. 12-15-89, Renumbered from 461-018-

0010; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0170; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; DMAP 21-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0050
Eligibility and Benefit Coverage

(1) Providers shall verify that an individual is an OHP client and eligible for benefits prior to providing services to ensure reimbursement for services provided. If the provider fails to confirm eligibility on the date of service, the provider may not be reimbursed. Providers must verify the client's eligibility including:

(a) That the individual receiving vision services is eligible on the date of service for the service provided;

(b) Whether an OHP client receives services on a fee-for-service basis or is enrolled with a PHP or CCO;

(c) That the service is covered under the client's OHP Benefit Package; and

(d) Whether the service is covered by a third party resource (TPR).

(2) The Division OHP vision benefit packages:

(a) For non-pregnant adults (age 21 and older):

(A) Visual services and materials to diagnose and correct disorders of refraction and accommodation are covered only when the client has a covered medical diagnosis or following cataract surgery or a corneal lens transplant as described in OAR 410-140-0140;

(B) Orthoptic and pleoptic training (vision therapy) is not covered; and

(C) Other visual services are covered with limitations as described in this rule.

(b) For pregnant adult women (age 21 and older):

(A) Orthoptic and pleoptic training (vision therapy) is not covered; and

(B) Other visual services are covered with limitations as described in these rules;

(c) For children (birth through age 20): Visual services are covered as described in this rule and without limitation when documentation in the clinical record justifies the medical need.

(3) Providers shall maintain accurate and complete client records, which includes documenting the quantity of services provided, as outlined in OAR 410-120-1360 (Requirements for Financial, Clinical and Other Records).

(4) The provider shall inform an OHP client when:

(a) Vision service or materials are not covered under the clients benefit package;

(b) Service limitation has been met and the benefit is no longer covered.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 11-2002, f. & cert. ef. 4-1-02; DMAP 21-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 43-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0080
Medicare/Medicaid Assistance Program Claims

(1) When a client has both Medicare and coverage through the Division, optometrists and ophthalmologists shall bill Medicare first for Medicare covered services.

(2) When an OHP client receives services on a fee-for-service basis under the Division's rules and has Medicare coverage:

(a) A provider may use any visual materials supplier to order visual materials; and

(b) The Division does not require PA for Medicare-covered services.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.025, 414.065, 414.075
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0190; HR 37-1992, f. & cert. ef. 12-18-92; HR 15-1994, f. & cert. ef. 3-1-94; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04; OMAP 22-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 33-2011, f. 12-5-11, cert. ef. 12-6-11; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0120
ICD-10-CM Diagnosis, CPT/HCPCs Procedure Codes, and Modifiers

(1) Providers shall use an International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis code on all claims.

(2) Providers shall provide the client's diagnosis to ancillary service providers (e.g., SWEEP Optical Laboratories) when prescribing services, equipment, and supplies.

(3) Providers shall use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Providers shall accurately code claims using the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the service was provided:

(a) Providers may not bill CPT or HCPCS procedure codes for separate procedures when a single CPT or HCPCS code includes all services provided. Providers shall comply with published coding guidelines;

(b) Intermediate and comprehensive ophthalmological services as described under the ophthalmology section of the CPT codebook shall be billed using codes included under this section and not those included under the Evaluation and Management section;

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider shall use the code for "unlisted services."

(4) The Division recognizes HIPAA compliant modifiers in coding.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0210; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 44-2001, f. 9-24-01 cert. ef. 10-1-01; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 11-2002, f. & cert. ef. 4-1-02; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0140
Vision Services Coverage and Limitations

(1) Providers shall comply with the following rules in addition to the Visual Services program rules to determine service coverage and limitations for OHP clients according to their benefit packages:

(a) General Rules (OAR chapter 410, division 120);

(b) OHP administrative rules (410-141-0480, 410-141-0500, and 410-141-0520);

(c) Health Evidence Review Commission's (HERC) Prioritized List of Health Services (List) (OAR 410-141-0520); and

(d) Referenced guideline notes (The date of service determines the correct version of the administrative rules and HERC List to determine coverage.); and

(e) The Authority's general rules related to provider enrollment and claiming (OAR 943-120-0300 through 1505).

(2) The Division covers ocular prosthesis (e.g., artificial eye) and related services. See OAR 410-122-0640 Eye Prostheses for service coverage and limitations.

(3) The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the HERC List. Once a diagnosis is established for a service, treatment, or item that falls below the funding line, the Division may not cover any other service related to the diagnosis.

(4) Coverage for eligible adults (age 21 and older):

(a) Diagnostic evaluations and medical examinations are not limited if documentation in the physician's or optometrist's clinical record justifies the medical need;

(b) Ophthalmological intermediate and comprehensive exam services are not limited for medical diagnosis;

(c) Vision therapy is not covered; and

(d) Visual services for the purpose of prescribing glasses or contact lenses, fitting fees, or glasses or contact lenses:

(A) One complete examination and determination of refractive state is limited to once every 24 months for pregnant adult women;

(B) Non-pregnant adults are not covered, except when the client:

(i) Has a medical diagnoses of aphakia, pseudoaphakia, congenital aphakia, keratoconus; or

(ii) Lacks the natural lenses of the eye due to surgical removal (e.g., cataract extraction) or congenital absence; or

(iii) Has had a keratoplasty surgical procedure (e.g., corneal transplant) with limitations described in OAR 410-140-0160 (Contact Lens Services and Supplies); and

(iv) Is limited to one complete examination and determination of refractive state once every 24 months.

(5) OHP Plus Children (birth through age 20):

(a) All ophthalmological examinations and vision services, including routine vision exams, fittings, repairs, and materials are covered when documentation in the clinical record justifies the medical need;

(b) Orthoptic and pleoptic training or "vision therapy" is:

(A) Covered when therapy treatment pairs with a covered diagnosis on the HERC List;

(B) Limited to six sessions per calendar year without PA:

(i) The initial evaluation is included in the six therapy sessions;

(ii) Additional therapy sessions require PA (OAR 410-140-0040);

(C) Shall be provided pursuant to OAR 410-140-0280 (Vision Therapy).

(6) Refraction determination is not limited following a diagnosed medical condition (e.g., multiple sclerosis).

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

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 24-1984(Temp), f. & ef. 5-29-84; AFS 31-1984(Temp), f. 7-26-84, ef. 8-1-84; AFS 5-1985, f. & ef. 1-25-85; AFS 22-1987, f. 5-29-87, ef. 7-1-87; AFS 75-1989, f. & cert. ef. 12-15-89, Renumbered from 461-018-0012; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0220; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; DMAP 20-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 44-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0160
Contact Lens Services and Supplies

(1) The following is general information regarding the Division's contact lens services and supplies coverage for clients who receive services on a fee-for-services basis:

(a) The prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation, is only covered when provided by an optometrist or other qualified physician. Contact lens fitting by an independent technician in an optometry office is not a covered service; and

(b) Contact lenses shall be billed to the Division at the provider's acquisition cost. Acquisition cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer or supplier plus any shipping and postage for the item. Payment for contact lenses is the lesser of the Division fee schedule or acquisition cost.

(2) Coverage for eligible adults (age 21 or older) as defined in OAR 410-140-0050:

(a) PA is required for contact lenses for adults, except for a primary keratoconus diagnosis;

(b) Contact lenses for adults are covered only when one of the following conditions exists:

(A) Refractive error which is 9 diopters or greater in any meridian;

(B) Keratoconus;

(C) Anisometropia when the difference in power between two eyes is 3 diopters or greater;

(D) Irregular astigmatism;

(E) Aphakia; or

(F) Post keratoplasty (e.g., corneal transplant), when medically necessary and within one year of procedure.

(c) Prescription and fitting of contact lenses is limited to once every 24 months. Replacement of contact lenses is limited to a total of two contacts every 12 months (or the equivalent in disposable lenses) and does not require PA;

(d) Corneoscleral lenses are not covered.

(3) Coverage for Children (birth through age 20):

(a) Contact lenses for children are covered and are not limited when it is documented in the clinical record that glasses may not be worn for medical reasons, including, but not limited to:

(A) Refractive error which is 9 diopters or greater in any meridian;

(B) Keratoconus;

(C) Anisometropia when the difference in power between two eyes is 3 diopters or greater;

(D) Irregular astigmatism; or

(E) Aphakia;

(b) Replacement of contact lenses is covered when documented as medically appropriate in the clinical record and does not require PA;

(c) Corneoscleral lenses are not covered.

(4) Contact lenses for treatment of disease or trauma (e.g., corneal bandage lens) are inclusive of the fitting. Follow up visits to determine eye health status may be separately reimbursed when the trauma or disease is clearly documented in the client record.

(5) An extra or spare pair of contacts is not covered.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0230; HR 37-1992, f. & cert. ef. 12-18-92; HR 5-1995, f. & cert. ef. 3-1-95; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04; DMAP 21-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 20-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 44-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0200
Dispensing, Fitting and Repair of Glasses

(1) The Division covers the fitting of glasses and the refitting and repair of glasses only when glasses and replacement parts are purchased from:

(a) The Division's contractor;

(b) Any visual materials supplier when the client has primary Medicare coverage and the glasses were a Medicare-covered benefit.

(2) Fitting of glasses for:

(a) Eligible adults (age 21 years and older) is limited to once every 24 months, except when dispensing glasses within 120 days of cataract surgery;

(b) Eligible children (birth through age 20) only when documented in the patient's record as medically necessary.

(3) Periodic adjustment of frames and tightening of screws is included in the dispensing fee and is not separately reimbursed.

(4) The Division accepts either the date of order or date of dispensing as the date of service on claims. Glasses must be dispensed prior to billing the Division, except under the following conditions:

(a) Death of the client prior to dispensing; or

(b) Client failure to pick up ordered glasses. Documentation in the client's record must show that the provider made serious efforts to contact the client.

(5) Providers must keep a copy of the delivery invoice included with all parts orders in the client's records or document the delivery invoice number in the client's records for all repair and refitting claims.

(6) Fitting of spectacle mounted low vision aids, single element systems, telescopic or other compound lens systems are not covered.

(7) All frames have a limited warranty. Check specific frame styles for time limits. All defective frames must be returned to the contractor.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0250; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 56-2002, f. & cert. ef. 10-1-02; OMAP 60-2003, f. 9-5-03, cert. ef. 10-1-03; DMAP 44-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0260
Contractor Services for Provider Ordering Vision Materials and Supplies

(1) The Division contracts with SWEEP Optical Laboratories (also referred to herein as contractor) to buy vision materials and supplies, excluding contact lenses. All frames, lenses, and miscellaneous items must be provided:

(a) Only by the contractor, unless the client has primary Medicare coverage; or

(b) By any visual materials supplier when the client has primary Medicare coverage for a Medicare covered item.

(2) Provider's shall:

(a) Verify the client's eligibility prior to submitting vision materials order to contractor;

(b) Obtain PA from the Division for items requiring PA prior to placing a vision materials order;

(c) Comply with the contractor's order submission requirements, as outlined in the Visual Services Supplemental Information Guide found at Division website: http://www.oregon.gov/OHA/healthplan/pages/vision.aspx;

(d) Submit prescription or order to the contractor upon notification of PA approval from the contractor; and

(e) Pay SWEEP Optical for any services provided by SWEEP Optical to a client who is not eligible for items. SWEEP Optical may not sell materials and supplies for non-eligible clients at the State Contracted Price.

(3) The Division covers glasses for:

(a) Eligible adults (age 21 and older) once every 24 months;

(b) Clients once within 120 days following cataract surgery. When ordering glasses from contractor, the date of surgery must be listed on the order form;

(c) Eligible children (birth through age 20) without limitation when it is documented in the physician's or optometrist's clinical record as medically appropriate.

(4) The contractor shall:

(a) Forward Division PA approval to the provider;

(b) Order specifications:

(A) The contractor shall provide the order as specified by the ordering provider;

(B) The contractor shall pay for all shipping and handling charges for shipments to the provider via United States mail or United Parcel Service for all returned orders that do not meet the order specifications or that are damaged in shipping;

(C) The contractor may not accept initial orders via telephone. The contractor shall accept telephone calls or faxed messages regarding orders that do not meet specifications;

(D) When the contractor is notified of an item to be returned because the item was not made to specifications in the original order, the contractor shall begin remaking the product as soon as they are notified, whether or not they have received the item being returned. The ordering provider shall return the original product to the contractor with a written explanation of the problem and indicate the date they notified the contractor to remake the order;

(c) Original order delivery:

(A) The contractor shall deliver the original order of materials and supplies to the provider within ten business days of the date the order is received;

(B) In the event of a delay in manufacturing or delivery, the contractor shall:

(i) Notify the ordering provider within two business days of receipt of the order;

(ii) Include a description of the order, the reason for delay, and the revised time of completion and delivery.

(C) Delivery of special order frames and lenses may exceed the required delivery time. In this event, the contractor shall provide the ordering provider with notice of the anticipated delay, provide a projected delivery date, and document the actual delivery time.

(5) The contractor:

(a) May use the date of order as the date of service (DOS) but may not bill the Division until the order has been completed and shipped;

(b) Shall bill the Division using Health Care Common Procedure Coding System (HCPC) Codes listed in the contract agreement. Payment will be at contracted rates;

(c) Shall include eyeglass cases with every frame. Cases may not be included in orders for only lenses, temples, or frame fronts;

(d) Shall have unisex frame styles available and shall allow clients to choose any frame regardless of category listed;

(e) Is not responsible if the Division determines the documentation in the client's record does not allow for the service pursuant to limitations indicated set forth in the administrative rules.

(6) The contractor and the Division may not pay for costs, expenses, or any required rework due to errors by the provider.

(7) Frames for display purposes may be purchased from the contractor for the same price as frames for glasses negotiated by the Oregon Department of Administrative Services:

(a) A case may not be provided with display frames; and

(b) Quantity, style, size, and color of frames should be specified in the order for display frames.

(8) Buying-up, as defined in OAR 410-120-0000 is prohibited.

(9) The following ophthalmic materials are not covered and include, but are not limited to:

(a) Glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes;

(b) Two pair of glasses instead of bifocals or trifocals in a single frame;

(c) Hand-held, low vision aids;

(d) Non-spectacle mounted aids;

(e) Single lens spectacle mounted low vision aids;

(f) Telescopic and other compound lens systems, including distance vision telescopic, near vision telescopes, and compound microscopic lens systems;

(g) Extra or spare pairs of glasses;

(h) Anti-reflective lens coating;

(i) U-V lens;

(j) Progressive and blended lenses;

(k) Bifocals and trifocals segments over 28mm including executive;

(L) Aniseikonic lenses;

(m) Sunglasses; and

(n) Frame styles outside of the contract between the Division and contractor based on client preference and are not medically necessary.

(10) Costs for the following are included in reimbursement for the lens and are not separately reimbursed by the Division:

(a) Scratch coating;

(b) Prism;

(c) Special base curve; and

(d) Tracings.

(11) Materials that require PA are set forth in OAR 410-140-0040.

(12) If a frame cannot be located in the contractor's catalog at www.sweepoptical.com that meets the medical needs of the client:

(a) Providers shall contact contractor for assistance with locating a frame to meet the client's need; and

(b) Frames not included in the contract between the Division and contractor may be purchased through contractor with PA.

(13) The following services do not require PA, are subject to strict limitations, and require the physician or optometrist to submit appropriate documentation to contractor:

(a) Replacement parts for non-contracted frame styles are limited to frames purchased with PA approval;

(b) Tints and photochromic lenses are limited to clients with documented albinism and pupillary defects. Documentation provided to contractor shall include the most appropriate International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code selected by a physician or optometrist;

(c) Other medically necessary items for a contract frame, when a client has a medical condition that requires the use of a specialty temple, nose pieces, head strap frame;

(d) Nonprescription glasses are limited to clients that do not require any correction in one eye and where there is blindness in one eye. The purpose of this exception is to offer maximum protection for the remaining functional eye;

(e) High Index Lenses:

(A) Power is +/- 10 or greater in any meridian in either eye; or

(B) Prism diopters are 10 or more diopters in either lens;

(f) Polycarbonate lenses are limited to the following populations:

(A) Eligible children (birth through age 20);

(B) Clients with developmental disabilities; and

(C) Clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required.

(14) Regardless of verification received via phone or electronic sources, the contractor may not fill orders for clients who do not have coverage or have met their vision benefit. When glasses are ordered and the client has met their vision benefit for the time period:

(a) The Division shall reimburse the provider for the exam only if the client is not an established client of the provider and the client is currently a fee-for-service (FFS) client with vision benefits;

(b) The provider shall contact the client's PHP or CCO if the client is enrolled with a PHP or CCO that contracts with SWEEP Optical. The contractor shall apply vision limitations pursuant to Division rules, regardless of changes to a client's enrollment status. The provider shall contact the client's PHP or CCO with the last date of service. The PHP or CCO shall determine if they will allow for an additional supply of glasses. If the client is an established client, regardless of incomplete information through phone or electronic verification systems or SWEEP Optical, the provider shall inform the PHP or CCO of the last date of service

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 279A.140, 414.025 & 414.065

Hist.: AFS 55-1983, f. 11-15-83, ef. 12-1-83; AFS 75-1989, f. & cert. ef. 12-15-89, Renumbered from 461-018-0011; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0280; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 56-2002, f. & cert. ef. 10-1-02; DMAP 21-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 44-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 33-2011, f. 12-5-11, cert. ef. 12-6-11; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0280
Vision Therapy Services

(1) The Division covers orthoptic and pleoptic training or "vision therapy" as outlined in OAR 410-140-0140 Vision Services Coverage and Limitations.

(2) Providers shall develop a therapy treatment plan and regimen that shall be taught to the client, family, foster parents, and caregiver during the therapy treatments. No extra treatments shall be authorized for teaching.

(3) Therapy that can be provided by the client, family, foster parents, and caregiver is not a reimbursable service.

(4) All vision therapy services including the initial evaluation shall be billed to the Division with the Current Procedural Terminology (CPT) code for orthoptic and pleoptic training.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0290; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 56-2002, f. & cert. ef. 10-1-02; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0300
Post-operative Care

(1) The Division reimburses all covered surgical procedures as global packages, except when the surgeon codes the surgical procedure with a modifier indicating surgical procedure only, excluding post-operative care.

(2) Post-operative care provided outside the global package is:

(a) Reimbursable to optometrists when furnished within their scope of practice;

(b) Billed with:

(A) The surgical CPT code billed by the surgeon;

(B) The appropriate modifier noting post-operative care only; and

(C) The first post-operative date of service; and

(c) Reimbursed a percentage of the global reimbursement.

(3) Post-operative care includes all related follow-up visits and examinations provided within:

(a) Ninety days following the date of major surgery; or

(b) Ten days following the date of minor surgery; and

(c) Claims for evaluation and management services and ophthalmological examinations billed within the follow-up period shall be denied.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: HR 15-1992, f. & cert. ef. 6-1-92; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14; DMAP 7-2016, f. 2-23-16, cert. ef. 3-1-16

410-140-0400
Contractor Services/Provider Ordering

(1) The Division of Medical Assistance Programs (Division) contracts with SWEEP Optical Laboratories (also referred to herein as contractor) to provide vision materials and supplies. Providers needing materials and supplies must order those directly from the contractor, except when the Oregon Health Plan client has primary Medicare coverage. See OAR 410-140-0080.

(2) Providers are responsible for:

(a) Verifying client eligibility prior to submitting an order to the contractor. Refer to OAR 410-120-1140 Verification of Eligibility;

(b) Obtaining prior authorization (PA) from the Division for items requiring PA prior to placing a vision materials order. (See OAR 410-140-0040 Prior Authorization.);

(c) Complying with the contractor's order submission requirements, as outlined in the Visual Services Supplemental Information Guide found on this Division website: http://www.oregon.gov/OHA/healthplan/pages/vision.aspx;

(d) Submitting prescription/order to the contractor upon notification of PA approval from the contractor; and

(e) Paying SWEEP Optical for any services provided by SWEEP Optical to a client who is not eligible for items. SWEEP Optical is prohibited by contract to sell materials and supplies for non-eligible clients at the State Contracted Price.

(3) The contractor's responsibilities:

(a) Forward Division prior authorization approval to the provider;

(b) Order specifications:

(A) The contractor shall provide the order as specified by the ordering provider;

(B) The contractor shall be responsible for all shipping and handling charges for shipments to the provider via United States mail or United Parcel Service for all returned orders that are not to the specifications of the order or that are damaged in shipping;

(C) The contractor may not accept initial orders via telephone. The contractor shall accept telephone calls or faxed messages regarding orders that are not made to specifications;

(D) When the contractor is notified of an item to be returned due to the item not being made to specifications in the original order, the contractor shall begin remaking the product as soon as they are notified, whether or not they have received the item being returned. (The ordering provider shall return the original product to the contractor with a written explanation of the problem and indicate the date they notified the contractor to remake the order.);

(c) Original order delivery:

(A) Delivery Date: The contractor shall deliver the original order of materials and supplies to the ordering provider within seven business days of the date the order is received;

(B) Delay: In the event of a delay in manufacturing or delivery, the contractor shall:

(i) Notify the ordering provider within two business days of receipt of the order;

(ii) Include a description of the order, the reason for delay and the revised time of completion and delivery; and

(C) Special Orders: Delivery of special order frames and lenses may exceed the required delivery time. In this event, the contractor shall provide the ordering provider with notice of the anticipated delay, give the ordering provider a projected delivery date, and document the actual delivery time for future reference.

(4) Provider Error: Neither the contractor nor the Division shall be responsible for costs, expenses or for any required rework due to errors by any provider.

(5) The contractor may use the date of order as the date of service (DOS) but may not bill the Division until the order has been completed and shipped.

(6) The contractor shall bill the Division using Health Care Common Procedure Coding System (HCPC) Codes listed in the contract agreement. Payment will be at contracted rates.

(7) The contractor shall include eyeglass cases with every frame. Cases may not be included in orders for only lenses, temples or frame fronts.

(8) Frame Displays: Frames for display purposes may be purchased from the contractor for the same price as frames for glasses negotiated by the Oregon Department of Administrative Services:

(a) A case may not be provided with display frames; and

(b) Quantity, style, size and color of frames should be specified in the order for display frames.

(9) Contractors will have unisex frame styles available and will allow clients to choose any frame regardless of category listed (i.e., women may choose "Girls" frames).

(10) Regardless of verification received via phone or electronic sources, the contractor may not fill orders for clients who do not have coverage or have met their vision benefit. See OAR 410-140-0140 Vision Services Coverage and Limitations. When glasses are ordered and the client has met their vision benefit for the time period:

(a) The Division will reimburse the provider for the exam only if the client is not an established client of the provider and the client is currently a fee-for-service (ffs) client with vision benefits. See OAR 410-140-0050 Eligibility and Benefit Coverage;

(b) The provider needs to contact the client's Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO) if the client is enrolled with a PHP or CCO that contracts with SWEEP Optical. The contractor applies vision limitations included in rule, regardless of changes to a client's enrollment status. It is the provider's responsibility to contact the client's PHP of CCO and give them the last date of service. The current PHP or CCO will then determine if they want to allow for an additional supply of glasses. If the client is an established client, regardless of incomplete information through phone or electronic verification systems or SWEEP Optical, it is the provider's responsibility to inform the PHP/CCO of the last date of service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 37-1992, f. & cert. ef. 12-18-92, Renumbered from 461-018-0300; HR 15-1994, f. & cert. e.f 3-1-94; HR 5-1995, f. & cert. ef. 3-1-95; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 44-2001, f. 9-24-01 cert. ef. 10-1-01; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; DMAP 21-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 33-2011, f. 12-5-11, cert. ef. 12-6-11; DMAP 26-2014, f. 4-29-14, cert. ef. 5-8-14

DIVISION 141

OREGON HEALTH PLAN

410-141-0000
Definitions

In addition to the definitions in OAR 410-120-0000, the following definitions apply:

(1) "Action" means in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

(a) The denial or limited authorization of a requested service including the type or level of service;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial in whole or in part of payment for a service;

(d) The failure to provide services in a timely manner as defined by the Health Systems Division, Medical Assistance Programs (Division);

(e) The failure of a PHP or CCO to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For a member who resides in a rural service area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain covered services outside of the PHP or CCO provider network under any of the following circumstances:

(A) From any other provider (in terms of training, experience, and specialization) not available within the network;

(B) From a provider not part of the network that is the main source of a service to the member as long as the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;

(C) Because the only plan or provider available does not provide the service due to moral or religious objections;

(D) Because the member's provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all related services are available within the network; or

(E) The Authority determines that other circumstances warrant out-of-network treatment for moral or religious objections.

(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final CCO or MCO claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

(3) "Capitated Services" means those covered services that a PHP agrees to provide for a capitation payment under contract with the Authority.

(4) "Capitation Payment" means monthly prepayment to a PHP for health services the PHP provides to members.

(5) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.

(6) "Certificate of Authority" means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.

(7) "Client" has the meaning given that term in OAR 410-120-0000.

(8) "Cold Call Marketing" means a PCP's or CCO's unsolicited personal contact with a potential member for the purpose of marketing.

(9) "Community Advisory Council" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.

(10) "Community Standard" means typical expectations for access to the health care delivery system in the member's community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members

in PHPs take into consideration the community standard and be adequate to meet the needs of the Division.

(11) "Contract" means an agreement between the State of Oregon acting by and through the Authority and a PHP or CCO to provide health services to eligible members.

(12) "Converting MCO" means a CCO that:

(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;

(b) Was formed by one or more MCOs that contracted with the Authority as of July 1, 2011.

(13) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

(14) "Coordinated Care Services" mean a CCO's fully integrated physical health, behavioral health services pursuant to ORS 414.651, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

(15) "Corrective Action or Corrective Action Plan" means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(16) "Dental Care Organization (DCO)" means a PHP that provides and coordinates dental services as capitated services under OHP.

(17) "Dental Case Management Services" means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

(18) "DCBS Reporting CCO" means for the purpose of OAR 410-141-3340 through 410-141-3395 a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

(19) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection agency.

(20) "Disenrollment" means the act of removing a member from enrollment with a PHP or CCO.

(21) "Exceptional Needs Care Coordination (ENCC)" means for PHPs a specialized case management service provided by FCHPs to members identified as aged, blind, or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes:

(a) Early identification of those members who are aged, blind, or disabled who have complex medical needs;

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

(22) "Enrollment" means the assignment of a member to a PHP or CCO for management and receipt of health services.

(23) "Free-Standing Mental Health Organization (MHO)" means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.

(24) "Fully-Capitated Health Plan (FCHP)" means PHPs that contract with the Authority to provide capitated health services including inpatient hospitalization.

(25) "Global Budget" means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.

(26) "Grievance" means a member's complaint to a PHP, CCO, or to a participating provider about any matter other than an action.

(27) "Grievance System" means the overall system that includes:

(a) Grievances to a PHP or CCO on matters other than actions;

(b) Appeals to a PHP or CCO on actions; and

(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or state statute.

(28) "Health Services" means:

(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health that includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;

(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.

(29) "Holistic Care" means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.

(30) "Home CCO" means enrollment in a CCO in a given service area based upon a client's most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization.

(31) "Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled who have complex medical needs including:

(a) Early identification of members eligible for ICM services;

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

(32) "Licensed Health Entity" means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(33) "Line Items" means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.

(34) "Managed care entity (MCE)" means, as stated in 42 CFR 457.10, 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, and primary care case managers.

(35) "Marketing" means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(36) "Medical Case Management Services" means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

(37) "Member" has the meaning given that term in OAR 410-120-0000.

(38) "Mental Health Organization (MHO)" means a PHP that provides capitated behavioral services for clients.

(39) "National Association of Insurance Commissioners (NAIC)" means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(40) "Net Premium" means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.

(41) "Non-Participating Provider" means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.

(42) "Oregon Health Authority or Authority Reporting CCO" means a CCO that reports its solvency plan and financial status to the Authority under these rules.

(43) "Other Non-Medical Services" means non-state plan, health related services, also referred to as "flexible services." These services are provided in–lieu of traditional benefits and are intended to improve care delivery, member health, and lower costs. Services may effectively treat or prevent physical or behavioral healthcare conditions. Services are consistent with the member's treatment plan as developed by the member's primary care team and documented in the member's medical record.

(44) "Participating Provider" means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.

(45) "Physician Care Organization (PCO)" means a PHP that contracts with the Authority to provide partially-capitated health services under OHP exclusive of inpatient hospital services.

(46) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.

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

(48) "Service Area" means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.

(49) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. This therapeutic strategy is designed in collaboration with the member, the member's family, or the member representative and may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000. f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 54-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 71-2015, f. & cert. ef. 12-10-15; DMAP 39-2016, f. 6-30-16, cert. ef. 7-1-16

410-141-0010
Prepaid Health Plan Contract Procurement Screening and Selection Procedures

(1) Basis and scope:

(a) The Oregon Health Authority (Authority) will use screening and selection procedures to procure managed care services pursuant to ORS 414.651. The Authority may award Qualified Managed Care Organizations (MCO) a contract as a prepaid health plan (PHP) for purposes of administering the Oregon Health Plan (OHP);

(b) The OHP is funded with federal Medicaid funds. The Authority will interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with PHPs. The Authority will seek prior federal approval of PHP contracts;

(c) For purposes of source selection and screening in the procurement of Managed Care Services, the Authority may use:

(A) The Request for Application (RFA) process described in sections (3) through (6) of this rule; or

(B) Any method described in the Department of Justice's (DOJ) Model Rules (chapter 137, division 047) for source selection and procurement process, except for bidding.

(2) In addition to the terms defined in OAR 410-141-0000, the following definitions for screening and selection procedures apply:

(a) Addendum or Addenda — an addition or deletion to, a material change in, or general interest explanation of an RFA;

(b) Application — Documents submitted by an MCO that seeks qualification to be Awarded a contract. The applicant is the MCO submitting the Application;

(c) Award — As the context requires, the act or occurrence of the Authority's identification of a qualified MCO with which the Authority will enter into a contract;

(d) Closing — The date and time announced in an RFA as the deadline for submitting Applications;

(e) MCO — A corporation, governmental agency, public corporation or other legal entity that operates as a managed health, dental, chemical dependency, physician care, or mental health organization;

(f) Managed care services— Capitated services provided by a PHP pursuant to ORS 414.651;

(g) Offer — A response to an RFA, including all required responses and assurances, and the Certification of Application;

(h) Request for applications (RFA) — All documents used by the Authority for soliciting applications for qualification in a specific RFA issued by the Authority, for one or more categories of contracts, one or more service areas or such other objective as the Authority may determine is appropriate for solicitation of managed care services.

(3) RFA process:

(a) The Authority will provide public notice of every RFA on its Web site. The RFA will indicate how prospective applicants will be made aware of addenda by posting notice of the RFA on the electronic system for notifying the public of the Authority procurement opportunities, or at the option of the requestor, mailing notice of the availability of the RFA to persons that have expressed interest in the Authority procurement of managed care services;

(b) The RFA process begins with a public notice of the RFA, which will be communicated with the electronic notification system used by the Authority to notify the public of procurement opportunities. A public notice of a RFA shall identify the qualification requirements for the category of contract (e.g., FCHP, DCO, etc.), the designated service area(s) where managed care services are requested or other objective that the Authority determines appropriate for solicitation of managed care services, and a sample contract;

(c) The Authority will provide notice of any RFA Addenda in a manner intended to foster competition and to make prospective applicants aware of the addenda. The RFA will specify how the Authority will provide notice of addenda;

(d) If the RFA so specifies, potential applicants must submit a letter of intent to the Authority within the time period specified in the RFA. The letter of intent does not commit any potential applicant to apply, however, if required, the Authority will not consider applications from applicants who do not submit a timely letter of intent;

(e) Submitting the application — the Authority will only consider applications that are submitted in the manner described in the RFA. Applicants must:

(A) Identify electronic application submissions as defined in the RFA. The Authority is not responsible for any failure attributable to the transmission or receipt of electronic or facsimile applications, including but not limited to receipt of garbled or incomplete documents, delay in transmission or receipt of documents, or security and confidentiality of data;

(B) Submit applications, when sent by mail, in a sealed envelope that is marked appropriately;

(C) Ensure the Authority receives their applications at the required delivery point prior to the closing date, listed in the RFA. the Authority will not accept late applications.

(f) The application must be completed as described in the RFA. To avoid duplication and burden, the Authority may permit a current contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the new contract or the new service area or capacity or other Authority objective that is the subject of the RFA;

(g) The Authority will enter into or renew a contract only if it determines that the action would be within the scope of the RFA and consistent with the effective administration of the OHP, including but not limited to:

(A) The capacity of any existing PHP(s) in the service area compared to the capacity of an additional PHP for the number of potential enrollees in the service area;

(B) The potential opportunity for clients to have a choice of more than one PHP.

(h) Disclosure of application contents and release of information:

(A) Application information, including the letter of intent, shall not be disclosed to any applicant (or other person) until the completion of the RFA process. The RFA process shall be considered complete when a contract has been awarded. No information will be given to any applicant (or other person) relative to their standing with other applicants during the RFA process;

(B) Application information shall be subject to disclosure upon the award date, with the exception of information that has been clearly identified and labeled "Confidential" under ORS 192.501–192.502, insofar as the Authority determines it meets the requirements for an exemption from disclosure;

(C) Any requestor shall be able to obtain copies of non-exempt information after the RFA process has been completed. The requestor shall be responsible for the time and material expense associated with the request. This fee includes the copying of the document(s) and the staff time (and agency attorney time, if requested by the Authority) associated with performing the task, in accordance with ORS 192.440(3). The Authority may require prepayment of estimated charges before acting on a request:

(i) Protests must be submitted, in writing, to the Authority prior to the protest date specified in the RFA. The protest shall state the reasons for the protest or request and any proposed changes to the RFA provisions, specifications or contract terms and conditions that the prospective applicant believes will remedy the conditions upon which the protest is based. Protests and judicial review of the RFA shall be handled using the process set forth in OAR 137-047-0730;

(j) The Authority is not obligated to enter into a contract with any applicant, and further, has no financial obligation to any applicant.

(4) Application for qualification:

(a) An MCO seeking qualification as a PHP must meet the requirements and provide the assurances specified in the RFA. The Authority determines whether the MCO qualifies based on the application and any additional information and investigation that the Authority may require;

(b) The Authority determines an MCO is qualified when the MCO meets the requirements of the RFA, including written assurances, satisfactory to the Authority, that the MCO:

(A) Provides or will provide the services described in the contract;

(B) Provides or will provide the health services described in the contract in the manner described in the contract;

(C) Is organized and operated, and will continue to be organized and operated, in the manner required by the contract and described in the application;

(D) Under arrangements that safeguard the confidentiality of patient information and records, will provide to the Authority, CMS, the Office of Inspector General, the Oregon Secretary of State, and the Oregon Medicaid Fraud Unit of the DOJ, or any of their duly authorized representatives, for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the MCO relating to its operation as a PHP and to any facilities that it operates; and

(E) Will continue to comply with any other assurances it has given the Authority.

(c) The Authority may determine that an MCO is potentially qualified if within a specified period of time the MCO is reasonably susceptible of being made qualified. The Authority is not obligated to determine whether an applicant is potentially qualified if, in its discretion, the Authority determines that sufficient qualified applicants are available to obtain the Authority objectives under the RFA. The Authority determines that an MCO is potentially qualified if:

(A) The Authority finds that the MCO is reasonably susceptible to meeting the operational and solvency requirements of the application within a specified period of time; and

(B) The MCO enters into discussions with the Authority about areas of qualification that must be met before the MCO is operationally and financially qualified. The Authority will determine the date and required documentation and written assurances required from the MCO;

(C) If the Authority determines that a potentially qualified applicant cannot become a qualified MCO within the time announced in the RFA for contract award, the Authority may:

(i) Offer the contract at a future date when the applicant demonstrates, to the Authority's satisfaction, that the applicant is a qualified MCO within the scope of the advertised RFA; or

(ii) Inform the applicant that it is not qualified for contract Award.

(5) Evaluation and determination procedures:

(a) The Authority evaluates an application for qualification on the basis of information contained in the RFA, the application and any additional information that the Authority obtains. Evaluation of the application will be based on the criteria in the RFA;

(b) The Authority will notify each MCO that applies for qualification of its qualification status;

(c) Review of the Authority's qualification decisions shall be as set forth in ORS 279B.425;

(d) The Authority may enter into negotiation with qualified or potentially qualified applicants concerning potential capacity and enrollment in relation to other available, or potentially available, capacity and the number of potential enrollees within the service area. The Authority may determine that it will limit contract award(s) to fewer than the number of qualified or potentially qualified applicants, to achieve the objectives in the RFA.

(6) Contract award conditions:

(a) The applicant's submission of the application with the executed Certification of Application is the MCO's offer to enter into a contract. The offer is a "Firm Offer," i.e., the offer shall be held open by the applicant for the Authority's acceptance for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract;

(b) No Contingent offers. Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an MCO shall not make its offer contingent upon the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(c) By timely signing and submitting the application and certification of application, the applicant acknowledges that it has read and understands the terms and conditions contained in the RFA and that it accepts and agrees to be bound by the terms and conditions of the RFA;

(d) The Authority may award multiple contracts in accordance with the criteria set forth in the RFA. The Authority may make a single award or limited number of awards rather than multiple awards to all qualified or potentially qualified applicants, in order to meet the Authority's needs including but not limited to adequate capacity for the potential enrollees in the service area;

(e) An applicant who claims to have been adversely affected or aggrieved by Authority contract award or intent to award a contract must file a written protest with the Authority issuing office within seven (7) calendar days after receiving the notice of award. Protests and judicial review of contract award shall be handled using the procedures set forth in OAR 137-047-9740.

(7) Applicability of DOJ Model Rules: Except where inconsistent with the preceding sections of this rule, the Authority will use the following DOJ Model Rules to govern solicitations for managed care services:

(a) OAR 137-046 — General Provisions Related to Public contracting: 137-046-0100, 137-046-0110 and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 — Public Procurements for Goods or Services: 137-047-0100, 137-047-0260 through 137-047-0330, 137-047-0400 through 137-047-0800.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 51-2005(Temp), f. 9-30-05, cert. ef. 10-1-05 thru 3-15-06; OMAP 3-2006, f. 2-7-06, cert. ef. 3-1-06

410-141-0020
Administration of Oregon Health Plan 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 medical assistance programs including the Oregon Health Plan (OHP) pursuant to ORS 414.065 (generally, fee-for-service), 414.651 (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, Division will construe them as much as possible to be complementary. In the event that the Division's policies, procedures, rules and interpretations may not be complementary, The Division will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to Division clients, including but not limited to authorization and delivery of service, or denials of authorization or services, the Division, clients, enrolled providers and the prepaid health plans (PHP) apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted Division by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the OHP;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for PHPs, requirements applicable to the provision of covered medical assistance to Division clients are provided in OAR 410-141-0000 through 410-141-0860, OHP administrative rules for prepaid health plans, inclusive, and where applicable, the Division's General Rules, 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to Division clients are provided in the Division's General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in 410-141-0480 to 410-141-0520, and the provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Authority necessary to administer the State of Oregon's medical assistance programs, such as Electronic Data Transaction rules in OAR 943-120-0100 to 943-120-0200; and

(F) The basic framework for provider enrollment in OAR 943-120-0300 through 943-120-0350 generally applies to providers enrolled with the Authority, subject to more specific requirements applicable to the administration of the OHP and medical assistance programs administered by the Division. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in subsections (i)–(v) of this section.

(b) For purposes of contract administration solely as between the Division and its PHPs, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to Division clients.

(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 supercede 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 person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 413.042
Stats. Implemented: 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-141-0050
MHO Enrollment for Children Receiving Child Welfare Services

Pursuant to and in the administration of the Authority in OAR 410-141-0060, Children, Adults and Families (CAF) or the Oregon Youth Authority (OYA) selects Prepaid Health Plans (PHPs) for a child receiving CAF Child Welfare services or OYA services with the exception of children in subsidized adoption and guardianship. This rule implements and further describes how the Oregon Health Authority (Authority) shall administer its authority under 410-141-0060 and 410-141-3060 for purposes of making enrollment decisions and 410-141-0080 and 410-141-3080 for purposes of making disenrollment decisions for children receiving CAF Child Welfare services or OYA services;

(1) The Authority has determined that, to the maximum extent possible, all children receiving CAF services should be enrolled in Mental Health Organizations (MHOs) or Coordinated Care Organizations (CCO) at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment from a MHO or CCO is authorized by the Authority in accordance with this section and OAR 410-141-0080 and 410-141-3080:

(a) Notwithstanding OAR 410-141-0060(4)(a) or 410-141-3060 or 410-141-0080(2)(b)(E) or 410-141-3080, children receiving CAF services are not exempt from mandatory enrollment in an MHO or CCO on the basis of third party resources (TPR) mental health services coverage;

(b) A decision to use fee-for-service (FFS) open card for a child receiving CAF services should be reviewed by the Authority if the child's circumstances change and at the time of redetermination to consider whether the child should be enrolled in a MHO or CCO.

(2) When a child receiving CAF services is being transferred from one MHO to another or one CCO to another or for children transferring from FFS to a MHO or CCO, the MHO or CCO shall facilitate coordination of care consistent with OAR 410-141-0160 or 410-141-3160:

(a) MHOs and CCOs shall work closely with the Authority to ensure continuous MHO or CCO enrollment for children receiving CAF services;

(b) If the Authority determines that disenrollment should occur, the MHO or CCO shall continue to be responsible for providing covered services until the disenrollment date established by

the Authority, which shall provide for an adequate transition to the next responsible MHO or CCO.

(3) It is not unusual for a child receiving CAF services to experience a change of placement that may be permanent or temporary in nature. Consistent with OAR 410-141-0080 or 410-141-3080, the Authority will verify the address change information to determine whether a child receiving CAF services no longer resides in the MHO's or CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the MHO's or CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to a placement in the MHO's or CCO's service area at the end of the temporary placement;

(b) Unless a corresponding change in MHO capitation rates is implemented, a child receiving CAF services placed in behavioral rehabilitation services (BRS) settings shall be enrolled in the MHO or CCO that serves the region in which the BRS setting is located, unless an out of area exception is requested by the MHO or CCO and agreed to by the Authority for purposes related to continuity of care.

(4) If the child receiving CAF services is enrolled in a MHO or CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the MHO or CCO shall be responsible for covered services during that placement even if the location of the facility is outside of the MHO's or CCO service area:

(a) The child receiving CAF services is presumed to continue to be enrolled in the MHO or CCO with which the child was most recently enrolled. An admission to a PRTS facility shall be deemed a temporary placement for purposes of MHO or CCO enrollment. Any address change or Authority system identifier (e.g., C5 status) change associated with the placement in the PRTS facility does not constitute a change of residence for purposes of MHO or CCO enrollment and shall not constitute a basis for disenrollment from the MHO or CCO, notwithstanding OAR 410-141-0080 and 410-141-3080. If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate MHO or CCO and assign an enrollment date that provides for continuous MHO or CCO coverage with the appropriate MHO or CCO. If the child had been enrolled in a different MHO or CCO in error, the Authority shall disenroll the child from that MHO or CCO and recoup the capitation payments;

(b) Immediately upon discharge from long-term psychiatric care and prior to admission to a PRTS, a child receiving CAF services should be enrolled in an MHO or CCO. At least two weeks prior to discharge of a child receiving CAF services from a long-term psychiatric care (SAIP, SCIP, or STS) facility to a PRTS facility, the long-term care facility shall consult with the Authority about which MHO or CCO will be assigned in order to provide for enrollment in the MHO or CCO and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge from long-term psychiatric care.

(5) Notwithstanding OAR 410-141-0060(6) and (7), 410-141-3060, 410-141-0080, and 410-141-3080, if a child receiving CAF services is enrolled in a MHO or CCO after the first day of an admission to PRTS, the date of enrollment shall be effective the next available enrollment date following discharge from PRTS to the MHO or CCO assigned by the Authority:

(a) For purposes of these rules and to assure continuity of care for the child upon discharge, the next available enrollment date shall mean immediately upon discharge;

(b) At least two weeks prior to discharge, the PRTS facility shall consult with the Authority about which MHO or CCO will be assigned and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO or CCO that will be assigned in order to provide for continuity of care upon discharge.

Stat. Auth.: ORS 413.042
Stats. Implemented: 414.065
Hist.: OMAP 30-2006(Temp), f. 6-30-06, cert. ef. 7-1-06 thru 10-27-06; OMAP 36-2006, f. 10-26-06, cert. ef. 10-27-06; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-0060
Oregon Health Plan Managed Care Enrollment Requirements

(1) For the purposes of this rule, the following definitions apply:

(a) Client means an individual found eligible to receive health services. "Client" is inclusive of members enrolled in PHPs and CCOs as stated in OAR 410-120-0000;

(b) Eligibility Determination means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) Member means a client enrolled with a pre-paid health plan or coordinated care organization as stated in OAR 410-120-0000;

(d) Newly Eligible means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) Redetermination means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date or a change in program are considered renewals as stated in OAR 410-200-0015;

(f) Renewal means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) The following populations may not be enrolled into an MCO or any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into an MCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with an MCO but not exempt from enrollment in a DCO, if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual will receive dental services through the DCO.

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in and ORS 414.631 and, except as provided for children in Child Welfare though the BRS and PRTS programs, outlined OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from auto assignment mandatory enrollment for their managed care plans, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health MCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These individuals are as follows:

(a) Children in the legal custody of the Department or Oregon Health Authority where the child is expected to be in a substitute care placement for less than 30 calendar days unless:

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care.

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these clients:

(A) A client who is also a Medicare beneficiary and is in a hospice program may not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan unless exempt for some other reason listed in this rule;

(B) The client is enrolled in Medicare and the only FCHP or PCO in the service area is a Medicare Advantage plan. The client may choose not to enroll in an FCHP or PCO;

(C) Enrollment in a FCHP or PCO of a client who is receiving Medicare and who resides in a service area served by PHPs shall be as follows:

(i) If the client who is Medicare Advantage eligible selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the client shall complete the 7208M or other CMS approved Medicare plan election form;

(ii) If the Medicare Advantage Plan Election form (OHP 7208M) described in this rule is signed by someone other than the client, the client's representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M;

(iii) If the client is a Medicare beneficiary who is capable of making enrollment decisions, the client's representative may not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components:

(I) If the FCHP or PCO has not received the form within ten calendar days after the date of enrollment, the FCHP or PCO shall send a letter to the member with a copy sent to the APD branch manager. The letter shall explain the need for the completion of the form; inform the member that if the form is not received within 30 days, the FCHP or PCO may request disenrollment; and instruct the member to contact their caseworker for other coverage alternatives.

(II) The FCHP or PCO shall choose whether to disenroll or maintain enrollment for all the clients from whom they do not receive a form at the end of 30 days, except as otherwise provided in this rule. The FCHP or PCO shall notify the PHP coordinator of the PHP's annual decision to disenroll or maintain enrollment for the clients in writing. This notification shall be submitted by January 31 of each year or another date specified by the Authority. If the FCHP or PCO has decided to:

(III) Disenroll the clients and has not received a client's form at the end of 30 days, the FCHP or PCO shall request disenrollment. HMU will disenroll the member effective the end of the month following the notification;

(D) Maintain enrollment. The FCHP or PCO may not request disenrollment at the end of 30 days.

(E) If the client is enrolled as a private member of a Medicare Advantage plan, the client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare Advantage plan:

(F) If the client chooses to remain as a private member in the Medicare Advantage plan, the client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;

(G) If the client chooses to discontinue the Medicare Advantage enrollment and then, within 60 calendar days of disenrollment from the Medicare Advantage plan, chooses the FCHP or PCO that corresponds to the Medicare Advantage plan that was discontinued, the client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other clients;

(H) A Fully Dual Eligible (FDE) client who has been exempted from enrollment in an MHO may not be enrolled in a FCHP or PCO that has a corresponding Medicare Advantage plan unless the exemption was done for a provider who is on the FCHP's or PCO's panel.

(6) The Authority may temporarily exempt clients from mandatory enrollment for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in MCOs on a case-by-case basis; children not enrolled in a MCO shall continue to receive services on a FFS basis;

(b) Until December 31, 2017, women who are pregnant and meet the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only until 60 days after the birth of her child. Women meeting the criteria for the pregnancy enrollment exemption for their physical health plan coverage will continue to be enrolled in the appropriate MCO or CCO plan in their service area for dental and mental health coverage. After the 60 day period, the member shall enroll in a plan as appropriate. Those women under consideration for a pregnancy enrollment exemption for their physical health enrollment shall receive a response from the Authority within 30 working days of request. Upon approval of the FFS pregnancy exemption for physical health enrollment only, the client shall remain FFS for as long as she continues to meet the requirements in A through E below. In order to qualify for the FFS pregnancy exemption for physical health only, there shall be no home birth option available to the client through her plan and the client shall:

(A) Be pregnant;

(B) State that her intention is to have a home birth;

(C) Have an established relationship for the purpose of home birth with a licensed qualified practitioner who is not a participating provider with the client's MCO;

(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and

(E) Meet any OAR and statutory requirements that define when a home birth is eligible for reimbursement by the Authority:

(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1), Table 1, either upon initial evaluation or once the exemption is granted, the exemption shall be withdrawn, and the client will be subject to MCO enrollment requirements as stated in OAR 410-141-3060;

(ii) Conditions arising during the pregnancy as listed in subsections (I) through (V) below shall be reviewed by the Authority on a case-by-case basis for continuation of the FFS enrollment exemption:

(I) Fetal presentation other than vertex when known;

(II) Abnormal bleeding;

(III) Low–lying placenta within 2 cm. or less of cervical os;

(IV) Genital herpes, primary; secondary uncoverable at onset of labor; and

(V) Current substance abuse that has the potential to adversely affect labor and the infant.

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with an MCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate MCO for their service area;

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless exempted above, enrollment is mandatory in all areas served by an MCO.

(8) When a service area changes from mandatory to voluntary, the member will remain with their PHP for the remainder of their eligibility period unless the member meets the criteria stated in this rule or as provided by OAR 410-141-0080.

(9) If the client resides in a mandatory service area and fails to select a DCO, MHO, PCO, or FCHP at the time of application for the OHP, the Authority shall enroll the client with a DCO, MHO, PCO, or FCHP as follows:

(a) The client shall be assigned to and enrolled with a DCO, MHO, PCO, or FCHP that meets the following requirements where MCO enrollment is not available or services are not available through the MCO:

(A) Is open for enrollment;

(B) Serves the county in which the client resides;

(C) Has practitioners located within the community-standard distance for average travel time for the client.

(b) Assignment shall be made first to an MCO;

(c) The Authority shall send a notice to the client informing the client of the assignments and the right to change assignments within 30 calendar days of enrollment. A change in assignment shall be honored if there is another DCO, MHO, PCO, or FCHP open for enrollment in the county in which the client resides;

(10) Clients shall be enrolled with PHPs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of Coordinated Care Organizations (CCOs), Fully Capitated Health Plans (FCHP), and Physician Care Organizations (PCO) shall be called mandatory service areas. In mandatory service areas, a client shall select:

(A) A CCO; or

(B) An FCHP or PCO:

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority.

(b) Service areas without sufficient physical health service capacity shall be called voluntary service areas. In voluntary service areas, a client has the option to:

(A) Select a CCO; or

(B) Select an FCHP or PCO;

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority; or

(C) Remain in the Medicaid fee-for-service (FFS) physical health care delivery system.

(c) Service areas with sufficient mental health and dental care service capacity through MHOs and DCOs shall be called mandatory MHO and DCO service areas. A client shall select an MHO and DCO in a mandatory MHO and DCO service area if mental health and dental services are not available through a CCO or the client is otherwise exempt from CCO enrollment;

(d) Service areas without sufficient dental care service capacity through MHOs and DCOs shall be called voluntary MHO and DCO service areas. In voluntary MHO and DCO service areas, a client may choose to:

(A) Select a CCO open to enrollment that offers dental services; or

(B) Select any MHO and DCO open for enrollment if CCO enrollment is not available; or

(C) Remain in the Medicaid FFS mental health and dental care delivery system;

(11) Enrollments resulting from assignments shall be effective the first of the month or week after the Department enrolls the client and notifies the client of enrollment and the name of the PHP: If enrollment is initiated by an Authority worker on or before Wednesday, the date of enrollment shall be the following Monday. If enrollment is initiated by an Authority worker after Wednesday, the date of enrollment shall be one week from the following Monday. Monthly enrollment in a mandatory service area, where there is only one plan or DCO, shall be initiated by an auto-enrollment program of the Authority, effective the first of the month following the month-end cutoff. Monthly enrollment in service areas, where there is a choice of PHPs, shall be auto-enrolled by computer algorithm.

(12) The provision of capitated services to a member enrolled with a PHP shall begin as of the effective date of enrollment with the MCO except for:

(a) A newborn whose mother was enrolled at the time of birth. The date of enrollment shall be the newborn's date of birth;

(b) Persons, other than newborns, who are hospitalized on the date enrolled. The date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above.

Stat. Auth.: ORS 413.042, 414,615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 & 414.685

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; HR 8-1994(Temp), f. & cert. ef. 2-1-94; DEQ 24-1994, f. 5-31-94, cert. ef. 6-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 29-1996(Temp), f. 12-31-96, cert. ef. 1-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 12-2002, f. & cert. ef. 4-1-02; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 10-2006(Temp), f. & cert. ef. 5-4-06 thru 10-27-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 72-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 8-2015, f. 2-26-15, cert. ef. 3-1-15; DMAP 56-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 2-4-16; Administrative correction, 12-24-16

410-141-0065

Fully Capitated Health Plan or Physician Care Organization (FCHP or PCO) Enrollment Requirements for Individuals Receiving Residential Substance Use Disorder (SUD) Treatment Services

This rule implements and further describes how the Oregon Health Authority (Authority) will administer its authority under 410-141-0060 for purposes of making enrollment decisions and 410-141-0080 for purposes of making disenrollment decisions for the adult and adolescent individuals receiving residential SUD treatment services;

(1) The Authority has determined that, to the maximum extent possible, all individuals should be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority, unless disenrollment is authorized by the Authority in accordance with this section, OAR 410-141-0050 and OAR 410-141-0080

(2) If the Authority determines that disenrollment should occur, the FCHP or PCO will continue to be responsible for providing covered services until the disenrollment date established by the Authority, which shall provide for an adequate transition to the next responsible FCHP or PCO when applicable.

(3) It is not unusual for individuals to receive residential SUD treatment services outside of their residential or home county and outside of the FCHP or PCO's delivery service area. Receiving residential SUD treatment is considered a temporary absence from the individual's residential or home county and does not represent a change of residence or a change in enrollment when the individual is reasonably likely to return to the FCHP or PCO's delivery service area at the end of the residential treatment stay.

(4) If the individual is enrolled in a FCHP or PCO on the same day the individual is admitted to the residential treatment services, the managed care organization shall be responsible for the covered services during that placement even if the location of the facility is outside of the FCHP or PCO's service area;

(5) The individual is presumed to continue to be enrolled in the FCHP or PCO with which the individual was most recently enrolled. An admission to a residential SUD facility is deemed a temporary placement and does not constitute a change of residence for the purposes of FCHP or PCO enrollment and does not constitute a basis for disenrollment from the FCHP or PCO, notwithstanding OAR 410-141-0080(2)(b)(F). If the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority will re-enroll the individual with the appropriate FCHP or PCO and assign an enrollment date that provides for continuous FCHP or PCO coverage with the appropriate FCHP or PCO. If the individual was enrolled in a different FCHP or PCO in error, the Authority will disenroll the individual and recoup the capitation payments.

(6) If the individual is enrolled in a FCHP or PCO after the first day of an admission to a residential SUD treatment service facility, the individual will be retro effectively disenrolled from the FCHPO or PCO, and capitation will be recouped. The date of enrollment shall be effective the next available enrollment date following discharge from the residential FCHP or PCO treatment service facility.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610-685
Hist.: DMAP 62-2013(Temp), f. 10-31-13, cert. ef. 11-1-13 thru 4-30-14; DMAp 6-2014, f. & cert. ef. 1-31-14

410-141-0070
Managed Care Fully Capitated Health Plan and Physician Care Organization Pharmaceutical Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. Fully Capitated Health Plan (FCHP)'s and Physician Care Organization (PCO)'s shall pay for prescription drugs, except:

(a) As otherwise provided, mental health drugs that are in Class 7 & 11 (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal and those drugs that the Division of Medical Assistance Programs (Division) specifically carved out from capitation according to sections (8) and (9) of this rule;

(c) Any applicable co-payments;

(d) For drugs covered under Medicare Part D when the client is Fully Dual Eligible.

(2) FCHPs and PCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list must:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) FCHPs and PCOs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but is not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) If a drug cannot be approved within the 72-hour time requirement for prior authorization of drugs and the medical need for the drug is immediate, FCHPs and PCOs must provide (within 24 hours of receipt of the drug prior authorization request) for the dispensing of at least a 72-hour supply of a drug that requires prior authorization.

(5) FCHPs and PCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referring provider, if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the Division member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded; payment is governed solely by OAR 410-121-0150.

(7) FCHPs and PCOs shall not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs which have reached the FDA Notice of Opportunity for Hearing NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. The DESI LTE drug list is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html.

(8) An FCHP or PCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Division no later than March 1 of any given contract year that contains all of the following information:

(a) The name of the drug;

(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and

(c) The reason that the Division should consider this drug for carve out.

(9) Upon receipt of a request from an FCHP or PCO requesting a drug not be paid within the capitation rate of the FCHP or PCO, the Division shall exclude the drug from capitation rate for the following January contract cycle if the Division determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar or schizophrenic disorders.

(10) The Division shall pay for a drug that is not included in the capitation rate pursuant to the Pharmaceutical Services rules (chapter 410, division 121). An FCHP or PCO may not reimburse providers for carved out drugs.

(11) FCHPs and PCOs shall submit quarterly utilization data, within 60 days of the date of service, as part of the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

Stat. Auth.: ORS 413.042
Stats. Implemented: 414.065
Hist.: OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 57-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 32-2011(Temp), f. & cert. ef. 11-21-11 thru 5-15-12; DMAP 24-2012, f. 4-27-12, cert. ef. 5-1-12

410-141-0080
Managed Care Disenrollment from Prepaid Health Plans

For purposes of this rule, "Managed Care Prepaid Health Plan" means Fully Capitated Health Plan, Dental Care Organization, Physician Care Organization, and Mental Health Organization.

(1) All Oregon Health Plan (OHP) member-initiated requests for disenrollment from a Prepaid Health Plan (PHP) shall be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035 and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.

(2) In accordance with 42 CFR 438.56(c)(2), the Authority and PHP shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Newly eligible members may change their PHP assignment within 12 months following the date of initial enrollment. The effective date of disenrollment shall be the first of the month following the Division's approval of disenrollment;

(B) At least once every 12 months;

(C) Existing members may change their PHP assignment within 30 days of the Authority's automatic assignment or reenrollment in a PHP;

(D) In accordance with ORS 414.645, members may disenroll from a PHP during their redetermination (enrollment period) or one additional time during their enrollment period based on the members choice and with Authority approval. The disenrollment shall be considered "recipient choice."

(b) With cause:

(A) At any time;

(B) Members who disenroll from a Medicare Advantage plan shall also be disenrolled from the corresponding PHP. The effective date of disenrollment shall be the first of the month that the member's Medicare Advantage plan disenrollment is effective;

(C) Members who are receiving Medicare (dual eligible) and who are enrolled in a PHP that has a corresponding Medicare Advantage component shall be disenrolled from the PHP if the contractor has declared its decision to disenroll members in accordance with OAR 410-141-0060 in the annual Dual Eligible Clients with Medicare Advantage Plans (Schedule 5) form. The effective date of disenrollment from the PHP shall be the first of the month following the date of request for disenrollment. Dual eligible shall receive choice counseling prior to reassignment;

(D) PHP does not, because of moral or religious objections, cover the service the member seeks;

(E) The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(F) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers experienced in dealing with the member's health care needs. Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the PHP's service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of 410-141-0060 or this rule. Participation in the Oregon Health Plan, including managed care, does not guarantee that any member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of a member or a provider of a treatment, service, or supply including, but not limited to, a decision of a provider to participate or decline to participate in a PHP;

(iv) As specified in ORS 414.645, the Authority may approve the transfer of 500 or more members from one PHP to another PHP if:

(I) The members' provider has contracted with the receiving PHP and has stopped accepting patients from or has terminated providing services to members in the transferring PHP; and

(II) Members are offered the choice of remaining enrolled in the transferring PHP; and

(III) The member and all family (case) members shall be transferred to the provider's new PHP;

(IV) The transfer shall take effect when the provider's contract with their current PHP contractual relationship ends or on a date approved by the Division;

(V) Members may not be transferred under section 2(E)(vi) until the Division has evaluated the receiving PHP and determined that the PHP meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the PHP maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(VI) The Division shall provide notice of a transfer to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(G) Members whose request for disenrollment is denied shall receive notice in accordance with OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing over the denial.

(c) If the following conditions are met:

(A) The applicant is in the third trimester of her pregnancy and has just been determined eligible for OHP, or the OHP client has just been redetermined eligible and was not enrolled in a PHP within the past three months; and

(B) The new PHP the member is enrolled with does not contract with the member's current OB provider, and the member wishes to continue obtaining maternity services from that non-participating OB provider; and

(C) The request to change PHP or return to FFS is made prior to the date of delivery;

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

(A) Transfer of a member from a PHP to a CCO or DCO;

(B) Involuntary transfer of a member from a PHP to another PHP; or

(C) Automatic enrollment of a member in a PHP.

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another PHP unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment as stated in 410-141-0060(4), and the member meets disenrollment criteria state in 42 CFR 438.56(c)(2), or there isn't another PHP in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

(C) If the Division fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.

(3) The PHP may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

(b) Because of an adverse change in the member's health;

(c) Because of the member's utilization of services, either excessive or lack thereof;

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the PHP disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(4) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the PHP requests it for cause that includes, but is not limited to, the following:

(a) Member commits fraudulent or illegal acts related to the member's participation in OHP such as: permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The PHP shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 1-888-Fraud01 (1-888-372-8301) or http://www.oregon.gov/DHS/aboutdhs/Pages/fraud/index.aspx consistent with 42 CFR 455.13;

(b) Member became eligible through a hospital hold process and placed in the Adults and Couples category as required under 410-141-0060(4).

(c) Requests by the PHP for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The PHP shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made;

(B) There shall be notification from the provider to the PHP at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the PHP. Such notification shall be documented in the member's clinical record. The PHP shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The PHP shall contact the member either verbally or in writing if it is a severe problem to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issues. Any contact with

the member shall be documented in the member's clinical record. The PHP shall inform the member that their continued behavior may result in disenrollment from the PHP;

(D) The PHP shall provide individual education, disability accommodation, counseling, and other interventions with the member in a serious effort to resolve the problem;

(E) The PHP shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;

(F) If the severity of the problem warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the PHP shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The PHP shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

(I) If the member's behavior is uncooperative or disruptive including, but not limited to, threats or acts of physical violence, as the result of his or her special needs or disability, the PHP shall also document each of the following:

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the PHP shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others shall actually occur, and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A PHP-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;

(v) Documentation of the PHP's rationale for concluding that the member's continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular member or other members;

(vi) If a Primary Care Provider (PCP) terminates the member as a patient, the PHP shall attempt to locate another PCP on their panel who will accept the member as their patient. If needed, the PHP shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of members as patients shall be according to the PHP's policies and shall be consistent with PHP or PCP's policies for commercial members and with applicable disability discrimination laws. The PHP shall determine whether the PCP's termination of the member as a patient is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements as stated above, requests by the PHP for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56, the PHP shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the PHP's staff so that it seriously impairs the PHP's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member will cause grievous physical injury to others (including, but not limited to, death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The PHP shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an Exception to the Disenrollment Process of a Member;

(B) The provider shall immediately notify the PHP about the incident with the member. The notification shall describe the problem and shall be maintained for documentation purposes;

(C) The PHP shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;

(D) The PHP shall provide any additional information requested by the CAR, the Authority, or Department of Human Services assessment team;

(E) If the member's behavior could reasonably be perceived as the result of his or her special needs or disability, the PHP shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined above;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the PHP shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others, the probability that potential injury to others will actually occur, and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(F) Documentation shall exist that verifies the provider or PHP immediately reported the incident to law enforcement. The PHP shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinic record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures will not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

(I) Documentation shall exist that verifies the PHP's rationale for concluding that the member's continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular member or other members.

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the PHP's CAR or a team of CARs who may request additional information from Ombudsman Services or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Division's substance use disorder specialist;

(B) In cases where the member is also enrolled in the PHP's Medicare Advantage plan, the PHP shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is not sufficient documentation, the CAR shall notify the PHP within two business days of initial receipt what sup-

porting documentation is needed for final consideration of the request;

(D) The CARs shall review the request and notify the PHP of the decision within ten working days of receipt of sufficient documentation from the PHP;

(E) Written decisions including reasons for denials shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the CAR.

(5) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the PHP and the member's care team;

(b) The notice shall give the reason for the denial of the disenrollment request and the notice of a member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing in accordance with 42 CFR 438.56;

(c) Written decisions including the reason for denials shall be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the CAR.

(6) The following procedures apply to all approved disenrollment requests:

(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the PHP and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint (as specified in 410-141-0260 through 410-141-0266) and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment will proceed unless the member requests continued enrollment, pending a decision;

(c) The disenrollment effective date will be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment, pending a hearing decision. The disenrollment will take effect immediately upon the issuing of a hearing officer's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another PHP;

(e) If no other PHP is available to the member, the member will be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the PHP, the PHP may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same PHP for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the PHP again requests disenrollment for cause, the request shall be referred to the OHA assessment team for review.

(7) Other reasons for the PHP's request for disenrollment shall include the following:

(a) If the member is enrolled in the PHP on the same day the member is admitted to the hospital, the PHP shall be responsible for said hospitalization. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;

(b) The member has surgery scheduled at the time their enrollment is effective with the PHP, the provider is not on the PHP's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the PHP;

(d) The member had End Stage Renal Disease at the time of enrollment in the PHP;

(e) Excluding the DCOs, if the PHP determines that the member has Third Party Liability (TPL), the PHP will contact the Health Insurance Group (HIG) to request disenrollment;

(f) If a PHP has knowledge of a member's change of address, the PHP shall notify the member's care team. The care team shall verify the address information and disenroll the member from the PHP, if the member no longer resides in the PHP's service area. Members shall be disenrolled if out of the PHP's service area for more than three months, unless previously arranged with the PHP. The effective date of disenrollment shall be the date specified by the Division and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the PHP;

(g) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The PHP is responsible for identifying the members and providing sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from PHPs for members who have been taken into custody;

(h) The member is in a state psychiatric institution.

(8) The Division has authority to initiate and disenroll members as follows:

(a) If informed that a member has a third party insurer (TPL), the Division shall refer the case to the HIG for investigation and possible exemption from PHP enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the PHP's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the PHP;

(c) If the member is no longer eligible for the Oregon Health Plan, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

(9) Unless specified otherwise in these rules or in the Division notification of disenrollment to the PHP, all disenrollments are effective the end of the month the Authority approves the request with the following exceptions:

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated.

(b) The Authority may retroactively disenroll enrollment if the member has TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

Stat. Auth.: ORS 413.042, 414.645, 414.647

Stats. Implemented: ORS 414.065, 414.645, 414.647

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 11-1997, f. 3-28-97, cert. ef. 4-1-97; HR 14-1997, f. & cert. ef. 7-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 34-2011(Temp), f. 12-9-11, cert. ef. 1-1-12 thru 6-28-12; DMAP 24-2012, f. 4-27-12, cert. ef. 5-1-12; DMAP 8-2014(Temp), f. 1-31-14, cert. ef. 2-1-14 thru 7-31-14; DMAP 30-2014, f. 5-23-14, cert. ef. 6-1-14; DMAP 71-2015, f. & cert. ef. 12-10-15

410-141-0120
Managed Care Prepaid Health Plan Provision of Health Care Services

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure the provision of all medically and dentally appropriate covered services, including urgent care services and emergency services, preventive services and ancillary services, and in those categories of services included in contract or agreements with the Division of Medical Assistance Programs (Division) and Addictions and Mental Health (AMH). PHPs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all participating providers providing covered services to Division members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination based on the requirements of the discipline or profession that participating providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges, and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on September 28, 2004, thereby implementing ORS 441.223. PHPs shall retain responsibility for delegated activities including oversight of the following processes:

(A) PHPs shall ensure that covered services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services and that participating providers are appropriately supervised according to their scope of practice;

(B) PHPs shall provide training for PHP staff and participating providers and their staff regarding the delivery of covered services, Oregon Health Plan (OHP) administrative rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and shall provide accurate and timely information about license or certification expiration and renewal dates to the Division. PHPs may not refer Division members to or use providers who do not have a valid license or certification required by state or federal law. If a PHP knows or has reason to know that a provider's license or certification is expired or not renewed or is subject to licensing or certification sanction, the PHP shall immediately notify the member's Provider Services Unit.

(D) PHPs may not refer members to or use providers who have been terminated from the Division or excluded as Medicare and Medicaid providers by Centers for Medicare and Medicaid (CMS) or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101. PHPs may not accept billings for services to members provided after the date of such provider's exclusion, conviction, or termination. The Oregon Health Authority (Authority) has developed disclosure statement forms for individual practitioners and entities. If a PHP wishes to use their own disclosure statement form, they shall submit to their Coordinated Care Account Representative (CAR) for Authority approval prior to use. PHPs shall obtain information required on the appropriate disclosure form from individual practitioners and entities and shall retain the disclosure statements in the PHP credential files. If a PHP knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contender"), the PHP shall immediately notify the Division's Provider Services Unit.

(E) PHPs shall obtain and use the Division's provider enrollment (encounter) number for providers when submitting provider capacity reports. Only registered National Provider Identifiers (NPIs) and taxonomy codes are to be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. Effective January 1, 2007, provider number "999999" may no longer be used in encounter data reporting or provider capacity reporting. PHPs shall require each qualified provider to have and use a National Provider Identifier as enumerated by the National Plan and Provider Enumeration System (NPPES).

(F) The provider enrollment request (for encounter purposes) and disclosure statement described in paragraphs (D) and (E) require the disclosure of taxpayer identification numbers. The taxpayer identification number will be used for the administration of this program including provider enrollment, internal verification and administrative purposes for the medical assistance program, administration of tax laws, and may be used to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and the Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification number(s) may result in denial of enrollment as a provider, denial of a provider number for encounter purposes, denial of continued enrollment as a provider, and deactivation of all provider numbers used by the provider for encounters.

(b) FCHPs, Physician Care Organization (PCOs), and Dental Care Organizations (DCOs) shall have written procedures that provide newly enrolled members with information about which participating providers are currently not accepting new patients (except for staff models);

(c) FCHPs, PCOs, and DCOs shall have written procedures that allow and encourage a choice of a Primary Care Provider (PCP) or clinic for physical health and dental health services by each member. These procedures shall enable a member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that member;

(d) If the member does not choose a PCP within 30 calendar days from the date of enrollment, the FCHP or PCO shall ensure the member has an ongoing source of primary care appropriate to his or her needs by formally designating a practitioner or entity. FCHPs and PCOs that assign members to PCPs or clinics shall document the unsuccessful efforts to elicit the member's choice before assigning a member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after enrollment shall notify the member of the assignment and allow the member 30 calendar days after assignment to change the assigned PCP or clinic.

(2) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to the member's satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded providers for payment of point-of-contact services in the following categories:

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) The following services may be received by Division members from appropriate non-participating Medicaid providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the OHP), the member is responsible for payment of such services:

(A) Family planning services; and

(B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded providers for authorization of and payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and planning committees;

(e) FCHPs and PCOs shall report to the Division on their status in executing agreements with publicly funded providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(3) FCHPs and PCOs shall ensure a newly enrolled member receives timely, adequate, and appropriate health care services necessary to establish and maintain the health of the member. An FCHP's liability covers the period between the member's enrollment and disenrollment with the FCHP, unless the member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the inpatient hospital services until discharge or until the member's PCP or designated practitioner determines the care is no longer medically appropriate.

(4) A PCO's liability covers the period between the member's enrollment and disenrollment with the PCO, unless the member is hospitalized at the time of disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services will be the responsibility of the Division.

(5) The member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of enrollment through the date of disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for capitated services and shall coordinate benefits for shared members to ensure that the member receives all medically appropriate services covered under respective capitation payments. If the fully dual eligible member is enrolled in a FCHP or PCO with a Medicare HMO component, the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(7) PHPs shall coordinate services for each member who requires services from agencies providing health care services not covered under the capitation payment. The PCP shall arrange, coordinate, and monitor other medical and mental health or dental care for that member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with local or allied agencies, community emergency service agencies, and local providers;

(b) PHPs shall refer members to the divisions of the Authority and local and regional allied agencies that may offer services not covered under the capitation payment;

(c) FCHPs and PCOs may not require members to obtain the approval of a PCP in order to gain access to mental health and Substance Use Disorder assessment and evaluation services. Division members may refer themselves to MHO services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.727 & 441.223

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-0140

Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services

(1) PHPs shall have written policies and procedures and monitoring systems that ensure the provision of appropriate urgent, emergency, and triage services 24-hours a day, 7-days-a-week for all Division members. PHPs shall:

(a) Communicate these policies and procedures to participating providers;

(b) Regularly monitor participating providers' compliance with these policies and procedures; and

(c) Take any corrective action necessary to ensure participating provider's compliance. PHPs shall document all monitoring and corrective action activities.

(2) PHPs shall have written policies and procedures and monitoring processes to ensure that a practitioner provides a medically or dentally appropriate response as indicated to urgent or emergency calls consisting of the following elements:

(a) Telephone or face-to-face evaluation of the Division member to determine the nature of the situation and the Division member's immediate need for services;

(b) Capacity to conduct the elements of an assessment that is needed to determine the interventions necessary to begin stabilizing the urgent or emergency situation;

(c) Development of a course of action at the conclusion of the assessment;

(d) Provision of services and/or referral needed to address the urgent or emergency situation, begin post-stabilization care or provide outreach services in the case of an MHO;

(e) Provision for notifying a referral emergency room, when applicable concerning the presenting problem of an arriving Division member, and whether or not the practitioner will meet the Division member at the emergency room; and

(f) Provision for notifying other providers requesting approval to treat Division members of the determination.

(3) PHPs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from Division members. Urgent calls shall be returned appropriate to the Division member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the call shall be returned within 60 minutes in order to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call shall be returned immediately.

(4) If a screening examination in an emergency room leads to a clinical determination by the examining physician that an actual emergency medical condition exists under the prudent layperson standard as defined in emergency services, the PHP must pay for all services required to stabilize the patient, except as otherwise provided in (6) of this rule. The PHP may not require prior authorization for emergency services:

(a) The PHP may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature;

(b) The PHP may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;

(c) The PHP may not deny a claim for emergency services merely because the Primary Care Physician (PCP) was not notified,

or because the PHP was not billed within 10 calendar days of the service.

(5) When a Division member's PCP, designated practitioner or other health plan representative instructs the Division member to seek emergency care, in or out of the network, the PHP is responsible for payment of the screening examination and for other medically appropriate services. Except as otherwise provided in (6) of this rule, the PHP is responsible for payment of post-stabilization care that was:

(a) Pre-authorized by the PHP;

(b) Not pre-authorized by the PHP if the PHP (or the on-call provider) failed to respond to a request for pre-authorization within one hour of the request being made, or the PHP or provider on call could not be contacted; or

(c) If the PHP and the treating physician cannot reach an agreement concerning the Division member's care and a PHP representative is not available for consultation, the PHP must give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with care of the patient until a PHP physician is reached or one of the following criteria is met:

(A) The participating provider with privileges at the treating hospital assumes responsibilities for the Division member's care;

(B) The participating provider assumes responsibility for the Division member's care through transfer;

(C) A contractor representative and the treating physician reach an agreement concerning the Division member's care; or

(D) The Division member is discharged.

(6) PCO responsibility with regard to emergency services, urgent care services, or post-stabilization care services is as follows:

(a) A PCO is not financially responsible for emergency services, urgent care services, or post-stabilization care services, to the extent such services are inpatient hospital services. The PCO shall not authorize, cause, induce or otherwise furnish any incentive for emergency services, urgent care services, or post-stabilization care services to be rendered as inpatient hospital services except to the extent medically appropriate.

(b) A PCO is financially responsible for post-stabilization services (other than Inpatient hospital services) obtained by Division members within or outside the PCO's network under the following circumstances:

(A) Post-stabilization services have been authorized by the PCO's authorized representative;

(B) Post-stabilization services have not been authorized by the PCO's authorized representative, but are administered to maintain the Division member's stabilized condition within 1 hour of a request to the PCO's authorized representative for approval of further post-stabilization services;

(C) Post-stabilization services have not been authorized by the PCOs authorized representative, but are administered to maintain, improve, or resolve the Division member's stabilized condition if:

(i) The PCO's authorized representative does not respond to a request for authorization within 1 hour;

(ii) The PCO's authorized representative cannot be contacted; or

(iii) The PCO's authorized representative and the treating physician cannot reach an agreement concerning the Division member's care and the participating provider is not available for consultation. In this situation, the PCO must give the treating physician the opportunity to consult with the participating provider and the treating physician may continue with the care of the Division member until the participating provider is reached or one of the criteria in Section (6) of this rule has been met.

(c) The PCO's financial responsibility for non-inpatient post-stabilization services it has not approved ends when:

(A) The participating provider with privileges at the treating hospital assumes responsibilities for the Division member's care;

(B) The participating provider assumes responsibility for the Division member's care through transfer;

(C) A PCO representative and the treating physician reach an agreement concerning the Division member's care; or

(D) The Division member is discharged.

(7) PHPs shall have methods for tracking inappropriate use of emergency care and shall take action, including individual Division member counseling, to improve appropriate use of urgent and emergency care settings. DCOs and MHOs shall be responsible for taking action to improve appropriate use of urgent and emergency care settings for dental or mental health related care when inappropriate use of emergency care is made known to them through reporting or other mechanisms.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0160

Oregon Health Plan Prepaid Health Plan (PHP) Coordination and Continuity of Care

(1) PHPs shall have written policies, procedures, and monitoring systems that ensure the provision of Medical Case Management Services and delivery of primary care to and coordination of health care services for all members:

(a) PHPs are to coordinate and manage capitated services and non-capitated services and ensure that referrals made by the PHP's providers to other providers for covered services are noted in the appropriate Division member's clinical record;

(b) PHPs shall ensure members receiving Exceptional Needs Care Coordination (ENCC) services for the aged, blind, or disabled who have complex medical needs as described in 410-141-0405 are noted in the appropriate Division member's record. ENCC is a service available through Fully Capitated Health Plans (FCHPs) or Physician Care Organizations (PCOs) that is separate from and in addition to medical case management services;

(c) These procedures must ensure that each member has an ongoing source of primary care appropriate to his or her needs and a practitioner or entity formally designated as primarily responsible for coordinating the health care services furnished to the member in accordance with OAR 410-141-0120;

(d) FCHPs and PCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. FCHPs and PCOs shall document all monitoring and corrective action activities:

(A) PHPs shall develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable Alternative Care Settings, for all services covered by contracts/agreements with the Division). PHPs shall ensure that access to and quality of care provided in all referral settings is monitored. Referral services and services received in alternative care settings shall be reflected in the member's clinical record. PHPs shall establish and follow written procedures for participating and non-participating providers in the PHP's referral system. Procedures shall include the maintenance of records within the referral system sufficient to document the flow of referral requests, approvals, and denials in the system;

(B) The member shall obtain all covered services either directly or upon referral from the PHP responsible for the service from the date of enrollment through the date of disenrollment, except when the member is enrolled in a Medicare HMO or Medicare Advantage FCHP or PCO:

(i) FCHPs or PCOs with a Medicare HMO component or Medicare Advantage and MHOs have significant and shared responsibility for prepaid services and shall coordinate benefits for the member to ensure that the member receives all medically appropriate services covered under respective capitation payments;

(ii) If the member is enrolled in a FCHP or PCO with a Medicare HMO component or Medicare Advantage, then Medicare covered mental health services shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO, respectively. Mental

health services that are not covered by the FCHP or PCO but are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(C) PHPs shall have written procedures for referrals that ensure adequate prior notice of the referral to referral providers and adequate documentation of the referral in the member's clinical record;

(D) PHPs shall designate a staff member who is responsible for the arrangement, coordination, and monitoring of the PHP's referral system;

(E) PHPs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional;

(F) PHPs shall have written procedures that ensure relevant medical, mental health, and dental information is obtained from referral providers including telephone referrals. These procedures shall include:

(i) Review of information by the referring provider;

(ii) Entry of information into the member's clinical record;

(iii) Monitoring of referrals to ensure that information, including information pertaining to ongoing referral appointments, is obtained from the referral providers, reviewed by the referring practitioner, and entered into the clinical record.

(G) PHPs shall have written procedures to orient and train their staff, participating practitioners and their staff, the staff in alternative care settings, and staff in urgent and emergency care facilities in the appropriate use of the PHP's referral, alternative care, and urgent and emergency care systems. Procedures and education shall ensure use of appropriate settings of care;

(H) PHPs shall have written procedures that ensure an appropriate staff person responds to calls from other providers requesting approval to provide care to members who have not been referred to them by the PHP. If the person responding to the call is not a health care professional, the PHP shall have established written protocols that clearly describe when a health care professional needs to respond to the call. These procedures and protocols shall be reviewed by the PHP for appropriateness. The procedures shall address notification of acceptance or denial and entry of information into the PCP's clinical record;

(I) FCHPs and PCOs shall have written policies and procedures to ensure information on all emergency department visits is entered into the member's appropriate PCP's clinical record. FCHPs and PCOs shall communicate this policy and procedure to providers, monitor providers' compliance with this policy and procedure, and take corrective action necessary to ensure compliance;

(J) If a member is hospitalized in an inpatient or outpatient setting for a covered service, PHPs shall ensure that:

(i) A notation is made in the member's appropriate PCP's clinical record of the reason, date, and expected duration of the hospitalization;

(ii) Upon discharge, a notation is made in the member's appropriate PCP's clinical record of the actual duration of the hospitalization and follow-up plans, including appointments for provider visits; and

(iii) Pertinent reports from the hospitalization are entered in the member's appropriate PCP's clinical record. Such reports shall include, as applicable, the reports of consulting practitioners' physical history, psycho-social history, list of medications and dosages, progress notes, and discharge summary.

(2) For members living in residential facilities or homes providing ongoing care, PHPs shall work with the appropriate staff person identified by the facility to ensure the member has timely and appropriate access to covered services and to ensure coordination of care provided by the PHP and care provided by the facility or home. PHPs shall make provisions for a PCP or the facility's "house doctor or dentist" to provide care to members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.

(3) For members living in residential facilities or homes providing ongoing care, FCHPs and PCOs shall provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, which meets state dispensing laws. FCHPs and PCOs shall provide emergency prescriptions on a 24-hour basis.

(4) For members who are discharged to post hospital extended care, the FCHP shall notify the appropriate Authority office at the time of admission to the skilled nursing facility (SNF) and begin appropriate discharge planning. The FCHP is not responsible for the post hospital extended care benefit unless the member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the member no later than two full working days prior to discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the appropriate DHS office shall be notified at the time the FCHP learns of the admission. The FCHP shall initiate appropriate discharge planning at the time of the notification to the Authority office.

(5) PHPs shall coordinate the services the PHP furnishes to members with the services the member receives from any other PHP (FCHP, PCO, DCO, CDO, or MHO) in accordance with OAR 410-141-0120(6). PHPs shall ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.

(6) When a member's care is being transferred from one PHP to another or for clients transferring from fee-for-service to a PHP, the PHP shall make every reasonable effort within the laws governing confidentiality to coordinate transfer of the client into the care of a PHP participating provider.

(7) PHPs shall make attempts to contact targeted Division populations by mail, telephone, in person, or through the Authority within the first three months of enrollment to assess medical, mental health, or dental needs appropriate to the PHP. The PHP shall, after reviewing the assessment, refer the member to his PCP or other resources as indicated by the assessment. Targeted populations shall be determined by the PHP and approved by the Division.

(8) MHOs shall establish working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area for the purposes of maintaining a comprehensive and coordinated mental health delivery system and to help ensure member access to mental health services that are not provided under the capitation payment.

(9) MHOs shall ensure that members receiving services from extended or long term psychiatric care programs (e.g., secure residential facilities, PASSAGES projects, state hospital) will receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.

(10) MHOs shall coordinate with Community Emergency Service Agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to members experiencing a mental health crisis.

(11) MHOs shall use a multi-disciplinary team service planning and case management approach for members requiring services from more than one public agency. This approach shall help avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, medically appropriate care in the least restrictive treatment setting (e.g., clinic, home, school, community).

(12) MHOs shall consult with and provide technical assistance to FCHPs and PCOs to help assure that mental health conditions of members are identified early so that intervention and prevention strategies can begin as soon as possible.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.651

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 71-2015, f. & cert. ef. 12-10-15

410-141-0180
Oregon Health Plan Prepaid Health Plan Record Keeping

(1) Maintenance and Security: Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete clinical records that document the care received by the members from the PHP's primary care and referral providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities. Such policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).

(2) Confidentiality and Privacy: PHPs and PHP's participating providers shall have written policies and procedures to ensure that clinical records related to the member's individual identifiable health information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through 179.507, 411.320, 433.045(3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50, and section (3) of this rule. If the PHP is a public body within the meaning of the Oregon public records law, the policies and procedures shall ensure that member privacy is maintained in accordance with 192.502(2), 192.502(8) (Confidential under Oregon law) and 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their participating providers may not release or disclose any information concerning a member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the member;

(b) Except in an emergency, PHPs' participating providers shall obtain a written authorization for release of information from the member or the legal guardian or the member's legal Power of Attorney for Health Care Decisions before releasing information. The written authorization for release of information shall specify the type of information to be released and the recipient of the information and shall be placed in the member's record. In an emergency, release of service information shall be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the member;

(c) PHPs may consider a member age 14 or older competent to authorize or prevent disclosure of mental health and substance use disorder treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the member's clinical treatment requirements.

(3) Exchange of Protected Health Information for Treatment Purposes without Authorization: In accordance with ORS 192.518 to 192.526 and with required acknowledgement, the Authority and PHP's may share the following protected health information without member authorization for the purpose of treatment activities. The protected health information that may be disclosed, commonly found in claims or encounters, includes the following:

(a) Oregon Health Plan member name;
(b) Medicaid recipient number;
(c) Performing provider number;
(d) Hospital provider name and attending physician name;
(e) Diagnosis;
(f) Dates of service;
(g) Procedure code;
(h) Revenue code;
(i) Quantity of units of service provided;
(j) Medication prescription and monitoring;

(4) Access to clinical records:

(a) Provider access to clinical records:

(A) PHPs shall release health service information requested by a provider involved in the member's care within ten working days of receiving a signed authorization for release of information;

(B) Mental Health Organizations (MHOs) shall assure that directly operated and subcontracted service components, as well as other cooperating health service providers, have access to the applicable contents of a member's mental health record when necessary for use in the member's diagnosis or treatment. Such access is permitted under ORS 179.505(6);

(b) Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' participating providers shall upon request, provide the member access to their own clinical record, allow for the record to be amended or corrected, and provide copies within ten working days of the request. PHPs' participating providers may charge the member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' participating providers shall upon receipt of a member's written authorization for release of information, provide access to the member's clinical record. PHPs' participating providers may charge for reasonable duplication costs;

(d) Authority Access to Records: PHPs shall cooperate with the Division, the Addictions and Mental Health Division (AMH), the Medicaid Fraud Unit, and AMH representatives for the purposes of audits, inspection, and examination of members' clinical and administrative records.

(5) Retention of Records: All clinical records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the clinical records shall be retained until all issues arising out of the action are resolved.

(6) Requirements for Clinical Records: PHPs shall have policies and procedures that ensure maintenance of a clinical record keeping system that is consistent with state and federal regulations to which the PHP is subject. The system shall assure accessibility, uniformity, and completeness of clinical information that fully documents the member's condition and the covered and non-covered services received from PHPs' participating or referred providers. PHPs shall communicate these policies and procedures to participating providers, regularly monitor compliance with these policies and procedures, and take any corrective action necessary to ensure compliance. PHPs shall document all monitoring and corrective action activities:

(a) A clinical record shall be maintained for each member receiving services that documents all types of care needed or delivered in all settings whether services are delivered during or after normal clinic hours;

(b) All entries in the clinical record shall be signed and dated;

(c) Errors to the clinical record shall be corrected as follows:

(A) Incorrect data shall be crossed through with a single line;

(B) Correct and legible data shall be added followed by the date corrected and initials of the individual making the correction;

(C) Removal or obliteration of errors shall be prohibited;

(d) The clinical record shall reflect a signed and dated authorization for treatment for the member, his or her legal guardian, or the Power of Attorney for Health Care Decisions for any invasive treatments;

(e) The PCP's or clinic's clinical record shall include data that forms the basis of the diagnostic impression of the member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP or clinic's member's clinical record receiving services shall include the following information as applicable:

(A) Member name, date of birth, sex, address, telephone number, and identifying number as applicable;

(B) Name, address, and telephone number of next of kin, legal guardian, Power of Attorney for Health Care Decisions, or other responsible party;

(C) Medical, dental, or psychosocial history as appropriate;

(D) Dates of service;

(E) Names and titles of individuals performing the services;

(F) Physicians' orders;

(G) Pertinent findings on examination and diagnosis;

(H) Description of medical services provided including medications administered or prescribed; tests ordered or performed, and results;

(I) Goods or supplies dispensed or prescribed;

(J) Description of treatment given and progress made;

(K) Recommendations for additional treatments or consultations;

(L) Evidence of referrals and results of referrals;

(M) Copies of the following documents if applicable:

(i) Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations, or evaluations;

(ii) Plans of care including evidence that the member was jointly involved in the development of the mental health treatment plan;

(iii) For inpatient and outpatient hospitalizations, history and physical, dictated consultations, and discharge summary;

(iv) Emergency department and screening services reports;

(v) Consultation reports;

(vi) Medical education and medical social services provided;

(N) Copies of signed authorizations for release of information forms;

(O) Copies of medical and mental health directives;

(f) Based on written policies and procedures, the clinical record keeping system developed and maintained by PHPs' participating providers shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment;

(g) The PCP or clinic shall have policies and procedures that accommodate members requesting to review and correct or amend their clinical record;

(h) PHPs' shall maintain other records in either the clinical record or within the PHP's administrative offices. Other records shall include the following:

(A) Names and phone numbers of the member's prepaid health plans, primary care physician or clinic, primary dentist, and mental health Practitioner, if any in the MHO records;

(B) Copies of Client Process Monitoring System (CPMS) also known as Measures and Outcomes Tracking System (MOTS) enrollment forms in the MHO's records;

(C) Copies of long-term psychiatric care determination request forms in the MHO's records;

(D) Evidence that the member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;

(E) Evidence that the member has been informed of his or her rights and responsibilities in the MHO records;

(F) ENCC records in the FCHP's or PCO's records;

(G) Complaint and Appeal records; and

(H) Disenrollment requests for cause and the supporting documentation.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.651

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 22-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-0200
Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System

(1) QI Program:

(a) FCHPs, PCOs, DCOs and CDOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division members. This process shall include an internal Quality Improvement (QI) program based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with relevant law and the community standards for dental care, and/or with accepted medical practice, whichever is applicable, and with accepted professional standards. The QI program shall include policies, standards, and written procedures that adequately address the needs of Division members, including those who are aged, blind or disabled who have complex medical needs; or children receiving CAF (SOSCF) or OYA services. FCHPs, PCOs, DCOs and CDOs shall establish or adopt written criteria to monitor and evaluate the provision of adequate medical and/or dental care. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(b) MHOs shall abide by the Quality Assurance Requirements as stated in the MHO Agreement.

(2) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. FCHPs, PCOs, DCOs and CDOs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The Quality Improvement Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Division members including those who are aged, blind or disabled who have complex medical needs and children receiving CAF (SOSCF) or OYA services, or shall be able to retain consultation from individuals who are qualified.

(3) FCHPs, PCOs, DCOs and CDOs shall establish a QI Committee that shall meet at least every two months; The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:

(a) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings;

(b) Conduct and submit to the Division an annual written evaluation of the QI Program and of Division member care as measured against the written procedures and protocols of Division member care. The evaluation of the QI program and Division member care is to include a description of completed and ongoing QI activities, Division member education and an evaluation of the overall effectiveness of the QI program. This evaluation shall include:

(A) Prevention programs;

(B) Care of Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services, and FCHP or PCO review of the Quality of Exceptional Needs Care Coordination program;

(C) Disease management programs;

(D) Adverse outcomes of Division members and Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services;

(E) Actions taken by the FCHPs, PCOs, DCOs or CDOs to address health care concerns identified by Division members or their Representatives and changes which impact quality or access to care. This may include: clinical record keeping; utilization review; referrals; comorbidities; prior authorizations; Emergency Services; out of FCHPs, PCOs, DCOs or CDOs utilization; medication review; FCHPs, PCOs, DCOs or CDOs initiated disenrollments; encounter data management; and access to care and services.

(c) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant Division member complaints and appeals;

(d) Review written procedures, protocols and criteria for Division member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.

(4) FCHPs or PCOs that are NCQA accredited or accredited by other Division recognized accreditation organizations shall be deemed for Section (3)(b) of this rule. FCHPs and PCOs deemed by the Division shall annually submit to the Division an evaluation of the Exceptional Needs Care Coordination program; and an evaluation of Division member care for Division members who are aged, blind or disabled who have complex medical needs or children receiving CAF (SOSCF) or OYA services. Copies of accreditation reports shall be submitted to the Division within 60 days of issuance.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 15-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10

410-141-0220
Managed Care Prepaid Health Plan Accessibility

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all members. PHPs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance with these policies and procedures, and take any corrective action necessary to ensure participating provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between members and non-members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures that ensure for 90 percent of their members in each service area, routine travel time or distance to the location of the PCP does not exceed the community standard for accessing health care participating providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by the Division:

(A) In urban areas: 30 miles, 30 minutes, or the community standard, whichever is greater;

(B) In rural areas: 60 miles, 60 minutes, or the community standard, whichever is greater.

(b) PHPs shall maintain and monitor a network of appropriate participating providers sufficient to ensure adequate service capacity to provide availability of and timely access to medically appropriate covered services for members:

(A) PHPs shall have an access plan that establishes standards for access, outlines how capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act;

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision, and ancillary services as accessible to members in terms of timeliness, amount, duration, and scope as those services are to non- members within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to the Division and shall provide reasonable alternatives for members to access care that must be approved by the Division. PHPs shall demonstrate to the Division that it surveys and monitors for equal access of member referrals to provider, pharmacy, hospital, vision, and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled who have complex medical needs or who are children receiving CAF (SOSCF services) or OYA services have access to primary care, dental care, mental health providers, and referral, as applicable. These providers shall have the expertise to treat, take into account, and accommodate the full range of medical, dental, or mental health conditions experienced by these members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs enrollment standards:

(a) PHPs shall remain open for enrollment unless the Authority has closed enrollment because the PHP has exceeded their enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by the Division and the PHP;

(b) PHPs enrollment may also be closed by the Division due to sanction provisions;

(c) PHPs shall accept all clients, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Division to provide covered services;

(d) PHPs may confirm the enrollment status of a client by one of the following:

(A) The individual's name appears on the monthly or weekly enrollment list produced by the Division;

(B) The individual presents a valid medical care identification that shows he or she is enrolled with the PHP;

(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the PHP;

(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the PHP.

(e) PHPs shall have open enrollment for 30 continuous calendar days during each twelve-month period of January through December, regardless of the PHPs enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.

(3) If a PHP is assumed by another PHP, members shall be automatically enrolled in the succeeding PHP. The member will have 30 calendar days to request disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding PHP.

(4) If a PHP engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area and necessitates either transferring members to other providers or the PHP withdrawing from part or all of a service area, the PHP shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:

(a) A PHP may provide less than the required 90 calendar-day notice to the Authority upon approval by the Authority when the PHP must terminate a participating provider or participating provider group due to problems that could compromise member care, or when such a participating provider or participating provider group terminates its contract with the PHP and refuses to provide the required 90 calendar-day notice;

(b) If DHS must notify members of a change in participating providers or PHPs, the PHP shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide members with at least a 30 calendar-day notice of such changes.

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit:

(a) PHPs shall have written policies and procedures and a monitoring system to assure that members have access to appointments according to the following standards:

(A) FCHPs and PCOs:

(i) Emergency Care: The member shall be seen immediately or referred to an emergency department depending on the member's condition;

(ii) Urgent Care: The member shall be seen within 48 hours or as indicated in initial screening, in accordance with OAR 410-141-0140; and

(iii) Well Care: The member shall be seen within four weeks or within the community standard.

(B) DCOs:

(i) Emergency Care: The member shall be seen or treated within 24-hours;

(ii) Urgent Care: The member shall be seen within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

(iii) Routine Care: The member shall be seen for routine care within an average of eight weeks and within twelve weeks or the community standard, whichever is less, unless there is a documented special clinical reason that would make access longer than 12 weeks appropriate.

(C) MHOs:

(i) Emergency Care: The member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care: The member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care: The member shall be seen for an intake assessment within two weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of members through the office such that members are not kept waiting longer than non-member patients under normal circumstances. If members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through complaint and appeal reviews, termination reports, and member surveys to determine if waiting times for clients in all settings are appropriate;

(c) PHPs shall have written procedures and a monitoring system for timely follow-up with members when participating providers have notified the PHP that the members have failed to keep scheduled appointments. The procedures shall address determining why appointments are not kept, the timely rescheduling of missed appointments, as deemed medically or dentally appropriate, documentation in the clinical record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the PHP's participating provider office or clinic, PHPs shall provide outreach services as medically appropriate;

(d) PHPs shall have policies and procedures that ensure participating providers will attempt to contact members if there is a need to cancel or reschedule the member's appointment and there is sufficient time and a telephone number available;

(e) PHPs shall have written policies and procedures to triage the service needs of members who walk into the PCP's office or clinic with medical, mental health, or dental care needs. Such triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the member's needs or be evaluated for treatment within two hours by a medical, mental health, or dental provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by the Division because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics as an operative element of FCHP's and PCO's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate clinical record of the Division member regardless of who responds to the call or the time of day the call is received. PHPs shall monitor for compliance with this requirement;

(d) Such policies and procedures shall include a written protocol specifying when a medical, mental health or dental provider must be consulted. When medically appropriate, all such calls shall be forwarded to the on-call PCP who shall respond immediately to calls which may be emergent in nature. Urgent calls shall be returned appropriate to the Division member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's participating providers) have sufficient communication skills and training to reassure members and encourage them to wait for a return call in appropriate situations. PHPs shall have written procedures and trained staff to communicate with hearing impaired members via TDD/TTY;

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take corrective action as needed, and report findings to the PHP's quality improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of member services and complaint and grievance representatives, and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health, or dental care visits including home health visits to interpret for members with hearing impairment or in the primary language of non-English speaking members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to be able to understand the member's complaint, to make a diagnosis, to respond to the member's questions and concerns, and to communicate instructions to the member;

(c) PHPs shall ensure the provision of care and interpreter services that are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the member;

(d) PHPs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating referral providers when necessary:

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether members are receiving accommodations for access and to determine what will be done to remove existing barriers and to accommodate the needs of members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all members including, but not limited to, the following:

(i) Street level access or accessible ramp into the facility;

(ii) Wheelchair access to the lavatory;

(iii) Wheelchair access to the examination room; and

(iv) Doors with levered hardware or other special adaptations for wheelchair access.

(e) PHPs shall ensure that participating providers, their facilities, and personnel are prepared to meet the complex medical needs of members who are aged, blind, or disabled:

(A) PHPs shall have a written plan for meeting the complex medical needs of members who are aged, blind, or disabled;

(B) PHPs shall monitor participating providers for compliance with the access plan and take corrective action when necessary.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 38-1998, f. & cert. ef. 10-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 71-2015, f. & cert. ef. 12-10-15

410-141-0260

Managed Care Prepaid Health Plan Complaint or Grievance and Appeal Procedures

(1) Definitions:

(a) Action — In the case of a PHP:

(A) The denial or limited authorization of a requested service, including the type or level of service;

(B) The reduction, suspension or termination of a previously authorized service;

(C) The denial in whole or in part, of payment for a service;

(D) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (Division);

(E) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or

(F) For a Division member in a single PHP service area, the denial of a request to obtain services outside of the PHP's participating provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(b) Appeal — A request by a Division member or representative for review of an "action" as defined in this section;

(c) Complaint — A Division member's or Division member's representative's expression of dissatisfaction to a PHP or to a practitioner about any matter other than an action, as "action" is defined in this section;

(d) Grievance System — The overall system that includes a complaint process, an appeals process and access to the Division's administrative hearing process.

(2) The purpose of OAR 410-141-0260 through 410-141-0266 is to describe the requirements for the overall grievance system. These rules will apply to all PHPs as defined in 410-141-0000.

(3) All PHPs shall have written policies and procedures for a grievance system that ensures that they meet the requirements of sections OAR 410-141-0260 to 410-141-0266.

(4) Information provided to the Division member shall include at least:

(a) Written material describing the PHP's complaint and appeal procedures, and how to make a complaint or file an appeal; and

(b) Assurance in all written, oral, and posted material of Division member confidentiality in the complaint and appeal processes.

(5) A Division member or a Division member's representative may file a complaint and a PHP level appeal orally or in writing, and may request a Division administrative hearing.

(6) PHPs shall keep all information concerning a Division member's complaint or appeal confidential as specified in OAR 410-141-0261 and 410-141-0262.

(7) Consistent with confidentiality requirements, the PHP's staff person who is designated to receive complaints or appeals, shall begin to obtain documentation of the facts concerning the complaint or appeal upon receipt of the complaint or appeal.

(8) PHPs shall afford Division members full use of the grievance system procedures. If the Division member decides to pursue a remedy through the Division's administrative hearing process, the PHP will cooperate by providing relevant information required for the hearing process.

(9) A request for a Division administrative hearing made to the Division outside of the PHP's appeal procedures, or without previous use of the PHP's appeal procedures shall be reviewed by the PHP through the PHP's appeal process upon notification by the Division as provided for in OAR 410-141-0264.

(10) Under no circumstances may a PHP discourage a Division member or a Division member's representative from using the Division's administrative hearing process.

(11) Neither implementation of a Division hearing decision nor a Division member's request for a hearing may be a basis for a request by the PHP for a Division member's disenrollment.

(12) PHPs shall make available a supply of blank complaint forms (OMAP 3001) in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to complaints or appeals. PHPs shall make available a supply of blank Administrative Hearing Request forms (DHS 443) and the Notice of Hearing Rights forms (DMAP 3030). PHPs shall develop an appeal form and shall make the appeal forms, along with the DHS 443 and DMAP 3030 forms, available in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to complaints or appeals.

(13) The PHP must provide information about the grievance system to all participating providers and subcontractors at the time they enter into a contract.

(14) The PHP must maintain logs that are in compliance with OAR 410-141-0266 to document complaints and appeals received by the PHP, and the State must review the information as part of the State quality strategy.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.651

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 22-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11

410-141-0261

PHP Complaint Procedures

The Division may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) A grievance (see definition) procedure applies only to those situations in which the Division member (see definition) or their respresentative (see definition) expresses concern or dissatisfaction about any matter other than an "action." PHPs shall have written procedures to acknowledge the receipt, disposition and documentation of each grievance from Division members. The PHP's written procedures for handling grievances, shall, at a minimum:

(a) Address how the PHP will accept, process and respond to each grievance from a Division member or their respresentative, including:

(A) Acknowledgment to the Division member or respresentative of receipt of each grievance;

(B) Ensuring that Division members who indicate dissatisfaction or concern are informed of their right to file a grievance and how to do so;

(C) Ensuring that each grievance is transmitted timely to staff having authority to act upon it;

(D) Ensuring that each grievance is investigated and resolved in accordance with these rules; and

(E) Ensuring that the practitioner(s) or staff person(s) who make decisions on the grievance must be persons who are:

(i) Not involved in any previous level of review or decision-making; and

(ii) Who are health care professionals who have appropriate clinical expertise in treating the Division member's condition or disease if the grievance concerns denial of expedited resolution of an appeal or if the grievance involves clinical issues:

(b) Describe how the PHP informs Division members, both orally and in writing, about the PHP's grievance procedures;

(c) Designate the PHP staff member(s) or a designee who will be responsible for receiving, processing, directing, and responding to grievances;

(d) Include a requirement for grievances to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(2) The PHP must provide Division members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a grievance. This includes, but is not limited to, providing interpreter services and toll free phone numbers that have adequate TTY/TTD and interpreter capabilities.

(3) The PHP shall assure Division members that grievances are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the Division member's right to confidentiality of information about the grievance as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a Division member's grievance is kept confidential, consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any practitioner whose services, items or quality of care is alleged to be involved in the grievance have a right to use this information for purposes of the PHP resolving the grievance, for purposes of maintaining the log required in OAR 410-141-0266, and for health oversight purposes, without a signed release from the Division member;

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the Division member to authorize a release of information regarding the grievance to other individuals as needed for resolution. Before any information related to the grievance is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the grievance file. Copies of the form for obtaining the release of information shall be included in the PHP's written process.

(4) The PHPs procedures shall provide for the disposition of grievances within the following timeframes:

(a) The PHP must resolve each grievance, and provide notice of the disposition, as expeditiously as the Division member's health condition requires, within the timeframes established in this rule;

(b) For standard disposition of grievances and notice to the affected parties, within 5 working days from the date of the PHP's receipt of the grievance, the PHP must either:

(A) Make a decision on the grievance and notify the Division member; or

(B) Notify the Division member in writing that a delay in the PHP's decision of up to 30 calendar days from the date the grievance was received by the PHP is necessary to resolve the grievance. The PHP shall specify the reasons the additional time is necessary.

(5) The PHP's decision about the disposition of a grievance shall be communicated to the Division member orally or in writing within the timeframes specified in (4) of this rule:

(a) An oral decision about a grievance shall address each aspect of the Division member's grievance and explain the reason for the PHP's decision;

(b) A written decision must be provided if the grievance was received in writing. The written decision on the grievance shall review each element of the Division member's grievance and address each of those concerns specifically, including the reasons for the PHP's decision.

(6) All grievances made to the PHP's staff person designated to receive grievances shall be entered into a log and addressed in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(7) All grievances that the Division member chooses to resolve through another process, and that the PHP is notified of, shall be noted in the grievance log.

(8) Division members who are dissatisfied with the disposition of a grievance may present their grievance to the Governors Advocacy Office.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 22-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10

410-141-0262
Prepaid Health Plan Appeal Procedures

(1) A Division of Medical Assistance Programs (Division) Member or their representative that disagrees with a Notice of Action may file a Prepaid Health Plan (PHP) level appeal or request a Division administrative hearing. Division members may not be required to go through a PHP level appeal in order to request a Division administrative hearing.

(2) The PHP must have a system in place for Division member which includes an appeal process when a Division member has requested a Division administrative hearing. For purposes of this rule, an appeal includes a request to the PHP for review of an Action upon notification from the Division.

(3) An appeal must be filed with the PHP no later than 45 calendar days from the date on the Notice of Action required under OAR 410-141-0263.

(4) If the Division member initiates an appeal directly with the PHP, it shall be documented in writing by the PHP and handled as an appeal consistent with this rule. The Division member or Division member's representative may file an appeal with the PHP either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed appeal.

(5) Each PHP must adopt written policies and procedures for handling appeals that, at a minimum, meet the following requirements:

(a) Give Division members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an appeal or administrative hearings request. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate Tele Typewriter (TTY)/ Telecommunications Devices for the Deaf (TTD) and interpreter capacity;

(b) Address how the PHP will accept, process and respond to such appeals, including how the PHP will acknowledge receipt of each appeal;

(c) Ensuring that Division members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an appeal and an administrative hearing request and how to do so;

(d) Ensuring that each appeal is transmitted timely to staff having authority to act on it;

(e) Ensuring that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensuring that the individuals who make decisions on appeals are individuals:

(A) Who were not involved in any previous level of review or decision making; and

(B) Who are health care professionals who have the appropriate clinical expertise in treating the Division member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues:

(g) Include a requirement for appeals to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(6) The PHP shall assure Division members that appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the Division member's right to confidentiality of information about the appeal as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a Division member's appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any practitioner whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the appeal have a right to use this information for purposes of resolving the appeal and for purposes of maintaining the log required in OAR 410-141-0266 and for health oversight purposes by Division, without a signed release from the Division member. The administrative hearing regarding the appeal without a signed release from the Division member, pursuant to 410-120-1360(4);

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the Division member to authorize a release of information regarding the appeal to other individuals. Before any information related to the appeal is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the appeal file.

(7) The process for appeals must:

(a) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the Division member or Division member's representative requests expedited resolution;

(b) Provide the Division member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PHP must inform the Division member or the Division member's representative of the limited time available in the case of an expedited resolution);

(c) Provide the Division member and/or the Division member's representative an opportunity, before and during the appeals process, to examine the Division member's file, including medical records and any other documents or records to be considered during the appeals process; and

(d) Include as parties to the appeal the Division member, the Division member's representative, or the legal representative of a deceased Division member's estate.

(8) The PHP must resolve each appeal and provide a client notice of the appeal resolution as expeditiously as the Division member's health condition requires and within the time frames in this section:

(a) For the standard resolution of appeals and client notices to the Division member or Division member's representative, the PHP shall resolve the appeal and provide a client notice no later than 16 calendar days from the day the PHP receives the appeal.

(b) When the PHP has granted a request for expedited resolution of an appeal, the PHP shall resolve the appeal and provide a client notice no later than 3 working days after the PHP receives the appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(c) In accordance with 42 CFR 438.408, the PHP may extend the timeframes from subsections (a) or (b) of this section by up to 14 calendar days if:

(A) The Division member or Division members representative requests the extension; or

(B) The PHP shows (to the satisfaction of the Division's Hearings Unit upon its request) that there is need for additional information and how the delay is in the Division member's interest;

(d) If the PHP extends the timeframes, it must, for any extension not requested by the Division member, give the Division member or Division member's representative a written notice of the reason for the delay.

(9) For all appeals, the PHP must provide written Notice of Appeal Resolution to the Division member or their representative. If the PHP knows that there is a representative, the PHP must send a copy of the Notice to the representative. For notice on an expedited resolution, the PHP must also make reasonable efforts to provide oral notice.

(10) The written Notice of Appeal Resolution must be on a Division approved form and include the following:

(a) The results of the resolution process and the date it was completed; and

(b) For appeals not resolved wholly in favor of the Division member, the notice must also include the following information:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) Unless the appeal was referred to the PHP from the Division as part of an administrative hearings process, the right to request a Division Administrative Hearing, and how to do so, which includes attaching the appropriate forms as outlined in 410-141-0263;

(C) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(D) That the Division member may be held liable for the cost of those benefits if the hearing decision upholds the PHP's Action.

(11) Unless the appeal was referred to the PHP as part of an administrative hearing process, a Division member may request a Division administrative hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution. The parties to the Division administrative hearing include the PHP as well as the Division member and/or Division member's representative, or the Representative of the deceased Division member's estate.

(12) Each PHP shall establish and maintain an expedited review process for appeals, consistent with OAR 410-141-0265.

(13) Each PHP shall maintain records of appeals, enter appeals and their resolution into a log, and address the appeals in the context of quality improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(14) Continuation of benefits pending appeal:

(a) As used in this section, "timely" filing means filing on or before the later of the following:

(A) Within 10 calendar days of the PHP mailing the Notice of Action; or

(B) The intended effective date of the PHP's proposed Action:

(b) The PHP must continue the Division member's benefits if:

(A) The Division member or Division member's representative files the appeal or administrative hearing request timely;

(B) The appeal or administrative hearing request involves the termination, suspension, or reduction of a previously authorized course of treatment;

(C) The services were ordered by an authorized provider;

(D) The original period covered by the original authorization has not expired; and

(E) The Division member or representative requests extension of benefits:

(c) Continuation of benefits pending administrative hearing — If, at the Division member's request, the PHP continues or reinstates the Division member's benefits while the appeal or administrative hearing is pending , the benefits must be continued pending administrative hearing pursuant to OAR 410-141-0264.

(15) If the final resolution of the appeal or administrative hearing is adverse to the Division member, that is, upholds the PHP's Action, the PHP may recover the cost of the services furnished to the Division member while the appeal or administrative hearing was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR 431.230(b).

(16) If the PHP or a Division administrative hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the Division member's health condition requires.

(17) If the PHP or the Division administrative hearing decision reverses a decision to deny authorization of services, and the Division member received the disputed services while the appeal was pending, the PHP or the Division must pay for the services in accordance with the Division policy and regulations.

(18) If the appeal was referred to the PHP from the Division as part of an administrative hearing process, the PHP must immediately (within two business days) transmit the Notice of Appeal Resolution and the complete record of the appeal to the Division Hearings Unit.

(19) If the appeal was made directly by the Division member or Representative, and if the Notice of Appeal Resolution was not favorable to the Division member, the PHP must: Retain a complete record of the appeal for not less than 45 days so that, if an administrative hearing is requested, the record can be submitted to the Division's Hearings Unit within two business days of the Division's request.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 22-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 10-2013(Temp), f. & cert. ef. 3-1-13 thru 8-27-13; DMAP 16-2013(Temp), f. & cert. ef. 4-10-13 thru 8-27-13; DMAP 46-2013, f. & cert. ef. 8-26-13; DMAP 60-2013, f. & cert. ef. 10-31-13

410-141-0263
Notice of Action by a Prepaid Health Plan

The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule.

(1) When a Prepaid Health Plan (PHP) or authorized practitioner (see definition) acting on behalf of the PHP takes or intends to take any "action," including but not limited to denials or limiting prior authorizations of a requested service in an amount, duration or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other action, the PHP or authorized practitioner acting on behalf of the PHP shall mail a written client (see definition) Notice of Action (NOA) in accordance with section (2) of this rule to the Division member (see definition) within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be on a Division approved form and must be used for all denials of a requested service, reductions, discontinuations or terminations of previously authorized services, denials of claims payment or other action. The client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the Division member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) The Division member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service;

(G) Effective date of the action, if different from the date of the NOA;

(H) Whether the PHP considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(b) The action the PHP or its participating provider (see definition) has taken or intends to take;

(c) Reasons for the action with enough specificity to clearly explain the actual reason for the denial, including but not limited to the following reasons:

(A) The item requires pre-authorization, and it was not pre-authorized;

(B) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(C) The person was not a Division member at the time of the service or is not a Division member at the time of a requested service; and

(D) The provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan rules);

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The Division member's right to file an appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The Division member's right to request a Division administrative hearing and how to exercise that right. A copy of the following forms must be attached to the Notice of Action:

(A) Hearing Request form (DHS 443) and the Notice of Hearing Rights (DMAP 3030), or

(B) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form DMAP 3302 or approved facsimile.

(g) The circumstances under which expedited appeal resolution is available and how to request it;

(h) The Division member's right to have benefits continue pending resolution of the appeal, how to request that benefit be continued and the circumstances under which the Division member may be required to pay the costs of these services; and

(i) The telephone number to contact the PHP for additional information.

(3) The PHP or practitioner acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension or reduction of previously authorized OHP covered services (see definition), the following time frames apply:

(A) The notice must be mailed at least ten calendar days before the date of action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP or authorized practitioner acting on behalf of the PHP may mail a notice not later than the date of action if:

(i) The PHP or practitioner receives a clear written statement signed by the Division member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The Division member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The Division member's whereabouts are unknown and the post office returns PHP or practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another state, territory, or commonwealth has accepted the Division member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the Division member's PCP or PCD; or

(vi) The date of action will occur in less than ten calendar days in accordance with 42 CFR 483.12(a)(5)(ii) related to discharges or transfers and long-term care facilities:

(C) The PHP may shorten the period of advance notice to five calendar days before the date of the action if the PHP has facts indicating that an action should be taken because of probable fraud by the Division member. Whenever possible, these facts should be verified through secondary sources:

(b) For denial of payment at the time of any action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the Division member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the Division member or the provider requests the extension or if the PHP justifies (to the Division upon request) a need for additional information and how the extension is in the Division member's interest;

(B) If the PHP extends the timeframe in accordance with subsection (A) of this section, it shall give the Division member written notice of the reason for the decision to extend the timeframe and inform the Division member of their right to file a grievance if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the Division member's health condition requires and no later than the date the extension expires;

(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section (which constitutes a denial and is thus an adverse action) on the date that the timeframes expire;

(e) For expedited prior authorizations within the timeframes specified in OAR 410-141-0265.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; DMAP 22-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 60-2013, f. & cert. ef. 10-31-13; DMAP 33-2014, f. 5-30-14, cert. ef. 7-1-14

410-141-0264
Administrative Hearings

(1) An individual who is or was a Division member at the time of the notice of action is entitled to a contested case hearing if a Prepaid Health Plan (PHP) has denied requested services, payment of a claim, or terminates, discontinues or reduces a course of treatment, or any other action.

(a) If a member receives an adverse notice of action, the member may file a request for a contested case hearing. :

(b) If a member receives an adverse notice of appeal resolution from the PHP, the member may request a contested case hearing based on the notice of appeal resolution.:

(c) Contested case hearings are governed by OAR 410-120-1860, 410-120-1865, and this rule.

(2) A written hearing request must be received by the Division not later than the 45th day following the date of the Notice of Action, or if the hearing request was initiated after an appeal, not later than the 45th day following the Notice of Appeal Resolution.

(3) Effective, February 1, 2012, the method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in the division of rules in OAR 410 division 120 and 141 applicable to timely filing of requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to Division hearing requests.

(4) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending.

(a)To be entitled to continuing benefits, the member must complete a hearing request or request for appeal, requesting continuing benefits, no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (4)(a) of this rule, delay caused by circumstances beyond the control of the member is not counted.

(c) The benefits must be continued until:

(A) A final appeal resolution resolves the appeal, unless the member requests a hearing with continuing benefits, no later than ten days following the date of the notice of appeal resolution;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for hearing.

(5) The Division representative shall review the hearing request, documentation related to the hearing issue, and computer records to determine whether the claimant or the individual for whom the request is being made is or was a Division member at the time the action was taken, and whether the hearing request was timely.

(6) PHPs shall immediately transmit to the Division any hearing request submitted on behalf of a member, including a copy of the notice of action and, if applicable, notice of appeal resolution.

(7) If the member files a request for hearing with the Division, the Division shall send a copy of the hearing request to the PHP.

(8) PHPs shall review a hearing request, which has not been previously received or reviewed as an appeal, using the PHP's appeal process as follows:

(a) The appeal shall be reviewed immediately and shall be resolved, if possible, within 16 calendar days, pursuant to OAR 410-141-0262;

(b) The PHP shall provide the member with a written notice of appeal resolution.

(9) When a member requests a hearing, the PHP shall cooperate with providing relevant information required for the hearing process to the Division, as well as the results of the review by the PHP of the appeal and the administrative hearing request, and any attempts at resolution by the PHP.

(10) Information about members used for administrative hearings is handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The Division shall safeguard the member's right to confidentiality of information used in the hearing as follows:

(a) The Division, the member and their representative, the PHP and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the hearing may use this information for purposes of resolving the hearing without a signed release from the member. The Division may also use this information, pursuant to OAR 410-120-1360(4), for health oversight purposes, and for other purposes authorized or required by law. The information may also be disclosed to the Office of Administrative Hearings and the Administrative Law Judge assigned to the hearing and to the Court of Appeals if the member seeks judicial review of the final order;

(b) Except as provided in subsection (a), the Division shall ask the member to authorize a release of information regarding the hearing to other individuals. Before any information related to the hearing is disclosed under this subsection, the Division must have an authorization for release of information documented in the hearing file.

(11) The hearings request and the notice of appeal resolution shall be referred to the Office of Administrative Hearings and the hearing will be scheduled.

(a) The parties to the hearing shall include the PHP, the member and his or her representative, or the representative of a deceased member's estate;

(b) The procedures applicable to the hearing shall be conducted consistent with OAR 410-120-1860 and 410-120-1865;

(c) A final order should be issued or the case otherwise resolved by the Division ordinarily within 90 calendar days from the earlier of the following:

(A) The date the member requested a PHP appeal, not including the number of days the member took to subsequently file a request for hearing or

(B) The date the member filed a request for contested case hearing.

(d) The final order is the final decision of the Division.

(12) If the hearing decision is adverse to the member, the PHP may recover the cost of the services furnished to the member while the hearing is pending, to the extent that they were furnished solely because of the requirements of this rule and in accordance with forth in 42 CFR 438.420.

(13) The PHP must promptly correct the action taken up to the limit of the original request or authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the member, or Division or the PHP decides in the member's favor before the hearing even if the member has lost eligibility after the date the action was taken:

(a) If the PHP, or a hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the hearing was pending, the PHP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires;

(b) If the PHP, or the hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the hearing was pending, the PHP must pay for the services in accordance with Division policy and regulations in effect when the member requested the services.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 22-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 7-2012(Temp), f. & cert. ef. 2-7-12 thru 8-4-12; DMAP 38-2012, f. 8-3-12, cert. ef. 8-4-12

410-141-0265
Request for Expedited Appeal or Expedited Administrative Hearing

(1) Each PHP shall establish and maintain an expedited review process for appeals, when the PHP determines (upon request from the Division of Medical Assistance Programs (Division) member) or the provider indicates (in making the request on a Division member's behalf or supporting the DMAP member's request) that taking the time for a standard resolution could seriously jeopardize the Division member's life, health, or ability to attain, maintain or regain maximum function.

(2) The PHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Division member's appeal.

(3) If the PHP provides an expedited appeal, but denies the services or items requested in the expedited appeal, the PHP shall inform the Division member of the right to request an expedited Administrative Hearing and send the member a Division approved Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-0263 with the Notice of Appeal Resolution.

(4) If the PHP denies a request for expedited resolution on appeal, it must:

(a) Transfer the appeal to the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) A Division member who believes that taking the time for a standard resolution of a request for an Administrative Hearing could seriously jeopardize the Division member's life or health or ability to attain, maintain or regain maximum function may request an expedited Administrative Hearing.

(6) The PHP shall submit relevant documentation to the Division's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. The Division's Medical Director shall decide within, as nearly as possible, 2 working days from the date of receiving the medical documentation applicable to the request, whether the Division member is entitled to an expedited Administrative Hearing.

(7) If the Division's Medical Director denies a request for expedited Administrative Hearing, the Division must:

(a) Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and

(b) Make reasonable efforts to give the Division member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 22-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 60-2013, f. & cert. ef. 10-31-13

410-141-0266
PHP's Responsibility for Documentation and Quality Improvement Review of the Grievance System

(1) The PHP's documentation shall include, at minimum, a log of all oral and written complaints and appeals received by the PHP. The log shall identify the Division member and the following additional information:

(a) For complaints, the date of the complaint, the nature of the complaint, the disposition and date of disposition of the complaint;

(b) For appeals, the date of the Notice of Action, the date of the appeal, the nature of the appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the appeal. If an administrative hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the administrative hearing.

(2) The PHP shall also maintain a record for each of the complaints and appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the Division member. The PHPs shall retain documentation of complaints and appeals for seven years to permit evaluation.

(3) The PHPs shall have written procedures for the review and analysis of the grievance system, including all complaints and appeals received by the PHP. The analysis of the grievance system shall be forwarded to the quality improvement committee as necessary to comply with the quality improvement standards:

(a) PHPs shall monitor the completeness and accuracy of the written log, on a monthly basis;

(b) Monitoring of complaints and appeals shall review, at minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of complaints and appeals, and compliance with Oregon Health Plan rules.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09

410-141-0270
Prepaid Health Plan Marketing Requirements for Potential Members

(1) For the purposes of this rule, the following definitions apply:

(a) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by

the PHP; Cold-call marketing methodologies may include, but are not limited to, door to door, telephone, mail, or e-mail.

(b) "Marketing" means any communication from a PHP to a potential member who is not enrolled in the PHP that can reasonably be interpreted as intended to compel or entice the potential members to enroll in that particular PHP;

(c) "Marketing Materials" means materials that are produced in any medium by or on behalf of a PHP and that can reasonably be interpreted as intended to market to potential members;

(d) "Outreach" means any communication from a PHP to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular PHP. Outreach activities include, but are not limited to, the act of raising the awareness of the PHP, the PHP's subcontractors and partners, the PHP contractually required programs and services, and the promotion of healthful behaviors, health education, and health related events.

(e) "Outreach Materials" means materials that are produced in any medium, by or on behalf of a PHP that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular PHP.

(f) "Potential Member" means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP.

(2) PHPs must comply with the information required in 42 CFR 438.10, 438.100, and 438.104 to ensure that before enrolling OHP clients, the PHP provides accurate oral and written information a potential member needs to make an informed decision on whether to enroll in that PHP. In so doing, the PHP must:

(a) Not distribute any marketing materials without first obtaining state approval;

(b) Distribute the materials to its entire service area as indicated in its PHP contract;

(c) Not seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance;

(d) Not directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The creation of name recognition shall not constitute an attempt by the PHP to compel or entice a client's enrollment and are expressly permitted. Communication methodologies may include, but are not limited to: brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(4) PHPs' or their subcontractor's communications that express participation in or support for a PHP by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(5) PHPs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA will confirm information before posting.

(6) PHPs have sole accountability for producing or distributing materials following OHA approval.

(7) PHPs shall comply with the Authority marketing materials submission guidelines. PHPs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

(a) A list of communication or outreach materials subject to review by the Authority;

(b) A clear explanation of the Authority's process for review and approval of marketing materials;

(c) A process for appeals of the Authority's edits or denials;

(d) A marketing materials submission form to ensure compliance with PHP marketing rules; and

(e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-0280

Managed Care Prepaid Health Plan Potential Member Informational Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCO or CCO;

(c) "Prevalent Non-English Language" means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the MCO's total OHP enrollment; or

(B) 1,000 of the MCO's members;

(d) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-0270, Prepaid Health Plan Marketing Requirements for Potential Members.

(3) The creation of name recognition because of the MCO's health promotion or education activities shall not constitute an attempt by the MCO to influence a client's enrollment.

(4) An MCO or its subcontractor's communications that express participation in or support for an MCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(5) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with provider service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) MCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) MCOs shall develop informational materials for potential members.

(8) MCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The MCO shall make available to potential members, upon request, information on participating providers.

(9) MCO provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.

(10) MCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(11) MCO's shall honor requests made by other sources such as potential members, potential family members, or caregivers for

language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include, but are not limited to, braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide:

(a) MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);

(b) MCOs shall ensure that all MCO staff who have contact with potential members are fully informed of MCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free certified interpreter services, and which participating providers' offices have bilingual capacity and which are accepting new members.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.725
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 16-2015, f. 3-31-15, cert. ef. 4-1-15; DMAP 21-2015, f. 4-14-15, cert. ef. 4-15-15; DMAP 24-2015, f. & cert. ef. 4-15-15

410-141-0300
Managed Care Organization (MCO) Member Education and Information Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to a person with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: Braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Alternate Format Statement Insert" means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state's top sixteen preferred written languages identified by OHP enrollees. MCOs shall insert their contact information into the template;

(c) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness;

(d) "Prevalent Non-English Language" means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the MCO's total OHP enrollment; or

(B) 1, 000 of the MCO's members;

(2) MCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the MCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining managed care services at service area sites or benefits.

(3) MCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications shall be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health–related events. MCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the MCO's health promotion or education activities shall not constitute an attempt by the MCO to influence a client's enrollment.

(5) An MCO or its subcontractor's communications that express participation in or support for an MCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(6) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with provider service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) MCOs shall have a mechanism to help members understand the requirements and benefits of the MCO plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) MCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. Member education shall:

(a) Include information about the Exceptional Needs Care Coordination (ENCC) or case management services to members who are aged, blind, disabled, or have complex medical needs consistent with OAR 410-141-0405 and how to access that system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that certified health care interpreter services at provider offices are free to MCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of an MCO receiving notice of a member's enrollment, MCOs shall mail a welcome packet to new members and to members returning to the MCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory.

(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. An MCO or the Division may include informational materials in the application packet for potential members.

(11) For those who are existing members, an MCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCOs shall send hard copies upon request.

(12) MCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the MCO:

(A) Welcome packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes;

(b) Include alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit;

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services.

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large (18 point) type, and braille.

(13) An MCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille;

(c) MCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and the MCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) What participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of Exceptional Needs Care Coordination (ENCC) services and how members with special health care needs who are aged, blind, or disabled, or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency can access ENCC services;

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(L) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the MCO's grievance and appeals processes and the Division's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the MCO to the member as outlined in OAR 410-141-3260;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3260;

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCO for non-emergent care; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill; including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(B) The MCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;

(t) Whether or not the MCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(z) The MCO's confidentiality policy;

(aa) How and where members are to access any benefits that are available under OHP but are not covered under the MCO's contract, including any cost sharing;

(bb) When and how members can voluntarily and involuntarily disenroll from MCOs and change MCOs;

(cc) MCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the MCO's internal changes. If changes affect the member's ability to use services or benefits, the MCO shall offer the updated member handbook to all members;

(dd) The "Oregon Health Plan Client Handbook" is in addition to the MCO's member handbook, and an MCO shall not use it to substitute for any component of the MCO's member handbook.

(14) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCO providers or other individuals or programs approved by the MCO may provide health education. MCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) MCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(c) Explanation of ENCC services and how to access ENCC services through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, or chemical dependency;

(d) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(e) MCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from MCO's participating providers. The MCO shall provide, translated as appropriate, the

notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the MCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that MCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) MCOs shall provide free certified health care interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care;

(b) MCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. MCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(c) MCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language;

(d) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.

(16) MCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCO, members, and providers.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.651
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 29-2011, f. 10-19-11, cert. ef. 10-20-11; DMAP 16-2015, f. 3-31-15, cert. ef. 4-1-15; DMAP 21-2015, f. 4-14-15, cert. ef. 4-15-15; DMAP 24-2015, f. & cert. ef. 4-15-15

410-141-0320
Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure Division of Medical Assistance Programs (Division) members have the rights and responsibilities included in this rule:

(a) PHPs shall communicate these policies and procedures to participating providers;

(b) PHPs shall monitor compliance with policies and procedures governing member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) The members shall have the following rights:

(a) To be treated with dignity and respect;

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

(c) To choose a PHP as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Physician (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies;

(d) To refer oneself directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other participating provider;

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

(f) To be actively involved in the development of the member's treatment plan;

(g) To be given information about the member's condition and covered and non-covered services to allow an informed decision about proposed treatments;

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

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

(j) To have written materials explained in a manner that is understandable to the member;

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

(L) To receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and is medically appropriate;

(m) To obtain covered preventive services;

(n) To have access to urgent and emergency services 24 hours a day, seven days a week as described in OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(o) To receive a referral to specialty practitioners for medically appropriate covered services;

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

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

(r) To transfer a copy of the member's clinical record to another provider;

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

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

(u) To know how to make a complaint or appeal with the PHP and receive a response as defined in OAR 410-141-0260 to 410-141-0266;

(v) To request an administrative hearing with the Authority;

(w) To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility; and

(x) To receive a notice of an appointment cancellation in a timely manner.

(3) The member shall have the following responsibilities:

(a) To choose or help with assignment to a PHP as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements and a PCP or service site;

(b) To treat the PHP, practitioner, and clinic staff with respect;

(c) To be on time for appointments made with practitioners and other providers and to call in advance either to cancel if unable to keep the appointment or if the member expects to be late;

(d) To seek periodic health exams and preventive services from a PCP or clinic;

(e) To use a PCP or clinic for diagnostic and other care except in an emergency;

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

(g) To use urgent and emergency services appropriately and notify the PHP within 72 hours of an emergency;

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

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

(j) To ask questions about conditions, treatments, and other issues related to the member's care that is not understood;

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

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

(m) To follow prescribed, agreed upon treatment plans;

(n) To tell the practitioner or provider that the member's health care is covered under OHP before services are received and, if requested, to show the practitioner or other provider the Division Medical Care Identification form;

(o) To tell the Authority worker of a change of address or phone number;

(p) To tell the Authority worker if the member becomes pregnant and to notify the Authority worker of the birth of the member's child;

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

(r) To tell the Authority worker if there is any other insurance available;

(s) To pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;

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

(u) To assist the PHP in pursuing any third party resources available and to pay the PHP the amount of benefits it paid for an injury from any recovery received from that injury;

(v) To bring issues or complaints or grievances to the attention of the PHP; and

(w) To sign an authorization for release of medical information so that the Authority and the PHP can get information that is pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.651
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 71-2015, f. & cert. ef. 12-10-15

410-141-0340
Oregon Health Plan Prepaid Health Plan Financial Solvency

(1) Prepaid Health Plans (PHPs) shall assume the risk for providing capitated services under their contracts and agreements with the Division of Medical Assistance Programs (Division). PHPs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to the Division:

(a) PHPs shall comply with solvency requirements specified in contracts and agreements with the Division. Solvency requirements of PHPs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in contracts and agreements with the Division. If the PHP has contracts and agreements with the Division, separate restricted reserve fund accounts shall be maintained for each contract and agreement;

(B) Protection against catastrophic and unexpected expenses related to capitated services for PHPs. The method of protection may include the purchase of stop loss coverage, reinsurance, self-insurance, or any other alternative determined acceptable by the Division. Self-insurance must be determined appropriate by the Division;

(C) Maintenance of professional liability coverage of not less than $1,000,000 per person per incident and not less than $1,000,000 in the aggregate either through binder issued by an insurance carrier or by self-insurance with proof of same, except to the extent that the Oregon Tort Claims Act, ORS 30.260 to 30.300 is applicable;

(D) Systems that capture, compile, and evaluate information and data concerning financial operations. Such systems shall provide for the following:

(i) Determination of future budget requirements for the next three quarters;

(ii) Determination of incurred but not reported (IBNR) expenses;

(iii) Tracking additions and deletions of members and accounting for capitation payments;

(iv) Tracking claims payment;

(v) Tracking all monies collected from third party resources on behalf of members; and

(vi) Documentation of and reports on the use of incentive payment mechanisms, risk-sharing, and risk-pooling, if applicable.

(b) PHPs shall submit the following applicable reports as specified in agreements with the Division:

(A) An annual audit performed by an independent accounting firm containing, but not limited to:

(i) A written statement of opinion by the independent accounting firm, based on the firm's audit regarding the PHP's financial statements;

(ii) A written statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities, and related items;

(iii) Balance Sheets;

(iv) Statement of Revenue, Expenses and Net Income, and Change in Fund Balance;

(v) Statements of Cash Flows;

(vi) Notes to Financial Statements;

(vii) Any supplemental information deemed necessary by the independent accounting firm or actuary; and

(viii) Any supplemental information deemed necessary by the Division.

(B) PHP-specific quarterly financial reports. Such quarterly reports shall include, but are not limited to:

(i) Statement of Revenue, Expenses and Net Income;

(ii) Balance Sheet;

(iii) Statement of Cash Flows;

(iv) Incurred But Not Reported (IBNR) Expenses;

(v) Fee-for-service liabilities and medical and hospital expenses that are covered by risk-sharing arrangements;

(vi) Restricted reserve documentation;

(vii) Third party resources collections (MHO Contractor); and

(viii) Corporate Relationships of Contractors (FCHPs, DCOs, and PCOs) or Incentive Plan Disclosure and Detail (MHOs).

(C) PHP-specific utilization reports;

(D) PHP-specific quarterly documentation of the Restricted Reserve. Restricted reserve funds of FCHPs, PCOs, and DCOs shall be held by a third party. Restricted reserve fund documentation shall include the following:

(i) A copy of the certificate of deposit from the party holding the restricted reserve funds;

(ii) A statement showing the level of funds deposited in the restricted reserve fund accounts;

(iii) Documentation of the liability that would be owed to creditors in the event of PHP insolvency;

(iv) Documentation of the dollar amount of that liability that is covered by any identified risk-adjustment mechanisms.

(2) MHOs shall comply with the following additional requirements regarding restricted reserve funds:

(a) MHOs that subcapitate any work described in agreements with the Division may require subcontractors to maintain a restricted reserve fund for the subcontractor's portion of the risk assumed or may maintain a restricted reserve fund for all risk assumed under the agreement with the Division. Regardless of the

alternative selected, MHOs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with the Division;

(b) If the restricted reserve fund of the MHO is held in a combined account or pool with other entities, the MHO and its subcontractors, as applicable, shall provide a statement from the pool or account manager that the restricted reserve fund is available to the MHO or its subcontractors, as applicable, and has not been obligated elsewhere;

(c) If the MHO must use its restricted reserve fund to cover services under its agreement with the Division, the MHO shall provide advance notice to the Division of the amount to be withdrawn, the reason for withdrawal, when and how the restricted reserve fund will be replenished, and steps to be taken to avoid the need for future restricted reserve fund withdrawals;

(d) MHOs shall provide the Division access to restricted reserve funds if insolvency occurs;

(e) MHOs shall have written policies and procedures to ensure that if insolvency occurs, members and related clinical records are transitioned to other MHOs or providers with minimal disruption.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.651
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; DMAP 71-2015, f. & cert. ef. 12-10-15

410-141-0400
Oregon Health Plan Prepaid Health Plan Case Management Services

DCO: Dental Care Organization
FCHP: Fully Capitated Health Plan
MHO: Mental Health Organization
OHP: Oregon Health Plan
PCO: Physician Care Organization
PHP: Prepaid Health Plan

(1) Prepaid health plans provide case management services under the Oregon Health Plan.

(2) Prepaid Health Plan case management services are defined as follows:

(a) FCHPs and PCOs provide medical case management as defined in OAR 410-141-0000, Definitions;

(b) DCOs provide dental case management as defined in OAR 410-141-0000, Definitions. DCOs shall make dental case management staff available for training, Regional OHP meetings, and case conferences involving their Division members in all service areas;

(c) MHOs provide mental health case management for capitated and non-capitated mental health services as defined in OAR 410-141-0000, Definitions.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.651
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0405
Oregon Health Plan Fully Capitated Health Plan and Physician Care Organization Exceptional Needs Care Coordination (ENCC)

Division may have specific definitions for common terms. Please use OAR 410-141-0000, Definitions, in conjunction with this rule. Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health Plan:

(1) FCHPs and PCOs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all capitated services;

(2) FCHPs and PCOs shall make ENCC services available to Division members (see definition) or Division member's representative (see definition) identified as aged, blind or disabled who have complex medical needs at the request of a Division member or Division member's representative, a physician, other medical personnel serving the Division member, or the Division member's agency case manager;

(3) FCHPs and PCOs shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving Division members or Division member's representative identified as aged, blind or disabled who have complex medical needs in all their service areas;

(4) FCHP and PCO staff who coordinate or provide ENCC services shall be trained to and exhibit skills in communication with and sensitivity to the unique health care needs of people who are aged, blind, disabled or who have complex medical needs. FCHPs and PCOs shall have a written position description for the staff member(s) responsible for managing ENCC services and for staff who provide ENCC services;

(5) FCHPs and PCOs shall have written policies that outline how the level of staffing dedicated to ENCC is determined;

(6) FCHPs and PCOs shall make ENCC services available to Division members identified as aged, blind or disabled who have complex medical needs during normal office hours, Monday through Friday. Information on ENCC services shall be made available when necessary to a Division member's representative during normal business hours, Monday through Friday;

(7) FCHPs and PCOs shall provide the aged, blind or disabled who have complex medical needs Division member or Division member's representative who requests ENCC services with an initial response by the next working day following the request, as appropriate;

(8) FCHPs and PCOs shall periodically inform all of their practitioners (see definition) and the practitioner's staff of the availability of ENCC services, provide training for medical office staff on ENCC services and other support services available for serving the aged, blind, disabled or who have complex medical l needs Division members or Division member's representative; FCHPs and PCOs shall assure that the ENCCs name(s) and telephone number(s) are made available to both agency staff and Division members or Division member's representative;

(9) FCHPs and PCOs shall have written procedures that describe how they will respond to ENCC requests;

(10) FCHPs and PCOs shall make ENCC services available to coordinate the provision of covered services to aged, blind or disabled who have complex medical needs to Division members or Division member's representative who exhibit inappropriate, disruptive or threatening behaviors in a practitioner's office;

(11) Exceptional Needs Care Coordinators shall document ENCC services in Division member medical records as appropriate and/or in a separate Division member case file.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.651
Hist.: HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10

410-141-0407
Oregon Health Plan Ombudsman Services

(1) The Authority provides ombudsman services to all Division members who are aged, blind or disabled who have complex medical needs as defined in OAR 410-141-0000, Definitions.

(2) The Authority shall inform all Division members who are aged, blind or disabled who have complex medical needs of the availability of ombudsman services.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.651
Hist.: HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10

410-141-0440
Prepaid Health Plan Hospital Contract Dispute Resolution

When there is a failure to reach agreement on a contract between a Fully Capitated Health Plan (FCHP) or a Physician Care

Organization (PCO) and a non Type A, Type B, or critical access hospital, the two disagreeing parties must engage in non-binding mediation. This requirement to engage in non-binding mediation does not apply to disagreements involving emergency or urgent services as defined in Oregon Health Plan administrative rules. The hospital, FCHP, or the PCO can call for mediation. If the parties agree on a mediator their selection shall stand. If a mediator cannot be mutually agreed on, the State will make the selection from the recommended names forwarded by each party. The cost of mediation will be evenly split between the FCHP or PCO and the hospital.

(1) The mediation will proceed under the following guidelines:

(a) Access to care for OHP members is of critical importance;

(b) Any agreement must operate within the capitation rate received by the FCHP or PCO;

(c) Reimbursement levels must bear some relationship to the cost of the services;

(d) Consideration shall be given to the efforts of each part to manage the overall utilization of health care resources and control costs;

(e) A comparison to statewide averages of each party's cost of services, service utilization rates and administrative costs may be considered in reaching a mediation recommendation.

(2) No client medical information, communication between parties, nor any other non public information used in the mediation may be disclosed to any person not a party to the mediation. All such information shall not be admissible nor disclosed in any subsequent administrative, judicial or mediation proceeding.

(3) Within thirty (30) days of the conclusion of the mediation, the mediator will issue a report to the State and to the involved parties that will include mediation findings, and recommendations. All confidential information will be excluded from the mediator's report.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0480
Oregon Health Plan Benefit Package of Covered Services

(1) Division members are eligible to receive, subject to section (11) of this rule, those treatments for the condition/treatment pairs funded on the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are medically or dentally appropriate, except that services shall also meet the prudent layperson standard defined in 410-141-0140. Refer to 410-141-0520 for funded line coverage information.

(2) Medical Assistance Benefit Packages follow practice guidelines adopted by the HERC in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.

(3) Diagnostic services that are necessary and reasonable to diagnose the member's presenting condition are covered services regardless of the placement of the condition on the Prioritized List of Health Services.

(4) Comfort care is a covered service for a member with a terminal illness.

(5) Preventive services promoting health and reducing the risk of disease or illness are covered services for members. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors (See OAR 410-141-0520 Prioritized List of Health Services).

(6) Ancillary services are covered subject to the service limitations of the OHP program rules when the services are medically or dentally appropriate for the treatment of a covered condition/treatment pair, or the provision of ancillary services will enable the member to retain or attain the capability for independence or self-care.

(7) The provision of SUD services shall comply with Addictions and Mental Health Division (AMH) administrative rules, OAR 415-012-0000 "Standards for Approval/Licensure of Alcohol and Other Drug Abuse Programs," OAR 415-020 "Standards for Outpatient Synthetic Opiate Treatment Programs," OAR 415-050 "Standards for Alcohol Detoxification Centers," OAR 309-018 "Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services," OAR 309-019 "Outpatient Addictions and Mental Health Services," OAR 309-022 "Intensive Treatment Services for Children and Adolescents and Children's Emergency Safety Intervention Specialist," and the requirements in the SUD subsection of the Statement of Work in the CCO and PCO contracts.

(8) In addition to the coverage available under section (1) of this rule, a member may be eligible to receive, subject to section (11), services for treatments that are below the funded line or not otherwise excluded from coverage:

(a) Services may be provided if it can be shown that:

(A) The OHP member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition;

(D) Ancillary services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded co-morbid conditions or disabilities shall be represented by an ICD-10-CM diagnosis code or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there shall be a medical determination and finding by the Division for fee-for-service OHP clients or a finding by the Prepaid Health Plan (PHP) for members that the terms of subsection (a)(A)–(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any member, especially a member with a disability or with a co-morbid condition, providers shall determine whether the member has a funded condition/treatment pair that would entitle the member to treatment under the program, and both the funded and unfunded conditions shall be represented by an ICD- 10-CM diagnosis code, or when the condition is a mental disorder, represented by DSM-V diagnosis coding to the highest level of axis specificity.

(9) The Division shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the OHP Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Division shall make a retrospective determination under this section, provided the Division is notified of the emergency situation during the next business day. If the Division denies a requested service, the Division shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five working days of making the decision.

(10) If a condition/treatment pair is not on the HERC Prioritized List of Health Services and the Division determines the condition/treatment pair has not been identified by the HERC for inclusion on the list, the Division shall make a coverage decision in consultation with the HERC.

(11) Coverage of services available through the OHP Benefit Package of Covered Services is limited by OAR 410-141-0500 (Excluded Services and Limitations for Oregon Health Plan Clients).

(12) General anesthesia for dental procedures that are medically and dentally appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 26-1995, f. 12-29-95, cert. ef. 1-1-96; HR 19-1996, f. & cert. ef. 10-1-96; HR 1-1997(Temp), f. 1-31-97, cert. ef. 2-1-97; HR 12-1997, f. 5-30-97, cert. ef. 6-1-97; HR 15-1997, f. & cert. ef 7-1-97; HR 26-1997, f. & cert. ef. 10-1-97; OMAP 17-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 32-1998, f. & cert. ef. 9-1-98; OMAP 39-1998, f. & cert. ef. 10-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 23-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 11-2010(Temp), f. & cert. ef. 6-3-10 thru 11-15-10; DMAP 25-2010, f. & cert. ef. 9-1-10; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-141-0500
Excluded Services and Limitations for Oregon Health Plan clients and/or Division members

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are excluded under the Division shall be excluded under the Oregon Health Plan (OHP);

(b) Any service or item identified in the appropriate provider guides as a non-covered service, unless the service is identified as specifically covered under the OHP administrative rules;

(c) Any treatment, service, or item for a condition that is not included on the funded lines of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(d) Services that are currently funded on the Prioritized List of Health Services that are not included in the OHP client's and/or Division member's OHP benefit package, are excluded;

(e) Any treatment, service, or item for a condition which is listed as a Condition/Treatment Pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(f) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or non-covered condition/ treatment pair;

(g) Services requested by OHP clients and/or Division member's in an emergency care setting which after a screening examination are determined not to meet the definition of emergency services and the provisions of 410-141-0140;

(h) Services provided to an OHP client and/or Division member outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(i) Services or items, other than inpatient care, provided to an OHP client and/or Division member who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080(2)(b)(G);

(j) Services received while the Division member is outside the contractor's service area that were either:

(A) Not authorized by the Division member's primary care provider; or

(B) Not urgent or emergency services, subject to the Division member's appeal rights, that the Division member was outside contractor's service area because of circumstances beyond the Division member's control. Factors to be considered include but are not limited to death of a family member outside of contractor's service area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are medically appropriate to provide reasonable diagnosis and treatment or to enable the OHP client to attain or retain the capability for independence or self-care. Included would be those services which upon medical review, provide only minimal benefit in treatment or information to aid in a diagnosis;

(b) Diagnostic services not reasonably required to diagnose a presenting problem, whether or not the resulting diagnosis and indicated treatment are on the currently funded lines under the OHP Prioritized List of Health Services;

(c) Services that are limited under the Division as identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are limited under the Division shall be limited under the OHP.

(3) In the case of non-covered condition/treatment pairs, providers shall ensure that OHP clients are informed of:

(a) Clinically appropriate treatment that may exist, whether covered or not;

(b) Community resources that may be willing to provide non-covered services;

(c) Future health indicators that would warrant a repeat diagnostic visit.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 26-1995, f. 12-29-95, cert. ef. 1-1-96; HR 19-1996, f. & cert. ef. 10-1-96; HR 1-1997(Temp), f. 1-31-97, cert. ef. 2-1-97; HR 12-1997, f. 5-30-97, cert. ef. 6-1-97; HR 18-1997, f. 7-11-97, cert. ef. 7-12-97; OMAP 17-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 32-1998, f. & cert. ef. 9-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 33-2003, f. & cert. ef. 4-15-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04

410-141-0520
Prioritized List of Health Services

(1) The Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and mental health services with "expanded definitions" of practice guidelines and statements of intent as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HERC. The HERC maintains the most current list on their website: http://www.oregon.gov/oha/herc/Pages/index.aspx. For a hard copy, contact the Division within the Oregon Health Authority (Authority).

(2) This rule, effective October 1, 2016, incorporates by reference new interim modifications to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2016–December 31, 2017, Prioritized List funded through line 475. These modifications include revised condition treatment pairings approved at the January 14, 2016, through August 11, 2016, HERC meetings not involving the changes to the prioritization of treatments for conditions of the back and spine already reflected in the July 1, 2016, Prioritized List. The October 1, 2016, Prioritized List includes revised line items and new/revised guideline notes and multisector interventions that supersede those found in the July 1, 2016, Prioritized List.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065 & 414.727
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 33-1998, f. & cert. ef. 9-1-98; OMAP 40-1998(Temp), f. & cert. ef. 10-1-98 thru 3-1-99; OMAP 48-1998(Temp), f. & cert. ef. 12-1-98 thru 5-1-99; OMAP 21-1999, f. & cert. ef. 4-1-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 9-2000(Temp), f. 4-27-00, cert. ef. 4-27-00 thru 9-26-00; OMAP 13-2000, f. & cert. ef. 9-12-00; OMAP 14-2000(Temp), f. 9-15-00, cert. ef. 10-1-00 thru 3-30-01; OMAP 40-2000, f. 11-17-00, cert. ef. 11-20-00; OMAP 22-2001(Temp), f. 3-30-01, cert. ef. 4-1-01 thru 9-1-01; OMAP 28-2001, f. & cert. ef. 8-10-01; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 18-2002, f. 4-15-02, cert. ef. 5-1-02; OMAP 64-2002, f. & cert. ef. f. & cert. ef. 10-2-02; OMAP 65-2002(Temp), f. & cert. ef. 10-2-02 thru 3-15-0; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 30-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 17-2004(Temp), f. 3-15-04 cert. ef. 4-1-04 thru 9-15-04; OMAP 28-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 48-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 68-2004(Temp), f. 9-14-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 83-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 54-2005(Temp), f. & cert. ef. 10-14-05 thru 4-1-06; OMAP 62-2005, f. 11-29-05, cert. ef. 12-1-05; OMAP 71-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 6-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 14-2007(Temp), f. &

cert. ef. 10-1-07 thru 3-28-08; DMAP 28-2007(Temp), f. & cert. ef. 12-20-07 thru 3-28-08; DMAP 8-2008, f & cert. ef. 3-27-08; DMAP 10-2008(Temp), f. & cert. ef. 4-1-08 thru 9-15-08; DMAP 23-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 31-2008(Temp), f. & cert. ef. 10-1-08 thru 3-29-09; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 4-2009(Temp), f. & cert. ef. 1-30-09 thru 6-25-09; DMAP 6-2009(Temp), f. 3-26-09, cert. ef. 4-1-09 thru 9-25-09; DMAP 8-2009(Temp), f. & cert. ef. 4-17-09 thru 9-25-09; DMAP 26-2009, f. 8-3-09, cert. ef. 8-5-09; DMAP 30-2009(Temp), f. 9-15-09, cert. ef. 10-1-09 thru 3-29-10; DMAP 36-2009(Temp), f. 12-10-09 ef. 1-1-10 thru 3-29-10; DMAP 1-2010(Temp), f. & cert. ef. 1-15-10 thru 3-29-10; DMAP 3-2010, f. 3-5-10, cert. ef. 3-17-10; DMAP 5-2010(Temp), f. 3-26-10, cert. ef. 4-1-10 thru 9-1-10; DMAP 10-2010, f. & cert. ef. 4-26-10; DMAP 27-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11; DMAP 43-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 4-2011, f. 3-23-11, cert. ef. 4-1-11; DMAP 24-2011(Temp), f. 9-15-11, cert. ef. 10-1-11 thru 3-26-12; DMAP 45-2011, f. 12-21-11, cert. ef. 12-23-11; DMAP 47-2011(Temp), f. 12-13-11, cert. ef. 1-1-12 thru 6-25-12; DMAP 22-2012(Temp), f. 3-30-12, cert. ef. 4-1-12 thru 9-21-12; DMAP 43-2012(Temp), f. 9-21-12, cert. ef. 9-23-12 thru 3-21-13; DMAP 11-2013, f. & cert. ef. 3-21-13; DMAP 50-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 57-2013(Temp), f. & cert. ef. 10-29-13 thru 3-30-14; DMAP 7-2014, f. & cert. ef. 1-31-14; DMAP 13-2014(Temp), f. 3-20-14, cert. ef. 4-1-14 thru 9-28-14; DMAP 31-2014, f. 5-30-14, cert. ef. 7-1-14; DMAP 63-2014(Temp), f. & cert. ef. 10-17-14 thru 12-31-14; DMAP 79-2014, f. 12-18-14, cert. ef. 12-31-14; DMAP 80-2014(Temp), f. 12-23-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 18-2015, f. & cert. ef. 4-1-15; DMAP 50-2015(Temp), f. 9-10-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 75-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-13-16; DMAP 10-2016, f. 2-24-16, cert. ef. 3-1-16; DMAP 37-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16; DMAP 55-2016(Temp), f. 9-22-16, cert. ef. 10-1-16 thru 12-27-16

410-141-0860
Oregon Health Plan Patient Centered Primary Care Home Provider Qualification and Enrollment

CCOs shall administer the Patient Centered Primary Care Home program and receive program required reporting as supposed by OAR 409-055-0000 through 409-055-0090 and the 2016 CCO contract.

Stat. Auth.: ORS 413.042, 414.065;
Stats. Implemented: ORS 414.065
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 28-2011, f. 9-30-11, cert. ef. 10-1-11; DMAP 14-2012, f. & cert. ef. 3-22-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 71-2015, f. & cert. ef. 12-10-15

410-141-3000
Definitions

The Oregon Health Authority adopts and incorporates by reference the definitions in the following administrative rules and applies them to Health System Transformation and the use of Coordinated Care Organizations:

(1) OAR 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;

(2) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and

(3) OAR 410-141-0000, definitions of the Oregon Health Plan's rules generally applicable to prepaid managed health care organizations and coordinated care organizations.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3010
CCO Application, Certification, and Contracting Procedures

(1) The following definitions apply to this rule:

(a) "Applicant" means the entity submitting an application to be certified as a CCO or to enter into or amend a contract for coordinated care services;

(b) "Application" means an entity's written response to a Request for Application (RFA);

(c) "Award Date" means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts;

(d) "Certification" means the Authority's determination that an entity meets the criteria in OAR 410-141-3015 and the standards set forth in the RFA for being a CCO through initial certification or recertification;

(e) "Coordinated Care Services" means fully integrated physical health services, Substance Use Disorder (SUD) treatment, and mental health services and shall include dental health services as provided in ORS 414.625(3) no later than July 1, 2014;

(f) "CMS Medicare/Medicaid Alignment Demonstration" means a demonstration proposal by the Authority to CMS that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent feasible for individuals who are eligible for both programs. The Authority and CMS shall jointly establish its timelines and requirements for participation in the demonstration;

(g) "Entity" means a single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization;

(h) "Request for Applications (RFA)" means the document used for soliciting applications for certification as a CCO, award of or amendment of a CCO services contract, or other objectives as the Authority may determine appropriate for procuring coordinated care services.

(2) The Authority shall establish an application process for entities seeking certification and contracts as CCOs.

(3) The Authority shall use the following RFA processes for CCO certification and contracting:

(a) The Authority shall provide public notice of every RFA on its website. The RFA shall indicate how prospective applicants will be made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities or, upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;

(b) The RFA process begins with a public notice that shall be communicated using the Authority's website. A public notice of an RFA shall identify the certification requirements for the contract, the designated service areas where coordinated care services are requested, and a sample contract;

(c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;

(d) The RFA may request applicants to appear at a public meeting to provide information about the application;

(e) The RFA will request information from applicants in order to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;

(f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require submission of the application on its web portal in accordance with OAR 137-047-0330 (Electronic Procurements). If electronic procurement is used, applications shall be accepted only from applicants who accept the terms and conditions for use of the Authority's web portal.

(4) At recertification the Authority may permit a current CCO contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the recertification and new contract or the new addenda or capacity or other purposes within the scope of the RFA.

(5) The Authority shall evaluate applications for certification on the basis of criteria in OAR 410-141-3015, information contained in the RFA, the application, and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria;

(a) The Authority may enter into negotiation with applicants concerning potential capacity and enrollment in relation to other available or potentially available capacity, the number of potential

enrollees within the service area, and other factors identified in the RFA;

(b) The Authority shall notify each applicant that applies for certification of its certification status;

(c) Applicants that meet the RFA criteria shall be certified to contract as a CCO.

(6) Review for certification:

(a) The Authority shall issue certification only to applicants that meet the criteria in OAR 410-141-3015, meet the requirements, and provide the assurances specified in the RFA. The Authority determines whether the applicant qualifies for certification based on the application and any additional information and investigation that the Authority may require;

(b) The Authority determines an applicant is eligible for certification when the applicant meets the requirements of the RFA including written assurances satisfactory to the Authority that the applicant:

(A) Provides or will provide the coordinated care services in the manner described in the RFA and the Authority's rules;

(B) Is responsible and meets or will meet standards established by the Authority and DCBS for financial reporting and solvency;

(C) Is organized and operated and shall continue to be organized and operated in the manner required by the contract and described in the application; and

(D) Shall comply with any assurances it has given the Authority.

(7) The Authority shall certify CCOs for a period of six years from the date the certification application is approved, unless the Authority certifies a CCO for a shorter period.

(8) The Authority may determine that an applicant is potentially eligible for certification in accordance with section (9). The Authority is not obligated to determine whether an applicant is potentially eligible for certification if, in its discretion, the Authority determines that sufficient applicants eligible for certification are available to attain the Authority's objectives under the RFA.

(9) The Authority may determine that an applicant is potentially eligible for certification if:

(a) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period of time; and

(b) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for certification. The Authority shall determine the date and required documentation and written assurances required from the applicant;

(c) If the Authority determines that an applicant potentially eligible for certification cannot become certified within the time announced in the RFA for contract award, the Authority may:

(A) Offer certification at a future date when the applicant demonstrates to the Authority's satisfaction that the applicant is eligible for certification within the scope of the RFA; or

(B) Inform the applicant that it is not eligible for certification.

(10) The Authority may award contracts to certified CCOs for administering the Oregon Integrated and Coordinated Health Care Delivery System.

(11) The Authority shall enter into or renew a contract with a CCO only if the CCO has been certified and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes, but is not limited to:

(a) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda;

(b) The number of CCOs in the region.

(12) The application is the applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract:

(a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(b) Only an entity that the Authority has certified to contract as a CCO may enter into a contract as a CCO. Certification to contract as a CCO does not assure the CCO that it will be offered a contract;

(c) The Authority may award multiple contracts or make a single award or limited number of awards to all certified or potentially certified applicants in order to meet the Authority's needs including, but not limited to, adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA;

(d) Subject to any limitations in the RFA, the Authority may renew a contract for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA;

(e) The suspension or termination of a CCO contract issued under an RFA due to noncompliance with contract requirements or by a CCO's voluntary suspension or termination shall also be a suspension or termination of certification.

(13) Disclosure of application contents and release of information:

(a) Except for the letter of intent to apply and the technical application (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA), information may not be disclosed to any applicant or the public until the award date. No information may be given to any applicant or the public relative to its standing with other applicants before the award date except under the following circumstances:

(A) The information in the application may be shared with the Authority, DCBS, CMS, and those individuals involved in the application review and evaluation process; and

(B) Information may be provided by the applicant to the public as part of a public review process.

(b) Application information may be disclosed on the award date (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA) if the Authority determines it meets the disclosure exemption requirements.

(14) CCOs may apply to participate in the CMS Medicare/Medicaid Alignment Demonstration, but participation is not required. This rule does not replace the CMS requirements related to the Medicare/Medicaid Alignment Demonstration, such as the CMS notice of intent to apply and required components for Part D coverage. The RFA provides information about the demonstration requirements. Upon approval of the demonstration by CMS, the Authority shall conduct jointly with CMS the evaluation for certification for the Medicare/Medicaid Alignment Demonstration and the award of three-way contracts between CMS, the state, and applicants who have been certified to contract as a CCO and participate in the demonstration.

(15) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts.

(16) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on January 1, 2012) to govern RFAs and certification and contracting with CCOs:

(a) OAR 137-046 — General Provisions Related to Public Contracting: 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 — Public Procurements for Goods or Services: 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review), and 137-047-0800;

(c) In applying the DOJ Model Rules to RFAs under this rule:

(A) An application is a proposal under the DOJ Model Rules;

(B) An RFA is an RFP under the DOJ Model Rules;

(C) Certification as a CCO is pre-qualification under the DOJ Model Rules;

(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are considered to be incorporated therein;

(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.

(17) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-3015
Certification Criteria for Coordinated Care Organizations

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO certification within the context of the Oregon Health Policy Board's report, Coordinated Care Organizations Implementation Proposal: HB 3650 Health System Transformation (Jan. 24, 2012).

(3) Applicants shall describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above $250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations will need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and the CCO's strategic plan for developing its community health assessment and community health improvement plan:

(a) In all cases, CCOs shall have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals established in contract;

(b) Each criterion will be listed followed by the elements that shall be addressed during the initial certification described in this rule without limiting the information that is requested in the RFA concerning these criteria.

(6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant shall:

(a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria is used to select governance structure members, and how it will assure transparency in governance;

(b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;

(c) Describe how its governance structure will reflect the needs of members with severe and persistent mental illnesses and members receiving DHS Medicaid-funded, long-term care services and supports.

(7) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC will be administered to achieve the goals of community involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.

(8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:

(a) Since community health assessments will evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before becoming certified;

(b) The applicant shall describe how it will develop its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community need that builds on community resources and skills and emphasizes innovation.

(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.

(10) Dental care organizations: On or before July 1, 2014, each CCO shall have a contractual relationship with any DCO in its service area.

(11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:

(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;

(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.

(12) CCOs shall provide integrated, person-centered care and services designed to provide choice, independence, and dignity:

(a) The applicant shall describe its strategy to assure that each member receives integrated, person-centered care and services designed to provide choice, independence, and dignity;

(b) The applicant shall describe its strategy for providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.

(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and

engagement to help members be active partners in their own care. Applicants shall:

(a) Describe their planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, personal health navigators, and qualified community health workers where appropriate;

(b) Describe planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.

(14) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:

(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;

(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.

(15) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:

(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of all members;

(b) Are educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;

(c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;

(d) Are permitted to participate in the networks of multiple CCOs;

(e) Include providers of specialty care;

(f) Are selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards.

(g) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and Substance Use Disorder (SUD) service providers, and dental care when the CCO includes a dental care organization and facilitate access to community social and support services including DHS Medicaid-funded long-term care services, mental health crisis services, and culturally and linguistically appropriate services;

(h) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.

(16) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:

(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;

(b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate follow-up care when entering or leaving an acute care facility or long-term care setting. Applicants shall:

(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;

(b) Demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;

(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and People with Disabilities concerning care coordination and transition strategies for members.

(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists where appropriate, and community health workers.

(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:

(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;

(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;

(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.

(21) Each CCO shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with severe and persistent mental illness covered under the State's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:

(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;

(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(22) Each CCO shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.

(23) Each CCO shall implement to the maximum extent feasible patient-centered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:

(a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;

(b) The applicant shall require its other health and services providers to communicate and coordinate care with patient−centered primary care homes in a timely manner using health information technology.

(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:

(a) Describe their strategy for ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;

(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;

(c) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.

(25) CCOs are encouraged to use alternative payment methodologies consistent with ORS 414.653. The applicant shall describe its plan to move toward and begin to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members.

(26) Each CCO shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:

(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT improvement plan for meeting transformation expectations;

(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.

(27) Each CCO shall report on outcome and quality measures identified by the Authority under ORS 414.638 and participate in the All Payer All Claims (APAC) data reporting system. The applicant shall provide assurances that:

(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;

(b) It will submit APAC data in a timely manner according to program specifications.

(28) Each CCO shall be transparent in reporting progress and outcomes. Applicants shall:

(a) Describe how it will assure transparency in governance;

(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that will be transparent and publicly reported and available on the Internet.

(29) Each CCO shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:

(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;

(b) Whether the CCO will use a clinical advisory panel (CAP) or other means to ensure clinical best practices;

(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

(30) Each CCO shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:

(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Insurance Division on behalf of the Authority to confirm financial solvency and assess fiscal soundness;

(b) The applicant shall provide information relating to assets and financial and risk management capabilities.

(31) Each CCO may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.

(32) A CCO shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.

(33) Each CCO shall provide covered Medicaid services, other than DHS Medicaid-funded long-term care services, to members who are dually eligible for Medicare and Medicaid. The applicant may participate in the CMS Medicare/Medicaid Alignment Demonstration if the Authority obtains necessary federal approvals.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3020
Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation and Rule Precedence

(1) The Authority and its Division of Medical Assistance Programs (Division) and Addictions and Mental Health Division (AMH) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Oregon Integrated and Coordinated Health Care Delivery System and medical assistance programs. This includes the Oregon Health Plan (OHP) pursuant to ORS Chapter 414, subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, the Authority shall construe them as much as possible to be consistent. In the event that Authority policies, procedures, rules, and interpretations are inconsistent, the Authority shall apply the following order of precedence:

(a) For purposes of the provision of covered coordinated care services to Authority clients, including but not limited to authorizing and delivering service, or denials of authorization or services, the Authority, clients, enrolled providers, and the CCOs shall apply the following order of precedence:

(A) Consistent with ORS 413.071 and notwithstanding any other provision of state law, those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services (CMS) shall govern the administration of the medical assistance programs;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for CCOs, requirements applicable to providing coordinated care services to members are provided in this rule, the Division's General Rules, OAR 410-120-0000 through 410-120-1980 and the provider rules applicable to the category of health service;

(D) Generally for enrolled fee-for-service providers, requirements applicable to the provision of covered medical assistance to clients are provided in the Division's General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage set forth in OAR chapter 410 division 141 and the provider rules applicable to the category of health service;

(E) Any other applicable properly promulgated rules adopted by the Division, AMH and other offices or units within the Authority necessary to administer medical assistance programs, such as Electronic Data Transaction rules in OAR 943-120-0100 through 943-120-0200; and

(F) The basic framework for provider enrollment in OAR chapter 943 division120 and chapter 410 division 120 generally applies to providers enrolled with the Authority, subject to more specific requirements applicable to the administration of medical assistance programs. For purposes of this rule, "more specific" means the requirements, laws, and rules applicable to the provider type and covered health services.

(b) For purposes of contract administration solely between the Authority and its CCOs, the contract terms and the requirements in section (2)(a) of this rule governing the provision of covered coordinated health services to clients.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3030
Implementation and Transition

Implementation of the Oregon Integrated and Coordinated Health Care Delivery System through CCOs is essential to achieve the objectives of health transformation and cost savings. The ability of CCOs to meet transformation expectations will be phased in over time to allow CCOs to develop the necessary organizational

infrastructure. During this initial implementation period, the Authority holds the following expectations:

(1) Contract provisions, including an approved CCO strategy or plan for implementing health services transformation, shall describe how the CCO must comply with transformation requirements under these rules.

(2) Local and community involvement is required, and the Authority will work with CCOs to achieve flexibilities that may be appropriate to achieve community-directed objectives, including addressing health care for diverse populations.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3040
Service Area Change (SAC) for Existing Coordinated Care Organizations (CCOs)

This rule shall be effective retroactively to December 27, 2015.

(1) For purposes of this rule, the following definitions apply:

(a) "Applicant" means a coordinated care organization (CCO) as defined in ORS 414.625 with a CCO contract with the Authority that submits an application seeking recertification and a contract amendment for a new service area. The CCO is described for purposes of this rule as the applicant upon its submission of the CCO Letter of Intent to Apply;

(b) "Document Review" means the review conducted by the Authority, occurring at the point after the receipt of the completed SAC packet and before the effective date of the contract amendment, to determine applicant's ability to serve Medicaid beneficiaries in the requested service areas;

(c) "Letter of intent to apply (LOIA)" means a letter from a CCO to the Authority stating the CCO's intent to submit a SAC packet in response to a service area need. A LOIA may be binding or non-binding, as specified in the Authority's announcement of the service area need;

(d) "Recertification" means the process outlined in this rule, allowing the CCO to submit an abbreviated application to apply as an existing CCO for a new CCO service area and that meets the requirements of ORS 414.625 and the standards set forth in this rule;

(e) "SAC packet" means the packet of application documents that the Authority provides to CCOs applying for a SAC;

(f) "Service Area Change" or "SAC" means a change in a CCO's service area as specified in the Authority's contract with the CCO;

(g) "Service area need" means when the Authority identifies a need, as defined in section (3) of this rule, for existing CCOs to apply to the Authority for a SAC to serve a service area.

(2) A CCO that desires to withdraw from all or a portion of its service area shall make every effort to provide the Authority with a form Letter of Intent to Exit the service area at least 150 calendar days prior to the intended date of withdrawal. The template for this form can be found on the CCO Contract Forms page at: www.oregon.gov/OHA/healthplan/pages/CCO-Contract-Forms.aspx. The Authority shall work with the CCO and any other impacted CCO for a workable exit transition.

(3) The Authority may determine a service area need exists, or is anticipated to exist, when a CCO would no longer be serving all or a portion of its service area.

(4) The Authority shall follow the process set forth in this rule when announcing a need for a SAC:

(a) Within thirty days of the Authority's identification of a need for a SAC, the Authority shall notify all existing CCOs that the Authority will begin accepting LOIAs for the SAC. The announcement shall specify when the LOIA is due;

(b) Not later than fifteen calendar days from the date of the Authority's notification in section (4)(a) above, the Authority shall issue a second announcement of the Authority's identification of a need for a SAC and when LOIAs are due;

(c) To be considered for a SAC, interested CCOs shall submit their LOIAs by the deadline indicated in the Authority's notice of a need for a SAC. CCOs shall designate a sole point of contact in their LOIA for this process. The Authority will not accept a LOIA or any subsequent SAC application materials from a CCO that has not submitted a LOIA by the deadline indicated in the Authority's notice;

(d) The Authority shall send a letter of acknowledgement to the CCO within ten calendar days of receipt of the LOIA.

(5) Within thirty calendar days of the date specified by the Authority as the due date for submission of a LOIA, the CCO shall complete a SAC packet in its entirety and submit it to the contract administration unit at the address indicated in the SAC application packet. CCOs can locate a SAC packet on the CCO Contract Forms page at: www.oregon.gov/OHA/healthplan/pages/CCO-Contract-Forms.aspx. The completed SAC recertification application is the applicant's offer to enter into a contract for the period and service area specified in the SAC packet.

(6) CCOs applying for the service area change process outlined in this rule must meet the requirements set forth in ORS 414.625 and submit documentation as it applies to the new service areas indicated in the application. Documentation requirements, based on criteria set forth in OAR 410-141-3010 and 410-141-3015, shall be included in the acknowledgement letter sent by the Authority as described in section 4(d), which shall include, but is not limited to, information related to the following:

(a) Delivery system network and provider capacity reports highlighting any providers operating in the new service area or existing contracted providers expanding their services into the new service area. This report would include providers of physical health, oral health, behavioral health, and non-emergent medical transportation. New relationships with dental care organizations (DCOs) and Non-Emergent Medical Transportation brokerages are to be included;

(b) Updated financial reports;

(c) Updated CCO governance organizational charts reflecting any changes due to new service area including CCO leadership and managerial staffing, changes to Community Advisory Committee members, Clinical Advisory Panels membership, and any other committee or governance structure change as a result of operating in the new service area;

(d) Letters of community support from the community or communities in the new service area in which the CCO is applying to operate;

(e) List of specific new zip codes the CCO intends to serve and the estimated enrollment for each zip code area;

(f) Memorandums of understanding or letters of intent to enter into memorandums of understanding with local APD/AAA agencies, local mental health authority, local public health authority, and any other key stakeholders represented in the new service area;

(g) Updated Community Health Improvement Plan (CHP) reflecting new service area goals, if applicable;

(h) Updated Transformation Plan benchmarks or focus areas reflecting new service area goals, if applicable;

(i) Information related to how services in the new service area will impact existing operations including updated policies and procedures as applicable;

(j) Information related to identifying regional, cultural, socioeconomic, and racial disparities in health care that exist among the enrollees in the new service area and establishing community support for those areas of need; and,

(k) Information related to coordination of care and transfer of new members, specifically high risk members or members with special health care needs.

(7) The Authority shall review SAC packets from all CCOs that have timely submitted a LOIA and SAC packet as required by this rule and that are considered responsive and completed as set forth in this rule.

(8) During its review of the SAC packets, the Authority may request additional information from a CCO. If additional information

is requested, the CCO shall submit the additional information to the Authority within 30 days of the request.

(9) Within sixty calendar days from the date the initial SAC packets were due, the Authority shall complete its document review. This includes the final submission date for the SAC packet and receipt by the Authority of all additional requested information. Applicants are eligible for recertification based on criteria specified in section (6) of this rule, supporting documentation submitted by the applicant, and any additional information that the Authority obtains as part of the SAC process. To be eligible for recertification in the new service area, the applicant must meet standards established by the Authority, this rule, and be in compliance with the contract between the CCO and the Authority.

(10) If two or more CCOs meet the requirements to expand into a service area based on criteria set forth in this rule, the Authority shall determine which CCO will be selected to serve the new service area utilizing the criteria set forth in OAR 410-141-3015(4).

(11) The Authority shall prepare a contract amendment for document review and signature to each CCO that receives recertification to expand into the new service area. The CCO shall have sixty calendar days to return an executed contract amendment for the service area change.

(12) Applicants shall have the right to dispute any Authority actions or decisions pertaining to service area changes as set forth in OAR 410-141-3267.

Stat. Auth: ORS 413.042, 414.645, 414.625
Stats. Implemented: ORS 413.042
Hist.: DMAP 38-2015(Temp), f. & cert. ef. 7-1-15 thru 12-27-15; DMAP 67-2015(Temp), f. & cert. ef. 11-6-15 thru 12-27-15; DMAP 1-2016, f. & cert. ef. 1-7-16

410-141-3050
CCO Enrollment for Children Receiving Health Services

Pursuant to OAR 410-141-3060, the Authority or Oregon Youth Authority (OYA) shall select CCOs for a child receiving services in an area where a CCO is available. If a CCO is not available in an area, the Authority shall enroll the child in accordance with 410-141-0050.

(1) The Authority shall to the maximum extent possible ensure that all children are enrolled in CCOs at the next available enrollment date following eligibility determination, redetermination, or upon review by the Authority unless the Authority authorizes disenrollment from a CCO:

(a) Except as provided in OAR 410-141-3060 (Coordinated Care Enrollment Requirements), 410-141-3080 (Disenrollment from Coordinated Care Health Plans), or ORS 414.631(2), children are not exempt from mandatory enrollment in a CCO on the basis of third party resources (TPR) coverage;

(b) The Authority shall review decisions to use fee-for-service (FFS) open card for a child if the child's circumstances change and at the time of redetermination consider whether the Authority shall enroll the child in a CCO.

(2) When a child is transferred from one CCO to another CCO or from FFS or a PHP to a CCO, the CCO shall facilitate coordination of care consistent with OAR 410-141-3160:

(a) CCOs shall work closely with the Authority to ensure continuous CCO enrollment for children;

(b) If the Authority determines that it should disenroll a child from a CCO, the CCO shall continue to provide health services until the Authority's established disenrollment date to provide for an adequate transition to the next CCO.

(3) When a child experiences a change of placement that may be permanent or temporary, the Authority shall verify the address change information to determine whether the child no longer resides in the CCO's service area:

(a) A temporary absence as a result of a temporary placement out of the CCO's service area does not represent a change of residence if the Authority determines that the child is reasonably likely to return to the CCO's service area at the end of the temporary placement;

(b) A CAF child receiving behavioral rehabilitation services (BRS) is considered a temporary placement;

(c) Children in OYA custody enroll with the CCO serving the geographic area of placement. OYA representatives may request a service area exemption (SAE) to maintain CCO coverage on a placement they consider temporary.

(4) If the Authority enrolls the child in a CCO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the CCO shall pay for covered health services during that placement even if the location of the facility is outside the CCO's service area:

(a) The child is presumed to continue to be enrolled in the CCO with which the child was most recently enrolled. The Authority considers an admission to a PRTS facility a temporary placement for purposes of CCO enrollment;

(b) Any address change associated with the placement in the PRTS facility is not a change of residence for purposes of CCO enrollment and may not be a basis for disenrollment from the CCO unless the provisions in OAR chapter 410, division 141 apply;

(c) If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments.

(5) Except for OAR 410-141-3060 and 410-141-3080, if a child is enrolled in a CCO after the first day of an admission to PRTS, the enrollment effective date shall be immediately upon discharge.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-3060
Enrollment Requirements in a CCO

(1) For the purposes of this rule, the following definitions apply:

(a) "Client" means an individual found eligible to receive OHP health services;

(b) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) "Member" means a client enrolled with a pre-paid health plan or a coordinated care organization as stated in OAR 410-120-0000;

(d) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) "Renewal", as stated in OAR 410-200-0015, means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) Pursuant to ORS 414.631, the following populations may not be enrolled into a CCO for any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into a CCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with a CCO but not exempt from enrollment in a DCO if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only

until the hospital discharges the client. The individual shall receive dental services through the DCO;

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt mandatory enrollment into a managed care plan, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health CCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These populations are as follows:

(a) Children in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days unless:

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care.

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these:

(A) A client has the option to enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;

(B) A client enrolled in Medicare Advantage, whether or not they pay their own premium, has the option to enroll in a CCO even if the CCO does not have a corresponding Medicare Advantage plan;

(C) A client has the option to enroll with a CCO even if the client withdrew from that CCO's Medicare Advantage plan. The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;

(D) A client has the option to enroll with a CCO even if the client is enrolled in Medicare Advantage with another entity.

(6) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;

(b) Separate from requirements in 410-141-3080, (3)(c)(A), a pregnant women at any point prior to the end of the twenty-seventh week and sixth day of pregnancy who meets the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only, until 60 days post estimated date of delivery. Women receiving services FFS for their physical health plan coverage shall continue to be enrolled in the appropriate CCO plan in their service area for dental and mental health coverage. Sixty days after the estimated date of delivery, the member shall re-enroll in a plan as appropriate. Qualifying criteria are as follows:

(A) Be pregnant;

(B) Have an established relationship with a licensed, practitioner who is not a participating provider with the client's CCO;

(C) Make a request to change to FFS. This request can be made through the end of the twenty-seventh week and sixth day of pregnancy;

(D) Meet all relevant state and federal rules;

(E) If a woman becomes unable to meet the requirements, the exemption shall be withdrawn and the client shall be subject to CCO enrollment requirements as stated in OAR 410-141-3060.

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area.

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless stated above, CCO enrollment is mandatory in all areas served by a CCO. A client who is eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4) and (5) and this rule.

(8) Enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP.

(9) Enrollment is mandatory in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. If upon application or redetermination a client does not select a CCO, the Authority shall auto-assign the client and the client's household to a CCO that has adequate health care access and capacity. The following outlines the priority of enrollment in service areas where enrollment is mandatory and a PHP remains available for enrollment:

(a) Priority 1: The client shall enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client has the option to enroll in a PHP through a manual process if:

(A) The client has an established relationship with a provider who is only contracted with the PHP; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members. Clients shall be FFS unless already established with a PHP's provider.

(c) Priority 3: The client shall receive services on an FFS basis.

(10) If a service area changes from mandatory enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-141-3080.

(11) Clients who are exempt from physical health services or who are enrolled with a PHP for physical health services shall receive managed or coordinated mental health and oral health services as follows:

(a) The client shall be enrolled with a CCO if the CCO offers mental health and oral health services; or

(b) The client shall be enrolled with an MHO for mental health services and with a DCO for oral health services if the CCO does not offer those services; or

(c) The client shall be enrolled with a DCO for oral health services and remain FFS for mental health services if an MHO is not available; or

(d) The client shall remain FFS for both mental health and oral health services if an MHO or DCO is unavailable.

(12) The following pertains to the effective date of the enrollment. If the enrollment occurs:

(a) On or before Wednesday, the date of enrollment shall be the following Monday; or

(b) After Wednesday, the date of enrollment shall be one week from the following Monday.

(13) Coordinated care services shall begin as of the effective date of enrollment with the CCO except for:

(a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;

(b) For persons other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible

enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 60 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above;

(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 62-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 4-2013(Temp), f. & cert. ef. 2-7-13 thru 6-29-13; DMAP 33-2013, f. & cert. ef. 6-27-13; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 35-2014(Temp), f. 6-25-14, cert. ef. 7-1-14 thru 12-27-14; DMAP 69-2014(Temp), f. 12-8-14, cert. ef. 12-27-14 thru 12-31-14; DMAP 70-2014, f. 12-8-14, cert. ef. 1-1-15; DMAP 72-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 8-2015, f. 2-26-15, cert. ef. 3-1-15; DMAP 56-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 2-4-16; DMAP 72-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; Administrative correction, 12-24-16; DMAP 29-2016, f. & cert. ef. 6-28-16

410-141-3066
CCO Enrollment Requirements for Temporary Out-of-Area Behavioral Health Treatment Services

(1) For purposes of this rule, the following definitions apply:

(a) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders;

(b) "Home CCO" means enrollment in a Coordinated Care Organization (CCO) in a given service area, based upon a client's most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization;

(c) "Temporary Placement" means hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.

(2) The Authority has determined that, to the maximum extent possible, all individuals shall be enrolled at the next available enrollment date following eligibility, redetermination, or upon review by the Authority. This rule implements and further describes how the Authority administers its authority under OAR 410-141-3060 and OAR 410-141-3080 for purposes of making enrollment decisions for adult and young adult individuals, 14 through and including 17 years of age, receiving temporary out-of-area behavioral health treatment services:

(a) For program placements in Child Welfare, Behavioral Rehabilitative Services, Oregon Youth Authority, and Psychiatric Residential Treatment Services, see OAR 410-141-3050 for program specific rules;

(b) For program placements in Secure Children's In-Patient (SCIP) and Secure Adolescent In-Patient (SAIP), CCOs shall work with the Authority in managing admissions and discharges;

(c) The member shall remain enrolled with the CCO for delivery of SCIP and SAIP services. The CCO shall bear care coordination responsibility for the entire length of stay, including admission, determination, and planning.

(3) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO on the same day the individual is admitted to the residential treatment services, the CCO shall be responsible for the covered services during that placement even if the location of the facility is outside of the CCO's service area. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(4) CCO assignment is based on the member's residence and referred to as Home CCO. Home CCO enrollment for temporary out-of-area placement shall:

(a) Meet Oregon residency requirements defined in OAR 410-200-0200;

(b) Be eligible for enrollment into a CCO as specified in OAR 410-141-3060;

(c) Be based on most recent permanent residency and related CCO enrollment history prior to hospital, institutional, and residential placement. If the client has no enrollment history, new enrollment shall reflect most recent permanent residence prior to hospital, institutional, and residential placement; and

(d) Be consistent with OAR 410-141-3080 when the client exercises recipient choice, where the client is able to actively participate in their own recovery and direct their own care. If the client is unable to designate county of residence, as indicated in OAR 410-200-0200, the Authority shall designate the Home CCO as the geographic location of the client at the most recent residency and CCO enrollment prior to hospitalization.

(5) Home CCO enrollment policy for State Hospital discharges shall be implemented as follows:

(a) Upon State Hospital discharge, the Authority and the State Hospital Benefit Coordination Unit shall consult and coordinate with the Home CCO for client placement;

(b) If the client has no residency or enrollment history or no recent pre-hospitalization enrollment history, but the client's permanent residency is indicated other than temporary placement location, the Authority shall enroll pursuant to section (3) (c) of this rule Home CCO enrollment;

(c) If the client has no residency or enrollment history prior to hospitalization, the Authority shall enroll in placement service area.

(6) For new and existing temporary residential placements, CCOs shall coordinate all behavioral health care and needs including, but not limited to, medication assisted treatment, routine non-emergent physical health care, dental, and transportation when within the scope of the CCO's contract, including when member's temporary placements are outside the CCO service area. CCO's shall coordinate care for members receiving behavioral health treatment while in temporary placement and discharge planning for the return to the Home CCO. Additionally, CCO's shall coordinate all care for accompanying dependent members.

(7) Enrollment shall follow the Home CCO enrollment policy outlined in this rule, except when:

(a) The Home CCO enrollment hinders access to care or puts the client at potential harm, or the Home CCO is unable to provide needed unique services, a change in enrollment may be requested for the member to a CCO serving the service area of the temporary out-of-area placement;

(b) Home CCO enrollment may create a continuity of care concern, as specified in OAR 410-141-3080. If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.

(8) Pursuant to OAR 410-141-3080, if the Authority determines that an individual was disenrolled for reasons not consistent with these rules, the Authority shall re-enroll the individual with the appropriate CCO and assign an enrollment date that provides for continuous CCO coverage with the appropriate CCO. If the individual was enrolled in a different CCO in error, the Authority shall disenroll the individual from the incorrect CCO and recoup the capitation payments, pursuant to OAR 410-120-1395. Re-enrollment to the correct CCO shall occur as specified in OAR 410-141-3060.

(9) For consideration of disenrollment decisions other than specified in this rule, OAR 410-141-3080 shall apply. If the Authority determines that disenrollment should occur, the CCO shall continue to provide covered services until the disenrollment date established by the Authority, pursuant to 410-141-3160. This shall provide for an adequate transition to the next responsible coordinated care organization.

Stats. Auth.: ORS 413.042, 414.610 - 414.685
Stats. Implemented: ORS 413.042, 414.610 - 414.685
Hist.: DMAP 48-2015, f. 8-28-15, cert. ef. 9-1-15

410-141-3070
Preferred Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. CCOs shall pay for prescription drugs except:

(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants), (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to sections (8) and (9) of this rule;

(c) Any applicable co-payments;

(d) For drugs covered under Medicare Part D when the client is fully dual eligible.

(2) CCOs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337. CCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list shall:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) CCOs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but are not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) Preauthorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent preauthorization for a prescription drug cannot be completed within 24 hours, the CCO shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All requests, including those not marked urgent, shall be reviewed and decision rendered within 72 hours of original receipt of the preauthorization request.

(5) CCOs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.

(7) CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List.

(8) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all of the following information:

(a) The drug name;

(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and

(c) The reason that the Authority should consider this drug for carve out.

(9) If a CCO requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.

(10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121). A CCO may not reimburse providers for carved-out drugs.

(11) CCOs shall submit quarterly utilization data within 60 days of the date of service as part of the CMS Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

(12) CCOs are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. CCOs may continue to have some flexibility in maintaining formularies of drugs regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610–414.685

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 21-2014(Temp), f. & cert. ef. 4-1-14 thru 9-28-14; DMAP 32-2014, f. 5-30-14, cert. ef. 7-1-14; DMAP 40-2016, f. 6-30-16, cert. ef. 7-1-16

410-141-3080
Disenrollment from Coordinated Care Organizations

(1) Continuity of care, for purpose of this rule, means the ability to sustain services necessary for a person's treatment. Continuity of care is a concern when a member is transferred from one service provider to another.

(2) All member-initiated requests for disenrollment from a Coordinated Care Organization (CCO) shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.

(3) In accordance with 42 CFR 438.56(c)(2), the Authority or CCO shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Clients may request to change their CCO enrollment within 30 days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle;

(B) Clients may request to change their CCO enrollment within 90 days of the initial CCO enrollment. If approved, the change would occur during the next weekly enrollment cycle;

(C) Clients may request to change their CCO enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur during the end of the month;

(D) Clients may request to change their CCO enrollment or upon OHP eligibility renewal, as defined in OAR 410-141-3060. The OHP eligibility period is typically 12 months. If approved, the change would occur during the end of the month;

(E) Clients have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. The plan change shall be considered "recipient choice." If approved, the change would occur at the end of the month. Once the recipient choice option has been applied, the client must be enrolled with the same plan at least six months or until the OHP eligibility renewal, whichever comes first, to request an additional plan change.

(b) With cause:

(A) At any time;

(B) Due to moral or religious objections, the CCO does not cover the service the member seeks;

(C) When the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the member's health care needs. Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the CCO service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3060, or as defined in this rule. Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an OHP member or a provider of a treatment, service, or supply, including, but not limited to, a decision of a provider to participate or decline to participate in a CCO;

(iv) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one CCO to another CCO if:

(I) The member's provider has contracted with the receiving CCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO; and

(II) Members are offered the choice of remaining enrolled in the transferring CCO; and

(III) The member and all family (case) members shall be transferred to the provider's new CCO; and

(IV) The transfer shall take effect when the provider's contract with their current CCO contractual relationship ends, or on a date approved by the Division; and

(V) Members may not be transferred under section (2)(E)(vi) until the Division has evaluated the receiving CCO and determined that the CCO meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the CCO maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(VI) The Division shall provide notice of a transfer to members affected by the transfer at least 90 days before the scheduled date of the transfer.

(E) If a member's disenrollment is denied, notice of denial shall be sent to the member pursuant to OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing.

(c) If the following conditions are met:

(A) As supported in 42 CFR 438.56(d)(2), if a client is at any point in the third trimester of pregnancy and if the client is newly determined eligible for OHP, or the client is newly re-determined eligible for OHP and not enrolled in a CCO within the past three months; or

(B) If the member is enrolled with a new CCO that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider;

(C) The enrollment exemption shall remain in place until 60 days post date of delivery of the member's child, at which time the member shall select and be enrolled in the appropriate CCO plan in their service area.

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

(A) Transfer of a member from a PHP to a CCO;

(B) Involuntary transfer of a member from a CCO to another CCO; or

(C) Automatic enrollment of a member in a CCO.

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another CCO unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3060 or 410-141-0060, or the member meets disenrollment criteria stated in 42 CFR 438.56(c)(2), or there is not another CCO in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

(C) If the Authority fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.

(4) The CCO may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

(b) Because of an adverse change in the member's health;

(c) Because of the member's utilization of services, either excessive or lack thereof;

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the CCO disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(5) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the CCO requests it for cause, which includes, but is not limited to, the following:

(a) The member commits fraudulent or illegal acts related to the member's participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The CCO shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 888-Fraud01 (888-372-8301) or http://www.oregon.gov/DHS/aboutdhs/fraud/ as appropriate, consistent with 42 CFR 455.13;

(b) The member became eligible through a hospital hold process and placed in the Adults and Couples category as required under OAR 410-141-3060;

(c) Requests by the CCO for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The CCO shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below shall be followed and documented prior to requesting disenrollment of a member;

(B) There shall be notification from the provider to the CCO at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the CCO. Such notification shall be documented in the member's clinical record. The CCO shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The CCO shall contact the member either verbally or in writing, if it is a severe problem, to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issue. Any contact with the member shall be documented in the member's clinical record. The CCO shall inform the member that their continued behavior may result in disenrollment from the CCO;

(D) The CCO shall provide individual education, disability accommodation, counseling, or other interventions with the member in a serious effort to resolve the problem;

(E) The CCO shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;

(F) If the severity of the problem warrants, the CCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the CCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The CCO shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

(I) If the member's behavior is uncooperative or disruptive including, but not limited to, threats or acts of physical violence as the result of his or her special needs or disability, the CCO shall also document each of the following:

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others shall actually occur; and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A CCO -staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;

(v) Documentation of the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members;

(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO shall attempt to locate another PCP on their panel who shall accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO's policies and shall be consistent with CCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements in subsection (c), requests by the CCO for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56, the CCO shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the CCO's staff so that it seriously impairs the CCO's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member may cause grievous physical injury to others (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The CCO shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an exception to the disenrollment process of a member;

(B) Providers shall immediately notify the CCO about the incident with the member. The notification shall describe the problem and be maintained for documentation purposes;

(C) The CCO shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;

(D) The CCO shall provide any additional information requested by the CAR, the Authority, or the Department assessment team;

(E) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the CCO shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined in section (2)(b)(C)(i) of this rule;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others may actually occur; and whether reasonable modifications of policies, practices, or procedures may mitigate the risk to others.

(F) Documentation shall exist that verifies the provider or CCO immediately reported the incident to law enforcement. The CCO shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinical record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures may not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

(I) Documentation shall exist that verifies the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members.

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the CCO's CAR or a team of CARs who may request additional information from Ombudsman Services, AMH, or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the AMH's substance use disorder specialist;

(B) In cases where the member is also enrolled in the CCO's Medicare Advantage plan, the CCO shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is insufficient documentation, the CAR shall notify the CCO within two business days of initial receipt what supporting documentation is needed for final consideration of the request;

(D) The CARs shall review the request and notify the CCO of the decision within ten working days of receipt of sufficient documentation from the CCO;

(E) Written decisions shall be sent to the CCO within 15 working days from receipt of request and sufficient documentation from the CAR.

(6) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the CCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint, as specified in 410-141-3260 through 410-141-3266, and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

(c) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;

(d) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO again requests disenrollment for cause, the request shall be referred to the Authority assessment team for review.

(7) The following procedures apply to all approved disenrollment requests:

(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the CCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of member's right to file a complaint, as specified in OAR 410-141-3260 through 410-141-3266, and to request an administrative hearing and the option to continue enrollment in the CCO pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

(c) The disenrollment effective date shall be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an Administrative Law Judge's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;

(e) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or the member again requests disenrollment for cause, the request shall be referred to the Authority's assessment team for review.

(8) Other reasons for the CCO's requests for disenrollment may include the following:

(a) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;

(b) The member has surgery scheduled at the time their enrollment is effective with the CCO, the provider is not on the CCO's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO;

(d) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Health Insurance Group (HIG) at www.reportTPL.org.HIG and send the CCO an email receipt, including a tracking number. The CCO may use this number, should they choose to follow up on their referral submission, via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO A or B, effective the end of the month the TPL is reported, as referenced above, and the member is not reflected on that month's 834 report;

(e) If a CCO has knowledge of a member's change of address, the CCO shall notify the member's care team. The care team shall verify the address information and disenroll the member from the CCO if the member no longer resides in the CCO's service area. Members shall be disenrolled if out of the CCO's service area for more than three months unless previously arranged with the CCO or DCO. The effective date of disenrollment shall be the date specified by the Division, and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the CCO;

(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO shall identify the members and provide sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from CCO's for members who have been taken into custody;

(g) The member is in a state psychiatric institution.

(9) The Division may initiate and disenroll members as follows:

(a) If informed that a member has TPL, the Division shall refer the case to the HIG for investigation and possible exemption from CCO enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the CCO's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the CCO;

(c) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

(10) Unless specified otherwise in these rules or in the Division notification of disenrollment to the CCO, all disenrollments are effective the end of the month the Authority approves the disenrollment with the following exceptions:

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated;

(b) The Authority may retroactively disenroll the member if they have TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

Stat. Auth.: ORS 413.032, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 47-2012(Temp), f. & cert. ef. 10-16-12 thru 4-13-13; DMAP 55-2012(Temp), f. & cert. ef. 11-15-12 thru 4-13-13; Administrative correction 4-22-13; DMAP 19-2013, f. & cert. ef. 4-23-13; DMAP 25-2013, f. & cert. ef. 6-11-13; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 8-2014(Temp), f. 1-31-14, cert. ef. 2-1-14 thru 7-31-14; DMAP 30-2014, f. 5-23-14, cert. ef. 6-1-14; DMAP 71-2015, f. & cert. ef. 12-10-15; DMAP 72-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 29-2016, f. & cert. ef. 6-28-16

410-141-3110
CCO Substance Use Disorder Provider, Treatment and Facility Certification and Licensure

(1) Certain Behavioral Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP), or authorized Coordinated Care Organization (CCO).

(2) Substance Use Disorder (SUD) treatment services are covered for eligible OHP clients when provided by a CCO:

(a) Outpatient substance use disorder providers that are facilities or agencies shall have a certificate issued by the Authority as described in OAR 415-012-0000 for the scope of services provided;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent persons under ORS 430.010 and 443.400 or detoxification center as defined in ORS 430.306 shall be licensed by the Authority as described in OAR 415-012-0000 for the scope of service provided;

(c) Synthetic opioid treatment programs shall meet the requirements described in OAR 415-020-0000;

(d) Detoxification centers shall have a license issued by the Authority as described in OAR 415-012-0000 and 415-050-0000 for the scope provided.

Stat. Auth.: ORS 192.527, 192.528, 413.042 & 414.065
Stat. Implemented: ORS 192.527, 192.528, 413.042, 414010, 414.065 & 414.727
Hist.: DMAP 38-2016, f. 6-30-16, cert. ef. 7-1-16

410-141-3120
Operations and Provision of Health Services

(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) At a minimum, CCOs shall provide medically appropriate health services including flexible services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the contract.

(3) CCOs shall select providers using universal application and credentialing procedures and objective quality information. CCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards:

(a) CCOs shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and recredentialed no less frequently than every three years. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank. CCOs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;

(b) CCOs shall screen their providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes;

(c) CCOs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be responsible for the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated:

(A) Ensuring that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;

(B) Providing training for CCO staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the CCOs administrative policies.

(d) The CCO shall provide accurate and timely information to the Authority about:

(A) License or certification expiration and renewal dates;

(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;

(C) If a CCO knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendre").

(e) CCOs may not refer members to or use providers that:

(A) Have been terminated from the Division;

(B) Have been excluded as a Medicaid provider by another state;

(C) Have been excluded as Medicare/Medicaid providers by CMS; or

(D) Are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101.

(f) CCOs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. CCOs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;

(g) CCOs shall require each atypical provider to be enrolled with the Authority and shall obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. CCOs shall require each qualified provider to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES);

(h) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.

(4) A CCO may not discriminate with respect to participation in the CCO against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If a CCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:

(a) Require that a CCO contract with any health care provider willing to abide by the terms and conditions for participation established by the CCO; or

(b) Preclude the CCO from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:

(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or

(B) Factors that add value to the service provided including, but not limited to, expertise, experience, accessibility, or cultural competence.

(c) The requirements in subsection (b) do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.

(5) A CCO shall establish an internal review process for a provider aggrieved by a decision under section (4) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.

(6) To resolve appeals made to the Authority under sections (4) and (5) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the CCO to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the CCO's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(7) A prevailing party in an appeal under sections (4) through (6) of this rule shall be awarded the costs of the appeal.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 20-2012(Temp), f. & cert. ef. 3-30-12 thru 9-25-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-3140
Emergency and Urgent Care Services

(1) CCOs shall have written policies, procedures, and monitoring systems that ensure the provision of appropriate urgent, emergency, and triage services 24-hours a day, 7-days-a-week for all members. CCOs shall:

(a) Communicate these policies and procedures to participating providers;

(b) Regularly monitor participating providers' compliance with these policies and procedures; and

(c) Take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(2) CCOs shall have written policies, procedures, and monitoring processes to ensure that a provider provides a medically or dentally appropriate response as indicated to urgent or emergency calls including but limited to the following:

(a) Telephone or face-to-face evaluation of the member;

(b) Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization;

(c) Development of a course of action;

(d) Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of a member requiring behavioral health services, or a member who cannot be transported or is homebound;

(e) Provision for notifying a referral emergency room, when applicable, concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and

(f) Provision for notifying other providers, when necessary, to request approval to treat members.

(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the CCO shall return the call.

(4) If emergency room screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard, the CCO must pay for all services required to stabilize the patient, except as otherwise provided in section (6) of this rule. The CCO may not require prior authorization for emergency services:

(a) The CCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent;

(b) The CCO may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;

(c) The CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not billed within ten calendar days of the service.

(5) When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, in or out of the network, the CCO shall pay for the screening examination and other medically appropriate services. Except as otherwise provided in section (6) of this rule, the CCO shall pay for post-stabilization care that was:

(a) Pre-authorized by the CCO;

(b) Not pre-authorized by the CCO if the CCO, or the on-call provider, failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or

(c) If the CCO and the treating provider cannot reach an agreement concerning the member's care and a CCO representative is not available for consultation, the CCO must give the treating provider the opportunity to consult with a CCO provider. The treating provider may continue with care of the member until a CCO provider is reached or one of the criteria is met.

(6) The CCO's responsibility for post-stabilization care it has not authorized ends when:

(a) The participating provider with privileges at the treating hospital assumes responsibilities for the member's care;

(b) The participating provider assumes responsibility for the member's care through transfer;

(c) A CCO representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(7) CCOs shall have methods for tracking inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for dental health care.

(a) CCOs shall educate members about how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home;

(b) CCOs shall apply and employ innovative strategies to decrease unnecessary hospital utilization.

(8) CCOs must limit charges to members for post-stabilization care services to an amount no greater than what the CCO would charge the member if he or she had obtained the services through the CCO. For purposes of cost sharing, post stabilization care services begin upon inpatient admission.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3145
Community Health Assessment and Community Health Improvement Plans

(1) Pursuant to ORS 414.627 to the extent practicable, CCOs shall partner with their local public health authority, local mental health authority, and hospital systems to develop a shared Community Health Assessment (CHA) process including conducting the assessment and development of the resulting Community Health Improvement Plan (CHP).

(2) CCOs shall work with the Authority to identify the components of the CHA. CCOs are encouraged to partner with their local public health authority, hospital system, type B Area Agency on Aging, APD field office and local mental health authority, the Early Learning Council, the Youth Development Council, and school health providers in the region using existing resources when available and avoiding duplication where practicable.

(3) In developing and maintaining a health assessment, CCOs shall meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community health needs that build on community resources and skills and emphasizes innovation including, but not limited to, the following:

(a) Emphasis on disproportionate, unmet, health-related need;

(b) Emphasis on primary prevention;

(c) Building a seamless continuum of care;

(d) Building community capacity;

(e) Emphasis on collaborative governance of community benefit.

(4) The CCO requirements for conducting a CHA and CHP will be met for purposes of ORS 414.627 if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007, and the Public Health Accreditation Board CHA and CHP requirements for local health departments and the AAA and local mental health authority in the process.

(5) The CCO's CAC shall oversee the CHA and adopt a plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the CHP.

(6) The CHP adopted by the Council shall describe the scope of the activities, services, and responsibilities that the CCO shall consider upon implementation. The activities, services, and responsibilities defined in the CHP may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities, and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery;

(f) Workforce development; and

(g) Public Health Accreditation Board standards for CHPs.

(7) CCOs and their participating providers shall work together to develop best practices of culturally and linguistically appropriate care and service delivery to eliminate health disparities and improve member health and well-being.

(8) CCOs and their CAC shall collaborate with the Authority's Office of Equity and Inclusion to develop meaningful baseline data on health disparities. CCOs shall include in the CHA identification and prioritization of health disparities among CCOs' diverse communities, including those defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, or other factors in their service areas such as type of living setting including, but not limited to, home independent support living, adult foster home, or homeless. CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority. CCOs shall also include representatives of populations experiencing health disparities in CHA and CHP prioritization. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement, and evaluate strategies to improve health equity among members. CCOs shall make this information available by posting on the web.

(9) To the extent practicable, CCOs shall:

(a) Base the CHP on research including research into adverse childhood experiences;

(b) Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system;

(c) Improve the integration of all services provided to meet the needs of children, adolescents, and families;

(d) Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents;

(e) With the development of its CHP SBHCs, school nurses, school mental health providers, and individuals representing child and adolescent health services shall be included.

(10) CCOs shall develop and review and update its CHA and plan at least every five years to ensure the provision of all medically appropriate covered coordinated care services including urgent care and emergency services, preventive, community support, and ancillary services in those categories of services included in CCO contracts or agreements with the Authority.

(11) CCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(12) If there is more than one CCO in a community, the CCOs and their community partners may work together to develop one shared CHA and one shared CHP.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3150
Flexible Services

(1) Flexible Services, as cross referenced in OAR 410-141-0000, in alignment with the CMS Waiver, and for purposes of this rule, means non-state plan, non-covered health related services. These services are provided instead of or as an adjunct to benefits and are intended to improve health delivery and member health and lower costs. Flexible services are likely to be cost-effective alternatives to covered benefits and are likely to generate savings. These services may effectively treat or prevent physical, oral, or behavioral health conditions, improve health outcomes, and prevent or delay health deterioration. Flexible services are consistent with the member's treatment plan as developed by the member's care team and documented in the member's medical record as specified in OAR 410-141-3180. Flexible services lack traditional billing or encounter codes, are not encounterable, and cannot be reported for utilization purposes.

(2) The Authority requires all CCOs to reflect the above standardized definition of flexible services in their policies and procedures (P&Ps). These P&Ps shall be written in collaboration with the Authority and are intended for administration of flexible services through their provider network. Flexible services P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability.

(3) CCO flexible services policies shall:

(a) Describe how members and primary care teams are engaged;

(b) Allow providers outside of the primary care team to render and coordinate flexible services efficiently;

(c) Provide mechanisms to capture services within the treatment plan and clinical record as specified in OAR 410-141-3180;

(d) Provide efficient decision making processes that are separate from CCO prior authorization protocols;

(e) Describe how community resources are considered and coordinated with community partners;

(f) Describe the data collection and tracking reporting plan;

(g) Efficiently and effectively reduce costs and improve care; validate that no cost sharing is required and that no administrative burden is imposed on the member;

(h) Provide clear accountability for service delivery;

(i) Allow for consideration of any flexible services requested; and

(j) Not limit the range of possible flexible services.

(4) Flexible services provided to individual members shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determination of the additional health

related services effective as alternative in the member's care. These services shall be documented in the member's treatment plan and clinical record, as specified in OAR 410-141-3180.

(5) Flexible services provided on a community based level and initiated by the CCO shall, for documentation purposes, be reflected with date and details within the Community Advisory Council (CAC) minutes in the same calendar quarter as the activity occurrence. Such activities might include: Programs to improve the general community health, e.g., farmers' market in the "food desert" or classes on healthy meal preparation.

(6) An enrollee's request to have an approved state plan service rather than a flexible service must be honored when medically necessary.

(7) Flexible services are not accounted for in the medical expenses part of the capitation rate.

(8) CCOs shall submit their financial reporting for flexible services as directed through their contracting agreement with the Authority.

(9) As allowed under 42 CFR 438.6(e), CCOs are always at liberty to offer any additional health related services. The services are separate from flexible services and delivered at the complete discretion of the CCO.

(10) All CCOs shall have written P&Ps for a grievance system. A grievance process, described in OAR 410-141-3261, applies only to those situations in which the member or their representative expresses concern or dissatisfaction about any matter other than an "Action," as referenced in 42 CFR 438.400, (b)(6). A flexible services outcome is not an "Action." CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members as specified in 42 CFR 438.402-408 and OAR 410-141-3260 through 410-141-3264.

(11) CCOs shall provide to members a written outcome regarding flexible services requests and shall be copied to any representative of the member and any provider who made or participated in the request on the member's behalf. Flexible services outcomes are subject to the grievance provisions of OAR 410-141-3260 and 410-141-3261. The written outcomes shall inform the member and any provider of the member's right to file a grievance in response to the outcome.

(12) Except as provided in section (11), members have no appeal or hearing rights in regard to a flexible services outcome.

Stat. Auth.: ORS 413.042
Stats Implemented: ORS 413.042
Hist.: DMAP 43-2015(Temp), f. & cert. ef. 8-13-15 thru 2-8-16; DMAP 90-2015, f. 12-31-15, cert. ef. 1-1-16

410-141-3160
Integration and Care Coordination

(1) In order to achieve the objectives of providing CCO members' integrated person centered care and services, CCOs must assure that physical, behavioral and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan (Plan). CCOs must develop, implement and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that are whole to the member and serve members in the most integrated setting appropriate to their needs:

(a) CCOs shall ensure the provision of care coordination, treatment engagement, preventive services, community based services, and follow up services for all members health conditions;

(b) CCOs must enter into contracts with providers of residential chemical dependency treatment services not later than July 1, 2013 and must notify the Authority within 30 calendar days of executing the contract;

(c) By July 1, 2014, each CCO must have a contractual relationship with any dental care organization that serves members in the area where they reside;

(d) CCOs must have adequate, timely and appropriate access to hospital and specialty services. CCOs must establish hospital and specialty service agreements that include the role of patient-centered primary care homes and that specify processes for requesting hospital admission or specialty services, performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments;

(e) CCOs must demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care. CCOs shall ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings and the state hospital.

(2) CCOs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs. CCOs must:

(a) Demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type.

(b) Ensure that members with high health needs, multiple chronic conditions, or behavioral health issues are involved in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services;

(c) Use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the state's 1915(1) State Plan Amendment, and those receiving DHS Medicaid-funded long-term care services. Plans should reflect member family, or caregiver preferences and goals to ensure engagement and satisfaction;

(d) Implement systems to assure and monitor improved transitions in care so that members receive comprehensive transitional care, and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care;

(e) Demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities);

(f) Work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs;

(g) Communicate its integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(3) CCO's must assess the needs of its membership and make available supported employment and assertive community treatment services available when medically appropriate and when an appropriate provider is available. Appropriate providers are those that meet the requirements in 309-016-0825. When no appropriate provider is available, the CCO must consult with AMH and develop an approved plan to make supported employment and assertive community treatment services available.

(4) CCOs must develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs to the maximum extent feasible:

(a) PCPCHs should become the focal point of coordinated and integrated care, so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;

(b) CCOs must develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely

manner, using electronic health information technology, where available;

(c) CCOs must engage other primary care provider (PCP) models to be the primary point of care and care management for members, where there is insufficient PCPCH capacity;

(d) CCOs must develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall ensure that all other services and supports are provided as close to the member's residence as possible.

(5) If a CCO implements other models of patient-centered primary health care in addition to the use of PCPCH, the CCO shall ensure member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

(6) If the member is living in a DHS Medicaid funded long-term care (LTC) nursing facility or community based care facility, or other residential facility, the CCO must communicate with the member and the DHS Medicaid funded long-term care provider or facility about integrated and coordinated care services:

(a) The CCO shall establish procedures for coordinating member health services, and how it will work with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services;

(b) CCOs shall coordinate transitions to DHS Medicaid-funded long-term care by communicating with local AAA/APD offices when members are being discharged from an inpatient hospital stay, or transferred between different LTC settings;

(c) CCOs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members' receiving Medicaid-funded LTC services.

(7) For members who are discharged to post hospital extended care, at the time of admission to a skilled nursing facility (SNF) the CCO shall notify the appropriate AAA/APD office and begin appropriate discharge planning. The CCO shall pay for the post hospital extended care benefit if the member was a member of the CCO during the hospitalization preceding the nursing facility placement. The CCO shall notify the SNF and the member no later than two working days before discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the CCO shall notify the appropriate AAA/APD office when the CCO learns of the admission.

(8) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service or PHP to a CCO, the CCO shall make every reasonable effort within the laws governing confidentiality to coordinate, including but not limited to ORS 414.679 transfer of the OHP client into the care of a CCO participating provider.

(9) CCOs shall establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to mental health services, some of which are not provided under the global budget.

(10) CCOs shall coordinate a member's care even when services or placements are outside the CCO service area. CCO assignment is based on the case member's residence, and referred to as county of origin or jurisdiction. Temporary placements by the Authority, Department or health services placements for services including residential placements may be located out of the service area, however, the CCO shall coordinate care while in placement and discharge planning for return to county of origin or jurisdiction. For out of area placements, an out of area exception must be made for the member to retain the CCO enrollment in the county of origin or jurisdiction, while the member's placement is a temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3050 for program specific rules.

(11) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs such as secure residential facilities, PASSAGES projects, or state hospital, shall receive follow-up services as medically appropriate to ensure discharge within five working days of receipt of notice of discharge readiness.

(12) CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs and CMHPs, to promote an appropriate response to members experiencing a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.

(13) CCOs shall accept FFS authorized services, medical, and pharmacy prior authorizations, ongoing services where a FFS prior authorization is not required, and services authorized by the Division's Medical Management Review Committee for 90 days, or until the CCO can establish a relationship with the member and develop an evidence based, medically appropriate coordinated care plan, whichever is later, except where customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

(14) Except as provided in OAR 410-141-3050, CCOs shall coordinate patient care, including care required by temporary residential placement outside the CCO service area, or out-of-state care in instances where medically necessary specialty care is not available in Oregon:

(a) CCO enrollment shall be maintained in the county of origin with the expectation of the CCO to coordinate care with the out of area placement and local providers;

(b) The CCO shall coordinate the discharge planning when the member returns to the county of origin.

(15) CCOs shall coordinate and authorize care, including instances where the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610–414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 1-2013(Temp), f. & cert. ef. 1-4-13 thru 7-2-13; DMAP 34-2013, f. & cert. ef. 6-27-13

410-141-3170
Intensive Care Coordination Services (Exceptional Needs Care Coordination (ENCC))

(1) CCOs are responsible for intensive care coordination services, otherwise known as Exceptional Needs Care Coordination (ENCC). Even if the CCO uses another term, these rules set forth the elements and requirements for intensive care coordination services. Where the term ENCC appears in rule or contract, it shall be given the meaning in this rule.

(2) CCOs shall make intensive care coordination services available to members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues, and for members with severe and persistent behavioral health issues receiving home and community-based services under the state's 1915(1) State Plan Amendment. The member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager may request intensive care coordination services.

(3) CCOs shall respond to requests for intensive care coordination services with an initial response made by the next working day following the request.

(4) CCOs shall periodically inform all participating providers of the availability of intensive care coordination services, provide

training for patient centered primary care homes and other primary care providers' staff on intensive care coordination services and other support services available for members.

(5) CCOs shall ensure that the case manager's name and telephone number are available to Authority staff and members or member representatives when intensive care coordination services are provided to the member.

(6) CCOs shall make intensive care coordination services available to coordinate the provision of these services to members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting.

(7) CCOs shall implement procedures to share the results of its identification and assessment of any member appropriate for intensive care coordination services, with participating providers serving the member so that those activities are not duplicated. Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(8) CCOs must have policies and procedures, including a standing referral process for direct access to specialists, for identifying, assessing and producing a treatment plan for each member identified as having a special health care need. Each treatment plan shall be:

(a) Developed by the member's designated provider with the member's participation;

(b) Include consultation with any specialist caring for the member;

(c) Approved by the CCO in a timely manner if CCO approval is required; and

(d) In accordance with any applicable quality assurance and utilization review standards.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3180
Record Keeping and Use of Health Information Technology

(1) CCOs shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC §1320-d et seq., and the federal regulations implementing the Act, and complete clinical records that document the coordinated care services received by the members. CCOs shall communicate these policies and procedures to participating providers, regularly monitor participating providers' compliance and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities. These policies and procedures shall ensure that records are secured, safeguarded and stored in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(2) A member must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member may share the information with others involved in the member's care and make better health care and lifestyle choices. CCO's participating providers may charge the member for reasonable duplication costs, as set forth in OAR 943-014-0030, when the member seeks copies of their records.

(3) Notwithstanding ORS 179.505, a CCO, its provider network and programs administered by the Department 's Aging and People with Disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the members.

(4) A CCO and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and behavioral health diagnoses, within the CCO for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the CCO and the CCO's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements including the Authority's rules established in OAR 943-014-0000 through 0070 for matters that involve privacy and confidentiality and privacy of members protected information.

(5) The CCO must document its methods and findings to ensure across the organization and the network of providers there is documentation of the following coordinated care services and supports:

(a) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery;

(b) The supportive and therapeutic needs of the member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;

(c) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility, including acute psychiatric facility, state hospital or residential care settings for members with mental illness or a DHS Medicaid funded long-term care setting, including engagement of the member and family in care management and treatment planning;

(d) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, for example, the use of certified or qualified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established in ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604;

(e) Members have access to advocates, for example, qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(f) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

(6) CCOs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, CCOs shall:

(a) Identify EHR adoption rates; rates may be divided by provider type and geographic region;

(b) Develop and implement strategies to increase adoption rates of certified EHRs;

(c) Encourage EHR adoption.

(7) CCOs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, behavioral health, and dental health information with any other provider in that CCO.

(8) CCOs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

(9) CCOs shall initially identify their current HIT capacity and develop and implement a plan for improvement in the following areas:

(a) Analytics that are regularly and timely used in reporting to its provider network (e.g. to assess provider performance, effectiveness and cost-efficiency of treatment);

(b) Quality and utilization reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the Authority to monitor the CCOs performance);

(c) Patient engagement through HIT (using existing tools such as e-mail); and

(d) Other appropriate uses for HIT (e.g. telehealth, mobile devices).

(10) CCOs shall maintain health information systems that collect, analyze, integrate, and report data and can provide information on areas including but not limited to the following:

(a) Names and phone numbers of the member's primary care provider or clinic, primary dentist and behavioral health provider;

(b) Copies of Client Process Monitoring System (CPMS) enrollment forms;

(c) Copies of long-term psychiatric care determination request forms;

(d) Evidence that the member has been informed of rights and responsibilities;

(e) Complaint and appeal records;

(f) Disenrollment requests for cause and the supporting documentation;

(g) Coordinated care services provided to enrollees, through an encounter data system; and

(h) Based on written policies and procedures, the record keeping system developed and maintained by CCOs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system to allow the CCO to ensure that data received from providers is accurate and complete by:

(A) Verifying the accuracy and timeliness of reported data;

(B) Screening the data for completeness, logic, and consistency; and

(C) Collecting service information in standardized formats to the extent feasible and appropriate.

(11) CCOs and their provider network shall cooperate with the Division, AMH, the Department of Justice Medicaid Fraud Unit, and CMS, or other authorized state or federal reviewers, for purposes of audits, inspection and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.

(12) Across the CCO's provider network, all clinical records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the clinical records must be retained until all issues arising out of the action are resolved.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3200
Outcome and Quality Measures

(1) CCOs shall report to the Authority its health promotion and disease prevention activities, national accreditation organization results, and HEDIS measures as required by DCBS in OAR 836-053-1000. A copy of the reports may be provided to the Authority's Performance Improvement Coordinator concurrent with any submission to DCBS

(2) As required by Health System Transformation, CCOs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the CCO's contract with the Authority. The measures are adopted by the Metrics and Scoring Committee using a public process; information can be requested from the Authority or viewed online at http://www.oregon.gov/oha/Pages/metrix.aspx.

(3) CCOs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral health treatment, oral health care (to the extent that dental services are the responsibility of a CCO under an agreement with a DCO), and all other health services provided by or under the responsibility of the CCO as specified in the CCO's contract with the A uthority.

(4) CCOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the CCO's community health assessment, community health improvement plan, and the standards in the CCO's contract. CCOs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction;

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3260; and

(d) Assess the quality and appropriateness of coordinated care services provided to members who are aged, blind, or disabled who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services; who received Medicaid funded long-term care benefits; or who are children receiving CAF (Child Welfare) or OYA services.

(5) CCOs shall implement policies and procedures that assure it will collect timely data including health disparities and other data required by rule or contract that will allow the CCO to conduct and report on its outcome and quality measures and report its performance. CCOs shall submit to the Authority the CCO's annual written evaluation of outcome and quality measures established for the CCO or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee.

(6) CCOs shall adopt practice guidelines consistent with 42 CFR 438.236 that address physical health care, behavioral health treatment, or dental care concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.

(7) CCOs shall be accountable for both core and transformational measures of quality and outcomes:

(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures will be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health);

(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation and require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

(8) CCOs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-3220
Accessibility

(1) Consistent with the community health assessment and health improvement plan, CCOs must assure that members have access to high quality care. The CCO shall accomplish this developing a provider network that demonstrates communication, collaboration, and shared decision making with the various providers and care settings. The CCO shall develop and implement the assessment and plan over time that meets access-to-care standards, and allows for appropriate choice for members. The goal shall be that services and supports should be geographically as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

(2) CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(3) In developing its access standards, the CCO should anticipate access needs, so that the members receive the right care at the right time and place, using a patient-centered approach. The CCO provider network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.

(4) CCOs shall have policies and procedures which ensure that for 90% of their members in each service area, routine travel time or distance to the location of the PCPCH or PCP does not exceed the community standard for accessing health care participating providers. The travel time or distance to PCPCHs or PCPs shall not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas-30 miles, 30 minutes or the community standard, whichever is greater;

(b) In rural areas-60 miles, 60 minutes or the community standard, whichever is greater.

(5) CCOs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

(6) CCOs shall make the services it provides including: primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services, as accessible to members for timeliness, amount, duration, and scope as those services are to other members within the same service area. If the CCO is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. CCOs shall have a monitoring system that shall demonstrate to the Authority that the CCO has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, and behavioral health services:

(a) CCOs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of behavioral health issues or when a member over utilizes services;

(b) CCOs must use a universal screening process that assesses members for critical risk factors that trigger intensive care coordination for high-needs members.

(7) CCOs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, behavioral health issues or who are children receiving Department or OYA services have access to primary care, dental care (when the CCO or DCO is responsible for dental care), mental health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.

(8) CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for, and urgency of, the visit. The member shall be seen, treated, or referred as within the following timeframes:

(a) Emergency care-Immediately or referred to an emergency department depending on the member's condition;

(b) Urgent care-Within 72 hours or as indicated in initial screening, in accordance with OAR 410-141-0140;

(c) Well care-Within 4 weeks or within the community standard;

(d) Emergency dental care (when dental care is provided by the CCO or DCO)-Seen or treated within 24- hours;

(e) Urgent dental care (when dental care is provided by the CCO or DCO)-Within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

(f) Routine dental care (when dental care is provided by the CCO or DCO)-Seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate;

(g) Non-Urgent behavioral health treatment-Seen for an intake assessment within 2 weeks from date of request.

(9) CCOs shall develop policies and procedures for communicating with, and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or here there is no telephone:

(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in CCO administrative offices, especially those of member services and complaint and grievance representatives and in emergency rooms of contracted hospitals;

(b) CCOs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health or dental care (when the CCO or DCO is responsible for dental care) visits, and home health visits, to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint; to make a diagnosis; respond to member's questions and concerns; and to communicate instructions to the member;

(c) CCOs shall ensure the provision of coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;

(d) CCOs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non- participating referral providers when necessary;

(e) CCOs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

Stat. Auth.: ORS 413.032, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14; DMAP 65-2013, f. & cert. ef. 11-29-13

410-141-3260
Grievance System: Grievances, Appeals and Contested Case Hearings

(1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.

(2) The CCO must establish and have a Division approved process and written procedures for the following:

(a) Member rights to appeal and request a CCO's review of an action;

(b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and

(c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;

(d) An explanation of how CCOs shall accept, process and respond to appeals, hearing requests and grievances;

(e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.

(3) Upon receipt of a grievance or appeal, the CCO must:

(a) Acknowledge receipt to the member;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Obtain documentation of all relevant facts concerning the issues;

(d) Ensure staff making decisions on the grievance or appeal are:

(A) Not involved in any previous level of review or decision-making; and

(B) Health care professionals as defined in OAR 410-120-0000 with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review.

(4) The CCO must analyze all grievances, appeals and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.

(5) CCOs must keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment or CCO health care operations are defined in 45 CFR 164.501.

(6) The following pertains to release of a member's information:

(a) The CCO and any provider whose authorizations, treatments, services, items, quality of care or requests for payment are involved in the grievance, appeal or hearing may use this information without the member's signed release for purposes of:

(A) Resolving the matter; or

(B) Maintaining the grievance or appeals log.

(b) If the CCO needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.

(7) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals or hearing requests. Reasonable assistance includes, but is not limited to:

(a) Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services;

(c) Toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(8) The CCO and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal or hearing process;

(b) Encourage the withdrawal of a grievance, appeal or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal or hearing request as a reason to retaliate against a member or to request member disenrollment.

(9) In all CCO administrative offices and in those physical, behavioral and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) Appeal forms;

(c) Hearing request form (DHS 443) and Notice of Hearing Rights (DMAP 3030); or

(d) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form (DMAP 3302) or approved facsimile.

(10) A member's provider:

(a) Acting on behalf of and with written consent of the member may file an appeal;

(b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.

(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests and grievances including providing all requested written materials.

(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the CCO's review, resolution or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.

(b) For each calendar year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:

(a) Life, health, mental health or dental health; or

(b) Ability to attain, maintain or regain maximum function.

(16) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) To be entitled to continuing benefits, the member must complete a hearing request or request for appeal requesting continuing benefits no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay for good cause, as defined in OAR 137-002-0528, is not counted;

(c) The benefits must be continued until:

(A) A final appeal resolution resolves the appeal unless the member requests a hearing with continuing benefits no later than ten days following the date of the notice of appeal resolution;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for hearing.

(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender identity, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

(18) If a CCO receives a complaint or grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the

receiving/sending CCO to ensure continuity of care during the transition.

Stat. Auth.: ORS 413.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 54-2012(Temp), f. & cert. ef. 11-1-2 thru 4-29-13; DMAP 22-2013, f. & cert. ef. 4-26-13; DMAP 60-2013, f. & cert. ef. 10-31-13; DMAP 33-2014, f. 5-30-14, cert. ef. 7-1-14; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3261
CCO Grievance Process Requirements

(1) A member may file a grievance:

(a) Orally or in writing; and

(b) With the Authority or the CCO. The Authority shall promptly send the grievance to the CCO.

(2) The CCO must resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires but no later than the following timeframes:

(a) Within 5 working days from the date of receipt of the grievance; or

(b) If the CCO needs additional time to resolve the grievance, the CCO shall respond within 30 calendar days from the date of receipt of the grievance. If additional time is needed the CCO shall notify the member, within 5 working days, of the reasons additional time is necessary.

(3) When informing members of the CCO's decision the CCO:

(a) May provide its decision about oral grievances either orally or writing;

(b) Must address each aspect of the grievance and explain the reason for the decision; and

(c) Must respond in writing to written grievances. In addition to written responses, the CCO may also respond orally.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3262
Requirements for CCO Appeal

(1) A member, their representative, or a subcontractor/provider with the member's consent, who disagrees with a notice of action (notice), has the authority to file an appeal with their CCO.

(2) For purposes of this rule, an appeal includes a request from the Division to the CCO for review of action.

(3) The member may request an appeal either orally or in writing directly to their CCO for any action by the CCO. Unless the member requests an expedited resolution, the member must follow an oral filing with a written, signed, and dated appeal.

(4) The member must file the appeal no later than 45 calendar days from the date on the notice.

(5) If after filing an oral appeal, a member does not submit a written appeal request within the appeals timeframe, the appeal will expire.

(6) The CCO does not need to notify the member if the CCO has already made attempts to assist the member in filling out the necessary forms to file a written appeal as required by rule.

(7) The CCO shall have written policies and procedures for handling appeals that:

(a) Address how the CCO will accept, process, and respond to such appeals, including how the CCO will acknowledge receipt of each appeal;

(b) Ensure that members who receive a notice are informed of their right to file an appeal and how to do so;

(c) Ensure that each appeal is transmitted timely to staff having authority to act on it;

(d) Consistent with confidentiality requirements, ensure that the CCO's staff person who is designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt of the appeal;

(e) Ensure that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensure that the individuals who make decisions on appeals are:

(A) Not involved in any previous level of review or decision making; and

(B) Health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues.

(g) Include a provision that the CCO must document appeals in an appeals log maintained by the CCO that complies with OAR 410-141-3260 and consistent with contractual requirements;

(h) Ensure oral requests for appeal of an action are treated as appeals to establish the earliest possible filing date for the appeal; and

(i) Ensure the member is informed that they must file in writing unless the person filing the appeal requests expedited resolution;

(j) Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;

(k) Provide the member an opportunity before and during the appeals process to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.

(8) Parties to the appeal include:

(a) The CCO;

(b) The member and the member's representative, if applicable;

(c) The legal representative of a deceased member's estate.

(9) The CCO shall resolve each appeal and provide the member and their representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within the following periods for:

(a) Standard resolution of appeal: No later than 16 calendar days from the day the CCO receives the appeal;

(b) Expedited resolution of appeal (when granted by the CCO): No later than three working days from the date the CCO receives the appeal. In addition, the CCO must:

(A) Inform the member and their representative of the limited time available;

(B) Make reasonable efforts to call the member to tell them of the resolution within three calendar days after receiving the request; and

(C) Mail written confirmation of the resolution to the member within three calendar days.

(c) In accordance with 42 CFR 438.408, the CCO may extend these timeframes from subsections (a) or (b) of this section up to 14 calendar days if:

(A) The member or their representative requests the extension; or

(B) The CCO shows (to the satisfaction of the Division's Hearing Unit, upon its request) that there is need for additional information and how the delay is in the member's interest;

(C) If the CCO extends the timeframes, it must for any extension not requested by the member, give the member or their representative written notice of the reason for the delay.

(10) For all appeals, the CCO must provide written notice of appeal resolution to the member and also to their representative when the CCO knows there is a representative for the member.

(11) The written notice of appeal resolution must include the following information:

(a) The results of the resolution process and the date the CCO completed the resolution; and

(b) For appeals not resolved wholly in favor of the member:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) Unless the appeal was referred to the CCO from the Division as part of a contested case hearings process, the right to request a hearing and how to do so;

(C) The right to request to receive benefits while the hearing is pending and how to do so; and

(D) That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCO's Action.

(12) Unless the appeal was referred to the CCO as part of a contested case hearing process, a member may request a hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution.

(13) If the appeal was referred to the CCO from the Division as part of a contested case hearing process within two business days from the date of the appeal resolution, the CCO must transmit the:

(a) Notice of Appeal Resolution; and

(b) Complete record of the appeal to the Division's Hearings Unit.

(14) If the appeal was made directly by the member or their representative, and the Notice of Appeal Resolution was not favorable to the member, the CCO must, if a contested case hearing is requested, submit the record to the Division's Hearings Unit within two business days of the Division's request.

(15) Documentation:

(a) The CCO's records must include, at a minimum, a log of all appeals received by the CCO and contain the following information:

(A) Member's name and Medical Care ID number;

(B) Date of the Notice;

(C) Date and nature of the appeal;

(D) Whether continuing benefits were requested and provided; and

(E) Resolution and resolution date of the appeal.

(b) The CCO shall maintain a complete record for each appeal included in the log for no less than 45 days to include:

(A) Records of the review or investigation; and

(B) Resolution, including all written decisions and copies of correspondence with the member.

(c) The CCO shall review the written appeals log on a monthly basis for:

(A) Completeness;

(B) Accuracy;

(C) Timeliness of documentation;

(D) Compliance with written procedures for receipt, disposition, and documentation of appeals; and

(E) Compliance with OHP rules.

(d) The CCO shall address the analysis of appeals in the context of quality improvement activity consistent with OAR 410-141-3200 — Outcome and Quality Measures and 410-141-3260 — Grievance System: Grievances, Appeals and Contested Case Hearings;

(e) The CCO shall have written policies and procedures for the review and analysis of all appeals received by the CCO. The analysis of the grievance system must be reviewed by the CCO's Quality Improvement Committee consistent with contractual requirements and comply with the quality improvement standards.

Stat. Auth.: ORS 413.032

Stats. Implemented: ORS 414.065

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 10-2013(Temp), f. & cert. ef. 3-1-13 thru 8-27-13; DMAP 16-2013(Temp), f. & cert. ef. 4-10-13 thru 8-27-13; DMAP 46-2013, f. & cert. ef. 8-26-13; DMAP 42-2016, f. & cert. ef. 7-1-16

410-141-3263
Notice of Action

(1) A CCO must provide a member with a notice of action when the CCO's decision about a health service constitutes an action. The notice of action must:

(a) Be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the action and requesting a hearing;

(b) Comply with the Authority's formatting and readability standards;

(c) The notice must include but is not limited to the following:

(A) Date of the notice;

(B) CCO's name and telephone number;

(C) Name of the member's PCP, PCD, or behavioral health professional, as applicable;

(D) Member's name and member ID number;

(E) Service requested and whether the CCO is denying, terminating, suspending or reducing a service or payment;

(F) Date of the service or date the member requested the service;

(G) Name of the provider who performed or requested the service;

(H) Effective date of the action if different from the date of the notice;

(I) Whether the CCO considered other conditions as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services;

(J) Clearly and thoroughly explain specific reasons for the action and a reference to the specific sections of the statutes and rules pertaining to each reason;

(K) Member's right to file an appeal with the CCO or request a contested case hearing;

(L) An explanation of circumstances under which the member may request expedited resolution of an appeal, and how to request one; and

(M) A statement that the member has the right to request to receive the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the CCO's action;

(d) The Notice of Action must be on a Division approved form.

(2) The CCO must include the appropriate forms based on the Division approved Notice of Action, as outlined in OAR 410-141-3260, to the notice.

(3) For actions affecting previously authorized services, the CCO must mail the notice at least 10 calendar days before the date of action with the exception of circumstances described in section (4) of this rule.

(4) The CCO may mail the notice no later than the date of action if:

(a) The CCO or provider has information confirming the death of the member;

(b) The member sends the CCO a signed statement stating the member no longer wants the service;

(c) The CCO can verify that the member is in an institution where the member is no longer eligible for OHP services;

(d) The CCO is unaware of the member's whereabouts; the post office returns the mail indicating no forwarding address; and the Authority or Department of Human Services has no other address;

(e) The CCO verifies another state, territory, or commonwealth has accepted the member for Medicaid services;

(f) The member's PCP, PCD, or behavioral health professional has prescribed a change in the level of health services; or

(g) The date of action shall occur in less than 10 calendar days when the CCO:

(A) Has facts indicating probable fraud by the member, and the CCO has certified those facts, if possible, through a secondary resource; or

(B) Denies payment for a claim.

(5) For actions affecting services not previously authorized, the CCO must send the notice as expeditiously as the member's health condition requires but no later than 14 calendar days following the date of receipt of the request for service.

(6) For actions affecting services not previously authorized and for which the CCO grants expedited review, the CCO must send the notice as expeditiously as the member's health condition requires but no later than three business days after receipt of the request for service.

(7) In accordance with 42 CFR 438.408, the CCO may extend the timeframes from (5) above by up to 14 calendar days, if:

(a) The Division member or Division member's representative requests the extension; or

(b) The CCO shows (to the satisfaction of the Division's Hearings Unit upon it request) that there is need for additional information and how the delay is in the Division member's interest.

(8) If the CCO extends the timeframes, it must, for any extension not requested by the Division member, give the Division member and Division member's representative, a written notice of the reason for the delay.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651
Stats. Implemented: ORS 414.610 – 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 60-2013, f. & cert. ef. 10-31-13

410-141-3264
Contested Case Hearings

(1) A CCO must have a system in place to ensure its members and providers have access to appeal a CCO's action by requesting a contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700.

(2) The member may request a hearing without first filing an appeal with their CCO. The member must file a hearing request with the Authority no later than 45 days from the date of the CCO's notice of action or notice of appeal resolution. If the member files the hearing request with the Department of Human Services or the CCO no later 45 days from the date of the notice, the Authority shall consider the request timely.

(3) In the event a request for hearing is not timely, the Authority shall determine whether the failure to timely file the hearing request was caused by circumstances beyond the member's control and enter an order accordingly. The member must submit a written statement explaining why the hearing request was late. The Authority may conduct further inquiry as the Authority deems appropriate. The Authority may refer an untimely request to the Office of Administrative Hearings (OAH) for a hearing on the question of timeliness;

(4) The CCO must conduct an appeal if the member requests an appeal without filing a request for hearing. If the member requests a hearing, without first requesting an appeal, the Authority may require the CCO to conduct an appeal prior to referring the matter to OAH.

(5) Effective February 1, 2012, the method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in the division of rules in OAR 410 division 120 and 141 applicable to timely filing of requests for hearing. Due to operational conflicts, the procedures needing revision and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a), which allows hearing requests to be treated as timely based on the date of postmark, does not apply to CCO hearing requests.

(6) If the member files a request for hearing with the Authority, the Authority shall provide a copy of the hearing request to the member's CCO. The CCO shall:

(a) Review the request immediately as an appeal of the CCO's action;

(b) Approve or deny the appeal within 16 calendar days, and provide the member with a notice of appeal resolution.

(7) If a member sends the hearing request to their CCO, the CCO must:

(a) Date-stamp the hearing request with the date of receipt; and

(b) Submit the following to the Authority within two business days:

(A) A copy of the hearing request, notice of action, and notice of appeal resolution, if applicable;

(B) All documents and records the CCO relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests.

(8) A member's provider may request a hearing about an action affecting the provider. However, the provider must resolve an appeal with the CCO before requesting a hearing.

(a) The CCO must approve or deny the appeal within 16 calendar days, and provide the provider with a notice of appeal resolution.

(b) The provider must file a hearing request with the Authority no later than 45 days from the date of the CCO's notice of appeal resolution.

(9) The parties to a contested case hearing include the:

(a) CCO and the member requesting a hearing; or

(b) CCO and the member's provider if the provider requests a hearing.

(10) The Authority shall refer the hearing request along with the notice of action or notice of appeal resolution to OAH for hearing.

(11) The Authority must issue a final order or the Authority must resolve the case ordinarily within 90 calendar days from the earlier of the date:

(a) The CCO receives the member's request for appeal. This does not include the number of days the member took to subsequently file a hearing request; or

(b) The Authority receives the request for hearing.

(12) If a member requests an expedited hearing, the Authority shall request documentation from the CCO, and the CCO shall submit relevant documentation, including clinical documentation, to the Authority within two working days.

(13) The Authority must determine whether the member is entitled to an expedited hearing within two working days from the date of receipt of the medical documentation. If the Authority denies a request for an expedited hearing, the Authority must make reasonable efforts to:

(a) Call the member; and

(b) Send written notice within two calendar days.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3267
Process for Resolving Disputes between Coordinated Care Organizations (CCOs) and the Oregon Health Authority

(1) If a CCO has a dispute with the Oregon Health Authority (Authority) as a result of a Division of Medical Assistance Programs (Division) decision that is perceived as adversely affecting a CCO, the CCO may submit a request to the Division director or his or her designee requesting an Administrative Review, as prescribed in OAR 410-120-1580.

(2) An example of such disputes include, but is not limited to, Authority decisions made through the OHA Provider Discrimination Review Process as a result of a provider discrimination appeal. These disputes primarily address legal or policy issues that may arise in the context of a Division decision that is perceived by the CCO to adversely affect the CCO and is not otherwise reviewed as a claim redetermination, a contested case, or client appeal. This rule does not involve claims that the Authority has breached its contract with a CCO. This CCO process is not mandatory, and it need not be exhausted before a CCO seeks judicial review or brings any other form of action related to any CCO/Authority dispute related decision.

(3) Within thirty calendar days of the conclusion of the administrative review, or such other time as may be agreed to by the CCO and the Division, the Division shall send written results of the administrative review to the initiating CCO and any other affected CCO. Should a resolution be reached through administrative review that is mutually agreeable to all involved, the process shall be considered complete and binding.

(4) If the dispute between the CCO and the Authority remains unresolved as a result of the administrative review, the CCO may request an alternative dispute resolution as set forth in section (5) of this rule to attempt to resolve the issue. The alternative dispute process is conducted pursuant to the Attorney General's Uniform Model Rules OAR 137-005-0060 and 137-005-0070.

(5) Not more than ten business days after receipt of the final administrative review decision, the CCO may contact the Division

director indicating the CCO's intent to pursue mediation. In that request, the CCO may request to stay the administrative review decision, which the Division will grant if the CCO alleges sufficient facts and provides good cause for the stay as provided in OAR 137-004-0090.The Division shall respond within ten business days of the date of the stay request

(6) After both the CCO and the Authority agree to enter into mediation, both shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the CCO and the Authority are unable to agree on the selection of a mediator, both shall appoint a mediator, and those mediators shall select the final mediator. To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(a) Be a knowledgeable and experienced mediator;

(b) Be familiar with health care and the disputed matters; and

(c) Follow the terms and conditions specified in this rule for the mediation process.

(7) If the dispute is likely to impact another CCO, the Authority shall notify all CCOs potentially impacted by the dispute and provide an opportunity for the impacted CCOs to participate in the dispute resolution process.

(8) The CCO and the Authority shall share in the cost of all mediation expenses, whether the dispute is resolved or not.

(9) Within ten business days of a selection of a mediator or upon a different schedule, as agreed to by the parties and the mediator, the CCO and the Authority shall submit to each other and to the mediator the following:

(a) Dispute resolution offer; and

(b) Explanation of their position, i.e., advocacy brief.

(10) The parties will engage in mediation as arranged by the mediator.

(11) The Authority shall maintain the confidentiality of proprietary information of all participating CCOs to the extent the information is protected under state or federal law.

Stat. Auth: ORS 413.042

Stats. Implemented: ORS 183.484, 183.502 & 413.042

Hist.: DMAP 39-2015(Temp), f. & cert. ef. 7-1-15 thru 12-27-15; DMAP 85-2015, f. 12-24-15, cert. ef. 12-27-15

410-141-3268

Process for Resolving Disputes on Formation, Certification, and Recertification of CCOs

(1) The dispute resolution process described in this rule applies only when, under ORS 414.635:

(a) An entity is applying to the Authority for certification as a CCO (applicant);

(b) A Health Care Entity (HCE) and the applicant (together, the "parties" for purposes of this rule) have failed to agree upon terms for a contract; and

(c) One or more of the following occurs:

(A) The applicant states that the HCE is necessary for the applicant to qualify as a CCO;

(B) An HCE states that its inclusion is necessary for the applicant to be certified as a CCO; or

(C) In reviewing the applicant's information, the Authority identifies the HCE as necessary for the applicant to qualify as a CCO.

(2) If an applicant and HCE disagree about whether the HCE is necessary for the applicant's certification as a CCO, the applicant or HCE may request the Authority to review the issue.

(3) If the Authority determines the HCE is not necessary for the applicant's certification, the process described in this rule does not apply.

(4) If the Authority determines or the parties agree the HCE is necessary for the applicant's certification, the following applies:

(a) The HCE and the applicant shall participate in good faith contract negotiations. The parties shall take the following actions in an attempt to reach a good faith resolution:

(A) The applicant shall provide a written offer of terms and conditions to the HCE. The HCE shall explain the area of disagreement to the applicant;

(B) The applicant's or HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or applicant shall have at least one face-to-face meeting in a good faith effort to resolve the disagreement.

(b) The applicant or HCE may request the Authority to provide technical assistance. The Authority also may offer technical assistance, with or without a request. The Authority's technical assistance is limited to clarifying the CCO certification process, criteria, and other program requirements.

(5) Pursuant to 2013 Engrossed SB 568 and 2013 Oregon Laws chapter 27, if the applicant and HCE cannot reach agreement on contract terms within ten calendar days of the face-to-face meeting, either party may request arbitration. The requesting party shall notify the other party in writing to initiate a referral to an independent third party arbitrator for an HCE's refusal to contract with the CCO or the termination, extension, or renewal of a HCE's contract with a CCO. The party initiating the referral shall provide a copy of the notification to the Authority.

(6) After notification that one party initiated arbitration, the parties shall attempt to agree upon the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator.

(7) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay.

(8) Within ten calendar days of a referral to an arbitrator, the applicant and HCE shall submit to each other and to the arbitrator the following:

(a) The most reasonable contract offer; or

(b) The HCE's statement that a contract is not desirable and an explanation of why this is reasonable.

(9) Within ten calendar days of receiving the other party's offer or the HCE's statement that a contract is not desirable, each party shall submit to the arbitrator and the other party the advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the applicant.

(10) The arbitrator shall apply the following standards when making a determination about whether an HCE reasonably or unreasonably refused to contract with the applicant:

(a) An HCE may reasonably refuse to contract when an applicant's reimbursement to an HCE for a health service is below the reasonable cost to provide the service. The arbitrator shall apply federal or state statutes or regulations that establish specific reimbursements, such as payments to federally qualified health centers, rural health centers, and tribal health centers; and

(b) An HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the Health Services Transformation (HST) legislative policies. Facts or circumstances outlining what is a reasonable or unreasonable refusal to contract include, but are not limited to:

(A) Whether contracting with the applicant would impose demands that the HCE cannot reasonably meet without significant negative impact on HCE costs, obligations, or structure while considering the proposed reimbursement arrangement or other CCO requirements. Some of the requirements include:

(i) Use of electronic health records;

(ii) Service delivery requirements, or

(iii) Quality or performance requirements;

(B) Whether the HCE's refusal affects access to covered services in the applicant's community. This factor alone cannot result in a finding that the refusal to contract is unreasonable; however, the HCE and applicant shall make a good faith effort to work out differences in order to achieve beneficial community objectives and HST policy objectives;

(C) Whether the HCE has entered into a binding obligation to participate in the network of a different CCO or applicant and that participation significantly reduces the HCE's capacity to contract with the applicant.

(11) The following outlines the arbitrator determination and the parties' final opportunity to settle:

(a) The arbitrator shall evaluate the final offers or statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' information;

(b) The arbitrator shall provide the determination to the parties. The arbitrator and the parties may not disclose the determination to the Authority for ten calendar days to allow the parties an opportunity to resolve the issue themselves. If the parties resolve the issue no later than the end of the tenth day, the arbitrator may not release the determination to the Authority;

(c) If the parties have not reached an agreement after ten calendar days, the arbitrator shall provide its decision to the Authority. After submission to the Authority, the arbitrator's determination becomes a public record, subject to protection of trade secret information if identified by one of the parties prior to the arbitrator's submission of the determination.

(12) If the parties cannot agree, the Authority shall evaluate the arbitrator's determination and may take the following actions:

(a) The Authority may certify an applicant if the arbitrator determined the applicant made a reasonable attempt to contract with the HCE or the HCE's refusal to contract was unreasonable;

(b) The Authority may refuse to certify, recertify, or continue to certify an applicant when the arbitrator determined the applicant did not reasonably attempt to contract with the HCE or the HCE's refusal to contract was reasonable, and the Authority determines that participation from the HCE remains necessary for certification of applicant as a CCO;

(c) The Authority may not pay fee-for-service reimbursements to an HCE if the arbitrator determined the HCE unreasonably refused to contract with the applicant. This applies to health services available through a CCO;

(d) In any circumstance within the scope of this rule when the parties have failed to agree, the current statutes regarding reimbursement to non-participating providers shall apply to certified CCOs and the HCE, consistent with ORS 414.743 for hospitals and consistent with Authority rules for other providers.

(13) To be qualified to resolve disputes under this rule, the arbitrator shall:

(a) Be a knowledgeable and experienced arbitrator;

(b) Be familiar with health care provider contracting matters;

(c) Be familiar with HST; and

(d) Follow the terms and conditions specified in this rule for the arbitration process.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 70-2013(Temp), f. 12-24-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 17-2015, f. & cert. ef. 4-1-15

410-141-3269
Process for Resolving Contract Disputes Between Health Care Entities and Coordinated Care Organizations

(1) Pursuant to ORS 414.635, Coordinated Care Organizations (CCOs) and Health Care Entities (HCE) shall participate in good faith contract negotiations. This rule covers the termination, extension, and renewal of an HCE's contract with a CCO.

(2) In the event of a dispute involving the termination, extension, or renewal of an HCE's contract with a CCO, the parties may take the following actions in an attempt to reach a good faith resolution:

(a) Both parties shall provide a written offer of terms and conditions to the other party. The parties shall explain the basis for their disagreement with the terms and conditions offered by the other party;

(b) The CCO's and HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or CCO shall have at least one face-to-face meeting in a good faith effort to resolve the disagreement;

(c) The CCO or HCE may request the Authority to provide technical assistance. The Authority's technical assistance is limited to clarifying the CCO contractual provisions, subcontracting criteria, current reimbursement requirements, access standards, and other legal requirements.

(3) If the CCO and HCE cannot reach agreement on contract terms, the parties may engage in mediation. Either the CCO or the HCE may request mediation:

(a) After the parties have agreed to enter into mediation, the parties shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the parties are unable to agree, each party shall appoint a mediator, and those mediators shall select the final mediator;

(b) To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(A) Be a knowledgeable and experienced mediator;

(B) Be familiar with health care and contracting matters; and

(C) Follow the terms and conditions specified in this rule for the mediation process.

(c) The parties shall pay for all mediation costs, whether a conclusion is reached or not. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the mediator to allocate costs between the parties based on the ability to pay;

(d) Within ten business days of a selection of a mediator, the CCO and HCE shall submit to each other and to the mediator the following:

(A) Contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) Unless an extension is agreed on by all parties, the mediator shall issue a report to the involved parties that will include mediation findings and recommendations no longer than 15 business days from the conclusion of the mediation.

(4) Pursuant to ORS 414.635, if the CCO and HCE cannot reach an agreement on contract terms within ten business days of receipt of the mediator's report, either party may request non-binding arbitration. The requesting party shall notify the other party in writing of the party's intent to refer the matter to arbitration:

(a) After notification that one party initiated arbitration, the parties shall agree on the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator;

(b) To be qualified to propose resolutions for disputes under this rule, the arbitrator shall:

(A) Be a knowledgeable and experienced arbitrator;

(B) Be familiar with health care provider contracting matters; and

(C) Follow the terms and conditions specified in this rule for the arbitration process.

(c) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay;

(d) Within ten business days of a selection of an arbitrator, the CCO and HCE shall submit to each other and to the arbitrator the following:

(A) Final contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) The arbitrator shall evaluate the final offers and the advocacy briefs from each party and issue a non-binding determination within 15 business days of the receipt of the parties' submissions.

Stat. Auth.: ORS 414.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 86-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 23-2015, f. 4-15-15, cert. ef. 5-1-15

410-141-3270
Coordinated Care Organization Marketing Requirements

(1) For the purposes of this rule, the following definitions apply:

(a) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the CCO.

(b) "Marketing" means any communication from a CCO to a potential member who is not enrolled in the CCO that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(c) "Marketing Materials" means materials that are produced in any medium by or on behalf of a CCO and that can reasonably be interpreted as intended to market to potential members.

(d) "Outreach" means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO's subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.

(e) "Outreach Materials" means materials that are produced in any medium, by or on behalf of a CCO that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO.

(f) "Potential Member" means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific CCO.

(2) CCOs shall comply with 42 CFR 438.10, 438.100 and 438.104 to ensure that before enrolling OHP clients, the CCO provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that CCO. CCOs shall distribute the materials to its entire service area as indicated in its CCO contract. The CCOs may not:

(a) Distribute any marketing materials without first obtaining state approval;

(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and

(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The following communications are expressly permitted:

(a) The creation of name recognition and communication methodologies may include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(b) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(4) CCOs shall update plan access information with the Authority on a monthly basis for use in updating the availability charts. The Authority shall confirm information before posting.

(5) CCOs have sole accountability for producing or distributing materials following Authority approval.

(6) CCOs shall comply with the Authority marketing materials submission guidelines. CCOs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

(a) A list of communication or outreach materials subject to review by the Authority;

(b) A clear explanation of the Authority's process for review and approval of marketing materials;

(c) A process for appeals of the Authority's edits or denials;

(d) A marketing materials submission form to ensure compliance with CCO marketing rules; and

(e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14

410-141-3280

Coordinated Care Organization (CCO) Potential Member Information Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific CCO;

(c) "Prevalent Non-English Language" means all non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO's total OHP enrollment; or

(B) 1,000 of the CCO's members;

(d) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(2) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-3270; Oregon Health Plan Marketing Requirements.

(3) The creation of name recognition because of the CCO's health promotion or education activities shall not constitute an attempt by the CCO to influence a client's enrollment.

(4) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(5) The following shall not constitute marketing or an attempt by the MCO to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align CCO provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with providers' service dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) CCOs shall update plan access information with OHA on a monthly basis for use in updating the availability charts. OHA shall confirm before posting.

(7) CCOs shall develop informational materials for potential members.

(8) CCOs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The CCO shall make available to potential members, upon request, information on participating providers.

(9) CCO provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients. A CCO or the Division may include informational materials in the application packet for potential members.

(10) CCOs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(11) CCO's shall honor requests made by other sources such as potential members, potential family members, or caregivers for language accommodation, translating to the potential member's

language needs as requested. Alternate formats shall be provided and may include but are not limited to braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide:

(a) CCOs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a12-point font or larger (18 point);

(b) CCOs shall ensure that all CCO staff who have contact with potential members are fully informed of CCO and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, and the availability of free certified health care interpreters, and which participating providers' offices have bilingual capacity and which are accepting new members.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 16-2015, f. 3-31-15, cert. ef. 4-1-15; DMAP 21-2015, f. 4-14-15, cert. ef. 4-15-15; DMAP 24-2015, f. & cert. ef. 4-15-15

410-141-3300
Coordinated Care Organization (CCO) Member Education and Information Requirements

(1) For the purpose of this rule, the following definitions apply:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Alternate Format Statement Insert" means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state's top sixteen preferred written languages as identified by OHP enrollees. CCOs shall insert their contact information into the template.

(c) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(d) "Prevalent Non-English Language" means: All non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO's total OHP enrollment; or

(B) 1, 000 of the CCO's members.

(2) CCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the CCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(3) CCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications should be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. CCOs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the CCO's health promotion or education activities shall not constitute an attempt by the CCO to influence a client's enrollment.

(5) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) CCOs shall have a mechanism to help members understand the requirements and benefits of the CCO's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that interpreter services at provider offices are free to CCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of a CCO's receiving notice of a member's enrollment, CCOs shall mail a welcome packet to new members and to members returning to the CCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory

(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients.

(11) For those who are existing members, a CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. CCOs shall send hard copies upon request.

(12) CCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the CCO:

(A) Welcome Packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes.

(b) Alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit.

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the CCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services.

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large type, and braille.

(13) A CCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille.

(c) CCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs and the CCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) What participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of intensive care coordination services and how members with the following special health care needs can access intensive care coordination services: Those who are aged, blind, or disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency.

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(L) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the CCO's grievance and appeals processes and the Division's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3260;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3263.

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO for non-emergent care; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(t) Whether or not the CCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(z) The CCO's confidentiality policy:

(aa) How and where members are to access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;

(bb) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;

(cc) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;

(dd) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.

(14) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. CCO providers or other individuals or programs approved by the CCO may provide health education. CCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) Information specifying that CCOs may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(A) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the enrollee needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(d) Explanation of intensive care coordination services and how to access intensive care coordination through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care

needs, multiple chronic conditions, mental illness, or chemical dependency;

(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(f) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from CCO's participating providers. The CCO shall provide, translated as appropriate, the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that CCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) CCOs shall provide free interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care:

(A) CCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. CCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(B) CCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter and a member handbook in all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language.

(b) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.

(16) CCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the CCO, members, and providers.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 16-2015, f. 3-31-15, cert. ef. 4-1-15; DMAP 21-2015, f. 4-14-15, cert. ef. 4-15-15; DMAP 24-2015, f. & cert. ef. 4-15-15; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3320
Coordinated Care Organization Member Rights and Responsibilities

(1) CCO members shall have the following rights and are entitled to:

(a) Be treated with dignity and respect;

(b) Be treated by participating providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;

(c) Choose a Primary Care Provider (PCP) or service site, and to change those choices as permitted in the CCO's administrative policies;

(d) Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;

(e) Have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines;

(f) Be actively involved in the development of their treatment plan;

(g) Be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments;

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

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

(j) Have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;

(k) Receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.

(l) Receive oversight, care coordination and transition and planning management from their CCO within the targeted population of AMH to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care.

(m) Receive necessary and reasonable services to diagnose the presenting condition;

(n) Receive integrated person centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

(o) Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

(p) Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(q) Obtain covered preventive services;

(r) Have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization;

(s) Receive a referral to specialty providers for medically appropriate covered coordinated care services, in the manner provided in the CCO's referral policy;

(t) Have a clinical record maintained which documents conditions, services received, and referrals made;

(u) Have access to one's own clinical record, unless restricted by statute;

(v) Transfer of a copy of the clinical record to another provider;

(w) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;

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

(y) Be able to make a complaint or appeal with the CCO and receive a response;

(z) Request a contested case hearing;

(aa) Receive certified or qualified health care interpreter services; and

(bb) Receive a notice of an appointment cancellation in a timely manner.

(2) CCO members shall have the following responsibilities:

(a) Choose, or help with assignment to, a PCP or service site;

(b) Treat the CCO, provider, and clinic staff members with respect;

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

(d) Seek periodic health exams and preventive services from his/her PCP or clinic;

(e) Use his/her PCP or clinic for diagnostic and other care except in an emergency;

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

(g) Use urgent and emergency services appropriately, and notify the member's PCP or clinic within 72 hours of using emergency services, in the manner provided in the CCO's referral policy;

(h) Give accurate information for inclusion in the clinical record;

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

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

(k) Use information provided by CCO providers or care teams to make informed decisions about treatment before it is given;

(l) Help in the creation of a treatment plan with the provider;

(m) Follow prescribed agreed upon treatment plans and actively engage in their health care;

(n) Tell the provider that his/her health care is covered under the OHP before services are received and, if requested, to show the provider the Division Medical Care Identification form;

(o) Tell the Department or Authority worker of a change of address or phone number;

(p) Tell the Department or Authority worker if the member becomes pregnant and to notify the worker of the birth of the member's child;

(q) Tell the Department or Authority worker if any family members move in or out of the household;

(r) Tell the Department or Authority worker if there is any other insurance available;

(s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(t) Pay the monthly OHP premium on time if so required;

(u) Assist the CCO in pursuing any third party resources available and reimburse the CCO the amount of benefits it paid for an injury from any recovery received from that injury; and

(v) Bring issues, or complaints or grievances to the attention of the CCO.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3340
Procedure for General Financial Reporting and for Determining Financial Solvency Matters

(1) The Authority shall determine financial solvency of a CCO in accordance with OAR 410-141-3345 through 410-141-3395, the request for applications and the CCO contract. In implementing OAR 410-141-3345 to 410-141-3395, the Authority may enter into a cooperative agreement with another state agency to carry out these provisions. For purposes of obtaining necessary information to determine financial solvency, any reference to OHA in these rules shall include DCBS when DCBS is working cooperatively with OHA to implement these provisions. However, only OHA may take enforcement action or other regulatory sanctions related to the implementation of OAR 410-141-3345 to 410-141-3395 and the CCO contract.

(2) OAR 410-141-3345 to 410-141-3395 are developed in consultation with DCBS in accordance with Section 13, chapter 602, Oregon Laws 2011 (Enrolled House Bill 3650) and Section 1, chapter 8, Oregon Laws 2012 (Enrolled Senate Bill 1580).

(3) Where these rules specify that the OHA may request or receive information or provide a response or take any action, DCBS may act on behalf of OHA. A response to DCBS under these rules shall be considered a response to the OHA on the matter, consistent with the objective of providing a single point of reporting by CCOs.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3345
General Financial Reporting and Financial Solvency Matters; CCO Reporting Method

(1) Each CCO must demonstrate that it is able to provide coordinated care services efficiently, effectively, and economically. CCOs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports as provided in these rules.

(2) The Authority shall collaborate with the Department of Consumer and Business Services (DCBS) to review CCO financial reports and evaluate financial solvency. CCOs are not required to file financial reports with both OHA and DCBS except as provided in this section or as outlined in the CCO contract:

(a) Initial applicants for certification as a CCO shall submit all required information to the Authority as part of the application process, and the Authority shall transmit that information to DCBS for its review. In making its determination about the qualifications of the applicant, the Authority shall consult with DCBS about the financial materials and reports submitted with the application;

(b) For purposes of these financial reporting and solvency rules, DCBS is authorized to make recommendations to the Authority and to act in conjunction with the Authority in accordance with these rules. If quarterly reports or other evidence suggest that a CCO's financial solvency is in jeopardy, the Authority shall act as necessary to protect the public interest.

(3) The Authority may address any proper inquiries to any CCO or its officers in relation to the activities or condition of the CCO or any other matter connected with its transactions. The person shall promptly and truthfully reply to the inquiries using the form of communication requested by the Authority. The reply shall be timely, accurate, and complete and, if the Authority requires, verified by an officer of the CCO. A reply is subject to the provisions of ORS 731.260.

(4) OAR 410-141-3345 through 410-141-3395 provide for three alternative methods for a CCO's solvency plan and financial reporting requirements, depending on the status of the CCO as described in this rule:

(a) The Authority reporting CCO: The CCO complies with restricted reserve and net worth requirements the Authority used to regulate financial solvency of MCOs on July 1, 2012, submitting financial information and reports to the Authority as detailed in the CCO contract. Under this approach, the Authority shall monitor the CCO's financial solvency utilizing the same reporting format and financial standards that the Authority used for MCOs on July 1, 2012;

(b) DCBS reporting CCO: The CCO complies with financial requirements as detailed in the CCO contract and in OAR 410-141-3345 through 410-141-3395, including risk-based capital and NAIC reporting requirements. These requirements shall be monitored by DCBS;

(c) Certificate of Authority: The CCO has a certificate of authority and complies with financial reporting and solvency requirements applicable to licensed health entities pursuant to applicable DCBS requirements under the Oregon insurance code

and DCBS rules. In addition, the CCO shall report to the Authority the schedules outlined in the CCO contract.

(5) CCO Status. The method described in this rule that applies to a CCO is determined as follows:

(a) If the CCO is a licensed health entity, the CCO shall use the method described in this rule for certificate of authority. The CCO shall submit a copy of its certificate of authority to the Authority, not later than the readiness review document submission date under the initial CCO contract, and annually thereafter, not later than August 31. The CCO shall report to the Authority immediately at any time that this certificate of authority is suspended or terminated;

(b) If the CCO is neither a converting MCO nor a licensed health entity, the CCO shall use the method described in this rule for DCBS reporting CCO;

(c) If the CCO is a converting MCO and is not a licensed health entity, the CCO shall elect either the method described in this rule for the Authority reporting CCO or the method described in this rule for DCBS reporting CCO. The CCO shall notify the Authority of its election no later than the readiness review document submission date under the initial CCO contract. The CCO shall comply with the requirements applicable to its elected method until it notifies the Authority of its intent to change its election. If the CCO expects to change its election, any elements of the solvency plan, or solvency protection arrangements, the CCO shall provide written advance notice to the Authority, at least 90-calendar days before the proposed effective date of change. Such changes are subject to written approval from the Authority.

(6) CCOs may be required to use specific required reporting forms or items in order to supply information related to financial responsibility, financial solvency, and financial management. The Authority or DCBS, as applicable, shall provide supplemental instructions about the use of these forms.

(7) The standards established in OAR 410-141-3350 through 410-141-3395 are intended to be consistent with, and may utilize procedures and standards common to insurers and to DCBS in its administration of financial reporting and solvency requirements. Any reference in these rules to the insurance code or to rules adopted by DCBS under the insurance code may not be deemed to require a CCO to be an insurer but is adopted and incorporated by reference as the Authority standard.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 81-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 2-2016, f. 2-3-16, cert. ef. 3-1-16

410-141-3350
Assets, Liabilities, Reserves — DCBS REPORTING CCOs ONLY

(1) The provisions of this rule apply only to DCBS reporting CCOs, and do not apply to Authority reporting CCOs.

(2) In any determination of the financial condition of a CCO, there shall be allowed as assets only such assets as are owned by the CCO and which consist of:

(a) Cash in the possession or control of the CCO, including the true balance of any deposit in a solvent bank or trust company;

(b) Investments held in accordance with these rules, and due or accrued income items in connection therewith to the extent considered by the Authority to be collectible;

(c) Due premiums, deferred premiums, installment premiums, and written obligations taken for premiums, to the extent allowed by the Authority;

(d) The amount recoverable from a reinsurer if credit for reinsurance may be allowed to the CCO pursuant to OAR 410-141-3380;

(e) Deposits or equities recoverable from any suspended banking institution, to the extent deemed by the Authority to be available for the payment of losses and claims;

(f) Other assets considered by the Authority to be available for the payment of losses and claims, at values determined by the Authority.

(3) In addition to assets impliedly excluded by this rule, the following expressly shall not be allowed as assets in any determination of the financial condition of a CCO:

(a) Advances to officers, employees, agents and other persons on personal security only;

(b) Stock of such CCO owned by it, or any material equity therein or loans secured thereby, or any material proportionate interest in such stock acquired or held through the ownership by such CCO of an interest in another firm, corporation or business unit;

(c) Tangible personal property, except such property as the CCO is otherwise permitted to acquire and retain as an investment under these rules and which is deemed by the Authority to be available for the payment of losses and claims or which is otherwise expressly allowable, in whole or in part, as an asset;

(d) The amount, if any, by which the book value of any investment as carried in the ledger assets of the CCO exceeds the value thereof as determined under these rules.

(4) In any determination of the financial condition of a CCO, liabilities to be charged against its assets shall be calculated in accordance with these rules and shall include:

(a) The amount necessary to pay all of its unpaid losses and claims incurred on or prior to the date of the statement, whether reported or unreported to the CCO, together with the expenses of adjustment or settlement thereof;

(b) For insurance other than specified in Subsection (c) of this section, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, calculated in accordance with these rules;

(c) Reserves which place a sound value on its liabilities and which are not less than the reserves according to accepted actuarial standards consistently applied and based on actuarial assumptions relevant to contract provisions;

(d) Taxes, expenses and other obligations due or accrued at the date of the statement;

(e) Any additional reserves for asset valuation contingencies or loss contingencies required by these rules or considered to be necessary by the Authority for the protection of the Authority and the members of the CCO.

(5) If the Authority determines that a CCO's reserves, however calculated or estimated, are inadequate, the Authority shall require the CCO to maintain reserves in such additional amount as is needed to make them adequate.

(6) Funds of a CCO may be invested in a bond, debenture, note, warrant, certificate or other evidence of indebtedness that are not investment grade as established by these rules, but the funds that a CCO may invest under this section shall not exceed 20 percent of the CCO's assets. For purposes of this rule CCOs shall be subject to the requirements of OAR 836-033-0105 through 836-033-0130.

(7) A CCO shall not have any combination of investments in or secured by the stocks, obligations, and property of one person, corporation or political subdivision in excess of 10 percent of the CCO's assets, nor shall it invest more than 10 percent of its assets in a single parcel of real property or in any other single investment. This subsection does not apply to:

(a) Investments in, or loans upon, the security of the general obligations of a sovereign; or

(b) Investments by a CCO in all real or personal property used exclusively by such CCO to provide health services or in real property used primarily for its home office.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3355
Restricted Reserves, Capital and Surplus– DCBS Reporting CCOs Only

(1) The provisions of OAR 410-141-3355 apply only to DCBS reporting CCOs, and do not apply to Authority reporting CCOs.

(2) A CCO shall:

(a) Establish a restricted reserve account; and

(b) Maintain adequate funds in this account to meet the Authority's primary and secondary restricted reserve requirements. Reserve funds are held for the purpose of making payments to providers in the event of the CCO's insolvency.

(3) A CCO shall establish a restricted reserve account with a third party financial institution for the purpose of holding the CCO's primary and secondary restricted reserve funds. CCOs shall use the model depository agreement to establish a restricted reserve account;

(a) A model depository agreement shall be used by the CCO to establish a restricted reserve account. CCOs shall request the model depository agreement form from the Authority. CCOs shall submit the model depository agreement to the Authority at the time of application and the model depository agreement shall remain in effect throughout the period of time that the CCO contract is in effect. The model depository agreement cannot be changed without the Authority's written authorization;

(b) The CCO shall not withdraw funds, change third party financial institutions, or change account numbers within the restricted reserve account without the written consent of the Authority;

(c) A CCO shall submit a copy of the model depository agreement at the time of application for certification. If a CCO requests and receives written authorization from the Authority to make a change to their existing restricted reserve account, the CCO shall submit a model depository agreement reflecting the changes to the Authority within 15 days of the date of the change;

(d) The following instruments are considered eligible deposits for the purposes of the Authority's primary and secondary restricted reserves:

(A) Cash;

(B) Certificates of Deposit; or

(C) Amply secured obligations of the United States, a state or a political subdivision thereof as determined by the Authority.

(e) In addition to the instruments allowed in this rule, a CCO may satisfy the primary restricted reserve amount by a surety bond that meets the requirements listed below:

(A) The bond is prepaid at the beginning of the contract year for 18 months;

(B) Evidence of prepayment is provided to the Authority;

(C) The surety bond is purchased by a surety bond company approved by the Oregon Insurance Division;

(D) The surety bond agreement contains a clause stating the payment of the bond will be made to the third party entity holding the restricted reserve account on behalf of the contracting company for deposit into the restricted reserve account;

(E) The surety bond agreement contains a clause that no changes to the surety bond agreement will occur until approved by the Authority; and

(F) The Authority approves the terms of the surety bond agreement.

(4) A CCO's primary and secondary reserve balances are determined by calculating the average monthly medical expense incurred. A CCO that has submitted quarterly financial statements for the current quarter and the prior three quarters, the average monthly medical expense incurred is derived by adding together the "total hospital and medical" expense (NAIC statement of revenue and expenses) for the prior four quarters and dividing by 12. A newly formed CCO will use an average of hospital and medical expense projected for the first four quarters of operation. Each quarter the average expense liability will be recalculated using historical quarter data available. The amount a CCO must deposit into the restricted reserve account shall be:

(a) If a CCO's average monthly medical expense incurred is less than or equal to $250,000, an amount equal to the average monthly medical expense incurred. This amount will be referred to as the CCO's primary reserve and the CCO shall have no secondary reserve, until such time as the average monthly medical expense exceeds $250,000;

(b) If a CCO's average monthly medical expense is greater than $250,000, funds equaling 50 percent of the difference between the average monthly medical expense and the primary reserve balance of $250,000. This amount will be referred to as the CCO's secondary reserve;

(c) Adjusted each quarter after the CCO calculates its average monthly medical expense each quarter.

(5) Working capital or surplus requirements:

(a) As used in this section, "net healthcare revenue" means direct healthcare premium less the following: amounts paid for reinsurance ceded, HRA and GME payments (if any received by a CCO), and MCO taxes. "Net healthcare revenue" includes all healthcare related revenue and fee-for-service revenue adjusted for the change in unearned premium reserves;

(b) Except as provided in Section (8) CCOs shall possess and thereafter maintain capital or surplus, or any combination thereof, equal to the greater of $2.5 million or the amount required from the application of the risk-based capital standards in OAR 410-141-3360;

(c) A CCO that possesses the amount required in this rule as of the effective date of this rule must thereafter maintain that capital and surplus;

(d) Except as provided in Section (8), if a CCO does not possess the minimum capital and surplus as of the effective date of these rules, the CCO shall possess and thereafter maintain capital or surplus, or any combination thereof as follows:

(A) Five percent of annualized total net healthcare revenue as of August 1, 2012. The CCO shall calculate its authorized control level and file the RBC report in accordance with these rules;

(B) The greater of five percent annualized total net healthcare revenue or its authorized control level risk-based capital as of January 1, 2014;

(C) The greater of six percent of annualized total net healthcare revenue or 125 percent of its authorized control level risk-based capital as of January 1, 2015;

(D) The greater of seven percent of annualized total net healthcare revenue or 150 percent of its authorized control level risk-based capital as of January 1, 2016;

(E) The greater of eight percent of annualized total net healthcare revenue or 175 percent of its authorized control level risk-based capital as of January 1, 2017;

(F) The greater of nine percent of annualized total net healthcare revenue or 200 percent of its authorized control level risk-based capital as of January 1, 2018;

(G) The greater of 10 percent of annualized total net healthcare revenue or 200 percent of its authorized control level risk-based capital as of January 1, 2019.

(e) A CCO may use a subordinated surplus note to meet its minimum capital and surplus requirement provided it meets the standards in Statements of Statutory Accounting Principles #41 and the Authority has given prior approval of the form and content of the surplus note;

(f) A converting CCO will initially be subject to financial responsibility and solvency standards applicable to the Authority reporting CCO. Effective January 1, 2014, the converting CCO shall comply with the minimum capital and surplus set forth in this rule;

(g) The converting CCO shall calculate its authorized control level and file the RBC report in accordance with this rule.

(6) Funds of a CCO at least equal to its required capital and surplus shall be invested and kept invested as follows:

(a) In amply secured obligations of the United States, a state or a political subdivision of this state;

(b) In loans secured by first liens upon improved, unencumbered real property (other than leaseholds) in this state where:

(A) The lien does not exceed 50 percent of the appraised value of the property and the loan is for a term of five years or less;

(B) The lien does not exceed 66-2/3 percent of the appraised value of the property provided there is an amortization plan mortgage, deed of trust or other instrument under the terms of which the

installment payments are sufficient to repay the loan within a period of not more than 25 years; or

(C) The investment is insured or guaranteed by the Federal Housing Administration, the United States Department of Veterans Affairs, or under Title I of the Housing Act of 1949 (providing for slum clearance and redevelopment projects) enacted by Congress on July 15, 1949.

(c) In deposits, certificates of deposit, accounts or savings or certificate shares or accounts of or in banks, trust companies, savings and loan associations or building and loan associations to the extent such investments are insured by the Federal Deposit Insurance Corporation.

(7) Investments made pursuant to Section (6) of this rule shall be kept free of any lien or pledge.

(8) A CCO that is not a converting CCO shall possess $500,000 working capital above the minimum capital and surplus requirement upon the CCO contract date sufficient to pay initial expenses without causing the CCO to fall below the minimum capital and surplus required by these rules.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3360
Risk-based capital — DCBS Reporting CCOs Only

(1) The provisions of OAR 410-141-3360 shall apply only to DCBS reporting CCOs, and do not apply to OHA reporting CCOs.

(2) As used in this rule:

(a) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

(b) "Company Action Level RBC" means, with respect to any CCO, the product of 2.0 and the CCO's Authorized Control Level RBC;

(c) "Mandatory Control Level RBC" means the product of .70 and the CCO's authorized control level RBC;

(d) "RBC Instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(e) "RBC Level" means a CCO's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC;

(f) "RBC Plan" means a comprehensive financial plan containing the elements specified in this rule. If OHA rejects the RBC plan and it is revised by the CCO with or without OHA's recommendation, the plan shall be called the "revised RBC plan;"

(g) "RBC Report" means the report required in OAR 410-141-3360;

(h) "Regulatory Action Level RBC" means the product of 1.5 and the CCO's authorized control level RBC;

(i) "Total Adjusted Capital" means the sum of:

(A) A CCO's capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under these rules; and

(B) Such other items, if any, as the RBC instructions may provide.

(3) For the purpose of determining the reasonableness and adequacy of a CCO's capital and surplus, the Oregon Health Authority must consider at least the following factors, as applicable:

(a) The size of the CCO, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(b) The number of lives insured;

(c) The extent of the geographical dispersion of the lives insured by the CCO;

(d) The nature and extent of the reinsurance program of the CCO;

(e) The quality, diversification and liquidity of the investment portfolio of the CCO;

(f) The recent past and projected future trend in the size of the investment portfolio of the CCO;

(g) The combined capital and surplus maintained by comparable CCOs;

(h) The adequacy of the reserves of the CCO;

(i) The quality and liquidity of investments in affiliates. OHA may treat any such investment as a disallowed asset for purposes of determining the adequacy of combined capital and surplus whenever in the judgment of OHA the investment so warrants; and

(j) The quality of the earnings of the CCO and the extent to which the reported earnings include extraordinary items.

(4) The following pertain to a CCO's RBC levels:

(a) On or before March 1 of each year, a CCO shall prepare and submit to OHA a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a CCO shall file its RBC report with the NAIC in accordance with the RBC instructions. The CCO shall report in its annual financial statement the authorized control level calculated using its RBC report. A CCO's RBC report will be considered confidential under OAR 410-141-3390;

(b) A CCO's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions:

(A) Asset risk;

(B) Credit risk;

(C) Underwriting risk; and

(D) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(c) An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in this rule and the formulas, schedules and instructions referenced in this rule is desirable in the business of a CCO. Accordingly, CCOs should seek to maintain capital above the RBC levels required by this rule. Additional capital is used and useful in the business of a risk-bearing entity and helps to secure a CCO against various risks inherent in, or affecting, the business of a CCO and not accounted for or only partially measured by the risk-based capital requirements contained in this rule;

(d) If a CCO files an RBC report that in the judgment of OHA is inaccurate, then OHA shall adjust the RBC report to correct the inaccuracy and shall notify the CCO of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

(5) "Company Action Level Event" means any of the following events:

(a) The filing of an RBC report by a CCO that indicates that the CCO's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(b) If a CCO has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(c) Notification by OHA to the CCO of an adjusted RBC report that indicates an event in Section 15 of this section, if the CCO does not challenge the adjusted RBC report in this rule; or

(d) If a CCO challenges an adjusted RBC report that indicates the event in Section (5)(a), the notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge.

(6) In the event of a company action level event, the CCO shall prepare and submit to OHA an RBC plan that shall:

(a) Identify the conditions that contribute to the company action level event;

(b) Contain proposals of corrective actions that the CCO intends to take and that would be expected to result in the elimination of the company action level event;

(c) Provide projections of the CCO's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the CCO's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the CCO's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(7) The RBC plan shall be submitted:

(a) Within 45 days of the Company Action Level Event; or

(b) Within 45 days after notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge, if the CCO challenges an adjusted RBC report;

(c) Within 60 days after the submission by a CCO of an RBC plan to OHA, OHA shall notify the CCO whether the RBC plan shall be implemented or is, in the judgment of OHA, unsatisfactory. If OHA determines the RBC plan is unsatisfactory, the notification to the CCO shall set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory, in the judgment of OHA. Upon notification from OHA, the CCO shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by OHA, and shall submit the revised RBC plan to OHA:

(A) Within 45 days after the notification from OHA; or

(B) Within 45 days after a notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge, if the CCO challenges the notification from OHA under this rule.

(8) In the event of a notification by OHA to a CCO that the CCO's RBC plan or revised RBC plan is unsatisfactory, OHA may at OHA's discretion, subject to the CCO's right to a hearing under this rule, specify in the notification that the notification constitutes a regulatory action level event.

(9)"Regulatory Action Level Event" means, with respect to a CCO, any of the following events:

(a) The filing of an RBC report by the CCO that indicates that the CCO's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) Notification by OHA to a CCO of an adjusted RBC report that indicates the event in Section (9)(a), if the CCO does not challenge the adjusted RBC report in this rule;

(c) If the CCO challenges an adjusted RBC report that indicates the event in this rule, the notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge;

(d) The failure of the CCO to file an RBC report by the filing date, unless the CCO has provided an explanation for the failure that is satisfactory to OHA and has cured the failure within ten days after the filing date;

(e) The failure of the CCO to submit an RBC plan to OHA within the time period set forth in this rule;

(f) Notification by OHA to the CCO that:

(A) The RBC plan or revised RBC plan submitted by the CCO is, in the judgment of OHA, unsatisfactory; and

(B) Notification constitutes a regulatory action level event with respect to the CCO, if the CCO has not challenged the determination in this rule.

(g) If the CCO challenges a determination by OHA, the notification by OHA to the CCO that OHA has, after a hearing, rejected the challenge;

(h) Notification by OHA to the CCO that the CCO has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the CCO to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and OHA has so stated in the notification, if the CCO has not challenged the determination; or

(i) If the CCO challenges a determination by OHA, the notification by OHA to the CCO that OHA has, after a hearing, rejected the challenge.

(10) In the event of a regulatory action level event OHA shall:

(a) Require the CCO to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as OHA deems necessary of the assets, liabilities and operations of the CCO including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as OHA shall determine are required (a "corrective order").

(11) In determining corrective actions, OHA may take into account factors OHA deems relevant with respect to the CCO based upon OHA's examination or analysis of the assets, liabilities and operations of the CCO, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within 45 days after the occurrence of the regulatory action level event;

(b) Within 45 days after the notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge; if the CCO challenges an adjusted RBC report, and the challenge is not frivolous in the judgment of OHA; or

(c) Within 45 days after the notification to the CCO that the care service CCO has, after a hearing, rejected the CCO's challenge, if the CCO challenges a revised RBC plan, and the challenge is not frivolous in the judgment of OHA.

(12) OHA may retain actuaries and investment experts and other consultants as may be necessary in the judgment of OHA to review the CCO's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the CCO and formulate the corrective order with respect to the CCO. The fees, costs and expenses relating to consultants shall be borne by the affected CCO or such other party as directed by OHA.

(13) "Authorized Control Level Event" means any of the following events:

(a) The filing of an RBC report by the CCO that indicates that the CCO's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by OHA to the CCO of an adjusted RBC report that indicates the event in this section, if the CCO does not challenge the adjusted RBC report;

(c) If the CCO challenges an adjusted RBC report that indicates the event in this section, notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge;

(d) The failure of the CCO to respond, in a manner satisfactory to OHA, to a corrective order if the CCO has not challenged the corrective order; or

(e) If the CCO has challenged a corrective order in this rule and OHA has, after a hearing, rejected the challenge or modified the corrective order, the failure of the CCO to respond, in a manner satisfactory to OHA, to the corrective order subsequent to rejection or modification by OHA.

(14) In the event of an authorized control level event with respect to a CCO, OHA shall:

(a) Take such actions as are required by this rule regarding a CCO with respect to which an regulatory action level event has occurred; or

(b) If OHA deems it to be in the best interests of the members and creditors of the CCO and of the public, take such actions as are necessary to work with the Authority, which may terminate the CCO contract and revoke or suspend its certification as a CCO.

(15)"Mandatory Control Level Event" means any of the following events:

(a) The filing of an RBC report that indicates that the CCO's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by OHA to the CCO of an adjusted RBC report that indicates the event in this section, if the CCO does not challenge the adjusted RBC report; or

(c) If the CCO challenges an adjusted RBC report that indicates the event in this section, notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge.

(16) In the event of a mandatory control level event, OHA shall take such actions as are necessary to work with the Authority, which may to terminate the CCO contract and revoke or suspend its certification as a CCO. Notwithstanding the provisions of this rule, OHA may forego action for up to 90 days after the mandatory control level event if OHA finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90 day period.

(17) Upon the occurrence of any of the following events, a CCO may request a hearing for the purpose of challenging any determination or action by OHA in connection with any event described in this rule. The CCO shall notify OHA of its request for a hearing not later than the fifth day after notification by OHA under any of the events described in this rule. Upon receipt of the CCO's request for a hearing, OHA shall set a date for the hearing. The date shall be not less than 10 or more than 30 days after the date of the CCO's request. The events to which the opportunity for a hearing under this rule relates are as follows:

(a) Notification to a CCO by OHA of an adjusted RBC report;

(b) Notification to a CCO by OHA that:

(A) The CCO's RBC plan or revised RBC plan is unsatisfactory; and

(B) Notification constitutes a Regulatory Action Level Event with respect to the CCO.

(c) Notification to a CCO by OHA that the CCO has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the CCO to eliminate the company action level event with respect to the CCO in accordance with its RBC plan or revised RBC plan; or

(d) Notification to a CCO by OHA of a corrective order with respect to the CCO.

(18) OHA may keep confidential a CCO's RBC plan or the results or report of any examination or analysis conducted in this rule if OHA determines that disclosure of such information would jeopardize the CCO's corrective action plan.

(19) This rule shall not preclude or limit any other powers or duties of OHA or OHA under other laws and rules.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3365
Financial Reporting– DCBS Reporting CCOs Only

(1) The provisions of OAR 410-141-3365 shall apply only to DCBS reporting CCOs and do not apply to OHA reporting CCOs.

(2) Every CCO shall file with DCBS, on or before March 1 of each year, a financial statement for the year ending December 31 immediately preceding. The CCO shall also file with DCBS, on or before May 15, August 15, and November 15 of each year, quarterly financial statements for the quarter ending March 31, June 30 and September 30, respectively. All financial statements shall be completed in accordance with NAIC annual statement instructions. OHA may also require additional filings as OHA determines necessary.

(3) The financial statement filed by a CCO under this rule shall be verified by the oaths of the president and secretary of the CCO or, in their absence, by two other principal officers.

(4) Each CCO shall have an annual audit conducted by an independent certified public accountant and shall file an audited financial report annually with DCBS. The annual audited financial report shall be in the form required of insurers by the insurance code, specifically ORS 731.488 and OAR 836-011-0100 through 836-011-0220.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 – 685 2011 OL Ch. 602 Sec. 13, 14, 16, 17, 62, 64(2), 65 & HB 3650
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3370
Solvency Monitoring and Corrective Actions

(1) For purposes of this rule, the CCO shall be monitored in the context of the financial standards applicable to the reporting method described in OAR 410-141-3345. An OHA reporting CCO is accountable under the standards in the CCO contract and this rule. A DCBS reporting CCO or a CCO with a certificate of authority is accountable under DCBS standards.

(2) OHA shall examine every CCO, including an audit of the financial affairs of such CCO, as often as OHA determines an examination to be necessary but generally at least once during the CCO's certification period. An examination shall be conducted for the purpose of determining the financial condition of the CCO, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with these rules and applicable CCO contract requirements.

(3) The following apply to CCO examinations:

(a) When OHA determines that an examination should be conducted, OHA shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the NAIC. OHA may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that OHA determines to be appropriate, taking into account whether the CCO is an OHA reporting CCO, is a DCBS reporting CCO, or has a certificate of authority;

(b) When making an examination, OHA may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as needed. The cost of retaining such professionals and specialists shall be borne by the CCO that is the subject of the examination;

(c) At any time during the course of an examination, OHA may take other action pursuant to these rules;

(d) Facts determined and conclusions made pursuant to an examination shall be presumptive evidence of the relevant facts and conclusions in any judicial or administrative action;

(e) Upon an examination or investigation OHA may examine under oath all persons who may have material information regarding the property or business of the person being examined or investigated;

(f) Every person being examined or investigated shall produce all books, records, accounts, papers, documents and computer and other recordings in its possession or control relating to the matter under examination or investigation, including, in the case of an examination, the property, assets, business and affairs of the person; and

(g) The officers, directors and agents of the person being examined shall provide timely, convenient and free access at all reasonable hours at the offices of the person being examined to all books, records, accounts, papers, documents and computer and other recordings. The officers, directors, employees and agents of the person must facilitate the examination.

(4) The following apply to the Authority's report following the examination:

(a) Not later than the 60th day after completion of an examination, the examiner in charge of the examination shall submit to OHA a full and true report of the examination, verified by the oath of the examiner. The report shall comprise only facts appearing upon the books, papers, records, accounts, documents or computer and other recordings of the person, its agents or other persons being examined or facts ascertained from testimony of individuals concerning the affairs of such person, together with such conclusions

and recommendations as reasonably may be warranted from such facts;

(b) OHA shall make a copy of the report submitted under this section available to the person who is the subject of the examination and shall give the person an opportunity to review and comment on the report. OHA may request additional information or meet with the person for the purpose of resolving questions or obtaining additional information, and may direct the examiner to consider the additional information for inclusion in the report;

(c) Before OHA files the examination report as a final examination report or makes the report or any matters relating thereto public, the person being examined shall have an opportunity for a hearing. A copy of the report must be mailed by certified mail to the person being examined. The person may request a hearing not later than the 30th day after the date on which the report was mailed. This subsection does not limit the authority of OHA to disclose a preliminary or final examination report as otherwise provided in this section, or to CMS or other federal or state authorities authorized to obtain access to CCO financial records in accordance with the CCO contract;

(d) OHA shall consider comments presented at a hearing requested under paragraph (c) of this section and may direct the examiner to consider the comments or direct that the comments be included in documentation relating to the report, although not as part of the report itself. OHA may file the report as a final examination report at any time after consideration of the comments or at any time after the period for requesting a hearing has passed if a hearing is not requested;

(e) A report filed as a final examination report is subject to public inspection. OHA, after filing any report, if OHA considers it for the interest of the public to do so, may publish any report or the result of any examination as contained therein in one or more newspapers of the state without expense to the person examined; and

(f) OHA may disclose the content of an examination report that has not yet otherwise been disclosed or may disclose any of the materials described in this section as provided in OAR 410-141-3390.

(5) No cause of action may arise and no liability may be imposed against OHA or DCBS, an authorized representative of OHA or DCBS or any examiner appointed by OHA or DCBS for any statements made or conduct performed in good faith pursuant to an examination or investigation. No cause of action may arise and no liability may be imposed against any person for communicating or delivering information or data to OHA or an authorized representative of OHA or examiner pursuant to an examination or investigation if the communication or delivery was performed in good faith and without fraudulent intent or intent to deceive.

(6) Section (5) does not abrogate or modify in any way any common law or statutory privilege or immunity otherwise enjoyed by any person to which this subsection applies.

(7) Any CCO or applicant for CCO certification examined under this rule shall pay to OHA the just and legitimate costs of the examination as determined by OHA, including actual necessary transportation and traveling expenses.

(8) In addition to other powers of OHA under these rules relating to the examination and investigation of CCOs, OHA may also order any CCO to produce such books, records, accounts, papers, documents and computer and other recordings in the possession of the CCO or its affiliates as are necessary to ascertain the financial condition of the CCO or to determine compliance with these rules. If the CCO fails to comply with such an order, OHA may examine the affiliates to obtain such information, in addition to imposing sanctions or other remedies under these OHA rules or the CCO contract. A CCO shall pay the costs of an examination of the CCO.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 – 414.685, 2011 OL Ch. 602 Sec. 13, 14, 16, 17, 62, 64(2) & 65 & HB 3650
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3375
Hazardous Operations

(1) For purposes of this rule, the CCO will be held financially responsible in the context of the financial standards applicable to the reporting method described in OAR 410-141-3345. An OHA reporting CCO is accountable under the standards in the CCO contract and this rule. A DCBS reporting CCO or a CCO with a certificate of authority is accountable under the DCBS standards:

(a) Based upon standards established by these rules, if OHA determines that the continued operation of a CCO is hazardous to its members or to the public in general, OHA may order the CCO to take one or more of the following actions:

(A) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(B) Reduce, suspend or limit the volume of business being accepted or renewed;

(C) Reduce general insurance and commission expenses by methods specified by OHA;

(D) Increase the capital and surplus of the CCO;

(E) Suspend or limit the declaration and payment of dividends by the CCO to its stockholders or members;

(F) Limit or withdraw from certain investments or discontinue certain investment practices to the extent OHA determines such action to be necessary.

(b) OHA may exercise authority under Subsection (a) of this section in addition to or instead of any other authority that OHA may exercise under these rules;

(c) OHA may issue an order with or without a hearing. A CCO subject to an order issued without a hearing may file a written request for a hearing to review the order. Such a request shall not stay the effect of the order. The hearing shall be held within 30 days after the filing of the request. OHA shall complete the review within 30 days after the record for the hearing is closed, and shall discontinue the action taken if OHA determines that none of the conditions giving rise to the action exists.

(2) OHA may consider the following standards, either singly or in combination of two or more, to determine whether the continued operation of any CCO might be determined to be hazardous to the CCO's members, its creditors or the general public:

(a) Adverse findings reported in financial condition examination reports, audit reports, and actuarial opinions, reports or summaries;

(b) Whether the CCO has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the CCO, when considered in light of the assets held by the CCO with respect to such reserves and related actuarial items including but not limited the investment earnings on such assets, and the considerations anticipated to be received and retained under such contracts;

(c) The ability of an assuming reinsurer to perform and whether the CCO's reinsurance program provides sufficient protection for the CCO's remaining capital and surplus after taking into account the CCO's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(d) Whether the CCO's operating loss in the last 12-month period or any shorter period of time is greater than 50 percent of the CCO's remaining capital and surplus in excess of the minimum required;

(e) Whether the CCO's operating loss in the last 12-month period or any shorter period of time, excluding net capital gains, is greater than 20 percent of the CCO's remaining surplus in excess of the minimum required;

(f) Whether a reinsurer or obligor, or any entity within the CCO's system is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations and which, in the opinion of OHA may affect the solvency of the CCO;

(g) Contingent liabilities, pledges or guaranties that either individually or collectively involves a total amount that in the opinion of OHA may affect the solvency of the CCO;

(h) Whether any "controlling person" of a CCO is delinquent in the transmitting to, or payment of, net premiums to the CCO;

(i) The age and collectability of receivables;

(j) Whether the management of a CCO, including officers, directors or any other person who directly or indirectly controls the operation of the CCO, fails to possess and demonstrate the competence, fitness and reputation determined by OHA to be necessary to serve the CCO in such position;

(k) Whether management of a CCO has failed to respond to inquiries relating to the condition of the CCO or has furnished false and misleading information concerning an inquiry;

(l) Whether the CCO has failed to meet financial responsibility, accountability or filing requirements in the absence of a reason satisfactory to OHA;

(m) Whether management of a CCO either has filed a false or misleading sworn financial statement or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the CCO;

(n) Whether the CCO has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

(o) Whether the CCO has experienced or will experience in the foreseeable future cash flow or liquidity problems, or both;

(p) Whether management has established reserves that do not comply with minimum standards established by the CCO contract or regulations, accounting standards, sound actuarial principles and standards of practice;

(q) Whether management persistently engages in material under reserving that results in adverse development;

(r) Whether transactions among affiliates, subsidiaries or controlling persons for which the CCO receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the CCO's ability to meet its outstanding obligations as they mature; and

(s) Any other finding determined by OHA to be hazardous to the CCO's members, creditors or general public.

(3) For the purposes of making a determination of the financial condition of a CCO under these rules or the CCO contract, OHA may do one or more of the following:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the CCO's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the CCO will be called upon to meet the obligation undertaken within the next 12-month period.

(4) In addition to the requirements OHA may impose, if OHA determines that the continued operation of the CCO may be hazardous to OHA, the members or the general public, OHA may require the CCO to:

(a) File reports in a form acceptable to OHA concerning the market value of the CCO's assets;

(b) In addition to regular annual statements, file interim financial reports on the form specified by OHA;

(c) Correct corporate governance practice deficiencies, and adopt and utilize the governance practices acceptable to OHA; or

(d) Provide a business plan to OHA demonstrating corrective action the CCO will take to improve its financial condition.

(5) No CCO shall reduce its combined capital and surplus by partial distribution of its assets, by payment in the form of a dividend to stockholders or otherwise, below:

(a) Its required capitalization; or

(b) A greater amount which OHA, by rule or by order after hearing upon the motion of OHA or the petition of any interested person, finds necessary to avoid injury or prejudice to the interest of OHA, members or creditors.

(6) Whenever OHA determines from any showing or statement made to OHA or from any examination made by OHA that the assets of a CCO are less than its liabilities plus required capitalization, OHA may proceed immediately to terminate the CCO contract and revoke or suspend its certification as a CCO, or OHA may allow the CCO a period of time, not to exceed 90 days, in which to make correct the amount of the impairment with cash or authorized investments. If the amount of any such impairment is not corrected within the time prescribed by OHA, OHA shall proceed immediately to terminate the CCO contract and revoke or suspend its certification as a CCO.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3380
Disallowance of Transactions — DCBS Reporting CCOs Only

(1)The provisions of OAR 410-141-3380 apply only to DCBS reporting CCOs, and do not apply to OHA reporting CCOs.

(2) OHA shall disallow as an asset or as a credit against liabilities any reinsurance found by OHA after a hearing thereon to have been arranged for the purpose principally of deception as to the ceding CCO's financial condition as of the date of any financial statement of the CCO. Without limiting the general purport of the foregoing provision, reinsurance of any substantial part of the CCO's outstanding risks contracted for in fact within four months prior to the date of any such financial statement and canceled in fact within four months after the date of such statement, or reinsurance under which the reinsurer bears no substantial insurance risk or substantial risk of net loss to itself, shall prima facie be deemed to have been arranged for the purpose principally of deception.

(3) OHA shall disallow as an asset any deposit, funds or other assets of the CCO found by OHA after a hearing thereon:

(a) Not to be in good faith the property of the CCO;

(b) Not freely subject to withdrawal or liquidation by the CCO at any time for the payment or discharge of claims or other obligations arising under its policies; and

(c) To be resulting from arrangements made principally for the purpose of deception as to the CCO's financial condition as of the date of any financial statement of the CCO.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3385
Holding Company

(1) As used in this rule, "Holding Company System" as it applies to a CCO means two or more affiliated persons, one or more of which is a CCO, and includes a financial holding company as referred to in section 103 of the federal Gramm-Leach-Bliley Act (P.L. 106-102). Such CCO shall also be subject to OAR 836-027-0001 through 836-027-0050 to the extent those rules relate to the filing of a registration statement (Form B filing).

(2) Every CCO that is a member of a holding company system shall be subject to ORS 732.551 to 732.572, except ORS 732.554.

(3) A transaction within a holding company system to which a CCO subject to registration is a party is subject to the following standards:

(a) The terms must be fair and reasonable;

(b) Charges or fees for services performed must be reasonable;

(c) Expenses incurred and payment received must be allocated to the CCO in conformity with customary insurance accounting practices consistently applied;

(d) The books, accounts and records of each party to the transaction must be so maintained as to disclose clearly and accurately the nature and details of the transaction, including accounting information necessary to support the reasonableness of the charges or fees to the respective parties; and

(e) The combined capital and surplus of the CCO following any transaction with an affiliate or any shareholder dividend must be reasonable in relation to the CCO's outstanding liabilities and adequate to its financial needs.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3390
Transparency

(1) Pursuant to ORS 414.018, interactions between OHA or DCBS and CCOs shall be done in a transparent and public manner. Without limitation of the preceding sentence, OHA or DCBS shall publicly disclose all information pertaining to CCOs of a character that DCBS publicly discloses pertaining to CCOs that are licensed health entities.

(2) Certain documents pertaining to a CCO's financial condition may be considered confidential, when so described in these rules. financial analysis solvency tools and analytical reports developed by the NAIC, and comparable reports developed or used by DCBS or OHA, are confidential. In addition, any work papers, recorded information, documents and copies thereof that are produced or obtained by or disclosed to OHA or DCBS, or any other person in the course of an examination or in the course of analysis by OHA or DCBS of the financial condition or market conduct of a CCO may be considered confidential, if the CCO specifically designates the confidential portions and cites an exemption from public disclosure under the Oregon Public Records Law, ORS 192.410 to 192.505. If OHA, in its sole discretion, determines that the cited exemption does not apply or disclosure is necessary to protect the public interest, OHA may make available work papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to OHA or any other person in the course of the examination.

(3) The OHA or DCBS may use a confidential document, material or other information in administering these rules and in furthering a regulatory or legal action brought as a part of the OHA's duties. In order to assist in the performance of OHA's duties, OHA may:

(a) Authorize sharing a confidential document, material or other information as appropriate among the administrative divisions and staff offices of the OHA or DCBS for the purpose of administering and enforcing the statutes within the authority of OHA, in order to enable the administrative divisions and staff offices to carry out their functions and responsibilities;

(b) Share a document, material or other information, including a confidential document, material or other information that is subject to this rule or that is otherwise exempt from disclosure under ORS 192.501 or ORS 192.502, with other state, federal, foreign and international regulatory and law enforcement agencies and with the NAIC and affiliates or subsidiaries of the NAIC, if the recipient agrees to maintain the confidentiality of the document, material or other information; and

(c) Receive a document, material or other information, including an otherwise confidential document, material or other information, from state, federal, foreign and international regulatory and law enforcement agencies and from the NAIC and affiliates or subsidiaries of the NAIC. As provided in this section, the OHA shall maintain the confidentiality of documents, materials or other information received upon notice or with an understanding that the document, material or other information is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(4) Disclosing a document, material or other information to the OHA, sharing a document, material or other information does not waive an applicable privilege or claim of confidentiality in the document, material or other information.

(5) OHA may release a final, adjudicated action, including a suspension or revocation of a CCO's certification, if the action is otherwise open to public inspection, to a database or other clearinghouse service maintained by the NAIC or affiliates or subsidiaries of the NAIC.

(6) All information, documents and copies thereof obtained by or disclosed to OHA, DCBS or any other person in the course of an examination or investigation made pursuant to OAR 410-141-3365 are subject to the provisions of ORS 731.312.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12

410-141-3395
Member Protection Provisions

(1) In the event of a finding of impairment by OHA or of a termination of certification as a CCO or of the CCO contract, members of the CCO shall be offered disenrollment from the CCO and enrollment in accordance with OHA rule.

(2) For the purpose of this section only, and only in the event of a finding of impairment by OHA or of a termination of certification or of the CCO contract, any covered health care service furnished within the state by a provider to a member of a CCO shall be considered to have been furnished pursuant to a contract between the provider and the CCO with whom the member was enrolled when the services were furnished.

(3) Each contract between a CCO and a provider of health services shall provide that if the CCO fails to pay for covered health services as set forth in the contract, the member is not liable to the provider for any amounts owed by the CCO.

(4) If the contract between the contracting provider and the CCO has not been reduced to writing or fails to contain the provisions required by this rule, the member is not liable to the contracting provider for any amounts owed by the CCO.

(5) No contracting provider or agent, trustee or assignee of the contracting provider shall bill a member, send a member's bill to a Collection Agency, or maintain a civil action against a member to collect any amounts owed by the CCO for which the member is not liable to the contracting provider in this rule and under 410-120-1280.

(6) Nothing in this section impairs the right of a provider to charge, collect from, and attempt to collect from or maintain a civil action against a member for any of the following:

(a) Deductible, copayment or coinsurance amounts;

(b) Health services not covered by the CCO, if a valid DMAP 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; or

(c) Health services rendered after the termination of the contract between the CCO and the provider, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract. Before providing a non-covered service, the provider must complete a DMAP 3165, or facsimile, as described in OAR 410-120-1280.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 60-2013, f. & cert. ef. 10-31-13

410-141-3420
Managed Care Entity (MCE) Billing and Payment

(1) Providers shall submit all billings for MCE members in the following timeframes:

(a) Submit bills within no greater than four months of the date of service for all cases, except as provided for in (1) (b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

(b) Submit billings within 12 months of the date of service in the following cases:

(A) Pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the MCE is responsible for the Medicare reimbursement;

(D) Other cases that could have delayed the initial billing to the MCE not including failure of the provider to verify the member's eligibility; or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered an alternative liability or TPL.

(2) Providers shall be enrolled with the Division to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Division before enrollment with the Authority or to be eligible for MCE payment for services. FFS providers may be retroactively enrolled in accordance with OAR 410-120-1260 Provider Enrollment.

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.

(4) Providers shall verify before providing services that the client is:

(a) Eligible for Division programs and;

(b) Whether the client is assigned to an MCE on the date of service.

(5) Providers shall use the Authority's tools and the MCE's tools, as applicable, to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an OHP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(6) MCEs shall pay for all covered capitated and coordinated care services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise. MCEs may require providers to obtain prior authorization to deliver certain capitated or coordinated care services.

(7) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider except as follows:

(a) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider and written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify time frames for:

(A) Date stamping prior authorization requests and claims when received;

(B) Determining within a specific number of days from receipt whether a prior authorization request or a claim is valid or non-valid;

(C) The specific number of days allowed for follow-up on pended prior authorization requests or pended claims to obtain additional information;

(D) The specific number of days following receipt of the additional information that an approval or denial shall be issued;

(E) Providing services after office hours and on weekends that require prior authorization;

(F) Sending written notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.

(b) MCEs shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to urgent services, alcohol and drug services, or care required while in a skilled nursing facility;

(c) Prior authorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent prior authorization for a prescription drug cannot be completed within 24 hours, the MCE shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All pharmacy requests, including those not marked urgent, shall be reviewed and a decision rendered within 72 hours of original receipt of the prior authorization request;

(d) For expedited prior authorization requests in which the provider indicates or the MCE determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(A) The MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;

(B) The MCE may extend the three working day time period no more than 14 calendar days if the member requests an extension or if the MCE justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(e) For all other prior authorization requests, MCEs shall notify providers of an approval, a denial, or the need for further information within 14 calendar days of receipt of the request as outlined in OAR 410-141-3263. MCEs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the MCE may use an additional 14 days to obtain follow-up information if the MCE justifies to the Authority, upon request, the need for additional information and how the delay is in the member's best interest. If the MCE extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in 410-141-3263. The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension;

(f) MCEs shall pay or deny at least 90 percent of valid claims within 30 calendar days of receipt and at least 99 percent of valid claims within 90 calendar days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

(g) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3263;

(h) MCEs may not require providers to delay billing to the MCE;

(i) MCEs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare or require non-Medicare approved providers to bill Medicare;

(j) MCEs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(k) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(L) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis.

(8) MCEs shall pay for Medicare coinsurances and deductibles up to the Medicare or MCE's allowable for covered services the member receives within the MCE participating provider network for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. MCEs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not

available within the state, unless otherwise approved by the Authority.

(10) MCEs shall pay for ancillary, as defined in 410-120-0000, covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

(a) It can be verified that a participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(b) The ancillary covered service was delivered in good faith without the prior authorization; and

(c) It was an ancillary covered service that would have been prior authorized with a participating provider if the MCE's referral procedures had been followed;

(d) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727;

(e) Except as specified in OAR 410-141-3140 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(f) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(g) MCEs shall reimburse hospitals for services provided on or after January 1, 2012, using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies including, but not limited to, pay-for-performance, bundled payments, and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements.

(11) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (11)–(13) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require MCEs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;

(c) For those Type A or Type B hospitals that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3268 and 410-141-3269, as applicable;

(d) For monitoring purposes, MCEs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.

(12) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:

(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;

(b) After determination for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1 of the following (even numbered) year;

(c) Type A and Type B hospitals located in a county that is designated as "Frontier" will not be subject to determination via the algorithm and shall remain on CBR.

(13) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:

(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;

(b) Reimbursement rates effective for the initial calendar year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table section at the following: http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

(14) Members may receive certain services on a Fee-for-Service (FFS) basis:

(a) Certain services shall be authorized by the MCE or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers shall verify a member's eligibility and MCE assignment as provided for in this rule;

(b) Services authorized by the MCE or CMHP are subject to the Authority's administrative rules and supplemental information including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the Authority's administrative rules, contracts, and billing instructions;

(e) The Authority may not pay a provider for providing services for which an MCE has received an MCE payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility, or foster home, provision of that item or service is not the responsibility of the Authority or an MCE except as provided in Authority administrative rules and supplemental information (e.g., coordinated care and capitated services that are not included in the nursing facility all-inclusive rate);

(g) CCOs and MHOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the CCO and MHOs would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(15) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 Excluded Services and Limitations for OHP Clients.

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.065 & 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14; DMAP 60-2013, f. & cert. ef. 10-31-13; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 34-2014(Temp), f. 6-25-14, cert. ef. 7-1-14 thru 12-27-14; DMAP 66-2014(Temp), f. 11-13-14, cert. ef. 12-28-14 thru 6-25-15; DMAP 71-2014, f. 12-8-14, cert. ef. 1-1-15; DMAP 41-2016, f. 6-30-16, cert. ef. 7-1-16

410-141-3430
Coordinated Care Organization Encounter Claims Data Reporting

(1) CCOs must meet the data content and submission standards as required by HIPAA 45 CFR Part 162, the Authority's electronic data transaction rules (OAR 943-120-0100 through 943-120-0200), the Division's 837 technical specifications for encounter data and the Division's encounter data submission guidelines which are subject to periodic revisions and available on the Authority's web site.

(2) CCOs must collect service information in standardized formats to the extent feasible and appropriate, if HIPAA standard, the CCO must utilize the HIPAA standards.

(a) CCOs shall submit encounter claims for all services, whether they are flexible services or covered services, provided to members as defined in OAR 410-120-0000 and 410-141-0000.

(b) CCOs shall submit encounter claims data including encounters for services where the CCO determined that:

(A) Liability exists;

(B) No liability exists even if the CCO did not make any payment for a claim;

(C) Including claims for services to members provided by a provider under a subcontract, capitation or special arrangement with another facility or program; and

(D) Including paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the CCO, or the CCO's subcontractor.

(c) CCOs shall submit encounter claims data for all services to members who also have Medicare coverage, if a claim has been submitted to the CCO.

(d) CCOs shall report encounter claims data whether the provider is an in network participating or out of network, non-participating, provider;

(3) CCOs must follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.

(4) CCOs must submit encounter claims in the time frames as described below for the following claim types:

(a) Non-pharmacy encounter claims; professional, dental, and institutional;

(A) CCOs must submit encounter claims at least once per month for no less than 50% of all claim types received and adjudicated that month;

(B) CCOs must submit all remaining unreported encounter claims for services received and adjudicated within 180 days of the date of service except as may be applicable in paragraph (C) below;

(C) CCOs may only delay submission of encounter claims within 180 days from the date of service with prior notification to the Authority and only for any of the following reasons:

(i) Member's failure to give the provider necessary claim information;

(ii) Resolving local or out-of-area provider claims;

(iii) Third-Party Resource liability or Medicare coordination;

(iv) Member's pregnancy;

(v) Hardware or software modifications to CCO's health information system, or;

(vi) Authority recognized system issues preventing timely submission or correction of encounter claims data.

(b) Pharmacy claims:

(A) CCOs must ensure all pharmacy encounter claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP), as available on their web site http://www.ncpdp.org/ or by contacting the National Council for Prescription Drug Programs organization;

(B) All pharmacy encounter claims data must be submitted by the CCO, whether by the CCO's pharmacy benefit manager or the CCO's subcontractor at least once a month for all services received and adjudicated that month and must submit all remaining unreported CCO pharmacy encounter claims within 60 days from the date of service.

(c) Submission Standards and Data Availability:

(A) CCOs must only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the CCO by the Authority in encounter claims;

(i) The National Provider Identifiers (NPI) for a provider covered entity enrolled with the Authority; or

(ii) The Oregon Medicaid proprietary provider numbers for the Authority enrolled non-covered atypical provider entities.

(B) CCOs must make an adjustment to any encounter claim when the CCO discovers the data is incorrect, no longer valid or some element of the claim not identified as part of the original claim needs to be changed;

(C) If the Authority discovers errors or a conflict with a previously adjudicated encounter claim except as specified in paragraph (E) below, the CCO must adjust or void the encounter claim within 14 calendar days of notification by the Authority of the required action or as identified in paragraph (E) below;

(D) If the Authority discovers errors with a previously adjudicated encounter claim resulting from a federal or State mandate or request that requires the completeness and accuracy of the encounter data, the CCO must correct the errors within a time frame specified by the Authority ;

(E) If circumstances prevent the CCO from meeting requested time frames for correction the CCO may contact the Authority to determine an agreed upon specified date except as required in subsection (d) below;

(F) CCOs must ensure claims data received from providers, either directly or through a third party submitter, is accurate, truthful and complete by:

(i) Verifying accuracy and timeliness of reported data;

(ii) Screening data for completeness, logic, and consistency;

(iii) Submitting a complete and accurate Encounter Data Certification and Validation Report available on the Authority's website; and

(H) CCOs must make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.

(d) Encounter Claims Data Corrections for "must correct" Encounter Claims:

(A) The Authority shall notify the CCO of the status of all encounter claims processed;

(B) Notification of all encounter claims processed that are in a "must correct" status shall be provided by the Authority to the CCO each week and for each subsequent week the encounter claim remains in a "must correct" status;

(C) The Authority may not necessarily notify the CCO of other errors however this information is available in the CCO's electronic remittance advice supplied by the Authority;

(D) CCOs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the CCO notice that the encounter claim remains in a "must correct" status.

(E) CCOs may not delete encounter claims with a "must correct" status as specified in section (3)(d) except when the Authority has determined the encounter claim cannot be corrected or for other reasons;

(5) Enrollment of providers included on an encounter claim.

(a) CCOs shall ensure that all providers are enrolled with the Authority prior to submission of the encounter claim as either;

(A) An Oregon Medicaid fee for service provider or

(B) A provider that is not a fee for service provider but does provide services to the CCO's enrolled members, and

(C) CCOs must ensure the provider is not excluded per federal and state standards as set forth in OAR 943-120-0100 through 943-120-0200 and as specified in 42 CFR 455.400 through 455.400.

(6) Electronic Health Records (EHR) Systems OAR 410-165-0000 to 410-165-0140. In support of an eligible provider's ability to demonstrate meaningful use as an EHR user, as described by 42 CFR 495.4 and 42 CFR 495.8, the CCO must:

(a) Submit encounter data in support of a qualified EHR user's meaningful use data report to the Authority for validation as set forth in OAR 410-165-0080;

(b) CCOs must respond within the time frame determined by the Authority to any request for:

(A) Any suspected missing CCO encounter claims, or;

(B) CCO submitted encounter claims found to be unmatched to an EHR user's meaningful use report.

(7) CCOs must comply with the following hysterectomy and sterilization standards as described in 42 CFR 441.250 to 441.259 and the requirements of OAR 410-130-0580:

(a) CCOs shall submit a signed informed consent form to the Authority for each member that received either a hysterectomy or sterilization service within 30 days of the date of service or

(b) Immediately upon notification by the Authority that a qualifying encounter claim has been identified;

(c) The Authority, in collaboration and cooperation, with the CCO shall reconcile all hysterectomy or sterilization services with informed consents with the associated encounter claims by either:

(A) Confirming the validity of the consent and notifying the CCO that no further action is needed;

(B) Requesting a corrected informed consent form, or;

(C) Informing the CCO the informed consent is missing or invalid and the payment must be recouped and the associated encounter claim must be changed to reflect no payment made for services within the time frame set by the Authority.

(8) Upon request by the Authority, CCOs must furnish information regarding rebates for any covered outpatient drug provided by the CCO, as follows:

(a) The Authority is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8), as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), for any covered outpatient drug provided by the CCO, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;

(b) CCOs shall report prescription drug data as specified in section (3)(b).

(9) Encounter Pharmacy Data Rebate Dispute Resolution as governed by SSA Section 1927 42 U.S.C. 1396r-8 and as required by OAR 410-121-0000 through 410-121-0625. When the Authority receives an Invoiced Rebate Dispute from a drug manufacturer, the Authority shall send the Invoiced Rebate Dispute to the CCO for review and resolution within 15 calendar days of receipt.

(a) The CCO shall assist in the dispute process as follows:

(A) By notifying the Authority that the CCO agrees an error has been made, and

(B) By correcting and re-submitting the pharmacy encounter data to the Authority within 45 calendar days of receipt of the Invoiced Rebate Dispute; or

(b) If the CCO disagrees with the Invoiced Rebate Dispute that an error has been made, the CCO shall send the details of the disagreement to the Authority's encounter data liaison within 45 calendar days of receipt of the Invoiced Rebate Dispute.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 39-2012(Temp), f. & cert. ef. 8-9-12 thru 2-5-13; DMAP 52-2012, f. & cert. ef. 11-1-12

410-141-3435
NEMT General Requirements

(1) A Coordinated Care Organization shall provide all NEMT services for its members. The Authority shall provide NEMT services in CCO's service area only to members not enrolled in a CCO.

(2) A CCO shall provide a toll-free call center for members to request rides.

(3) A CCO and its contracted transportation provider may not bill a member for any transport to and from medical services that are covered and where the CCO or its contracted transportation provider denied reimbursement.

(4) CCOs shall require NEMT providers to obtain and maintain insurance at limits no less than is required under OAR 410-136-3060.

(5) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3180 (Record Keeping and Use of Health Information Technology).

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3440
Vehicle Equipment and Driver Standards

(1) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

(2) The CCO shall require all vehicles used for NEMT services to meet the following requirements for the comfort and safety of the members:

(a) The interior of the vehicle shall be clean and free from any debris impeding a member's ability to ride comfortably;

(b) Smoking, aerosolizing or vaporizing of inhalants is prohibited in the vehicle at all times in accordance with ORS 433.835 to 433.990 and OAR 333-015-0025 to 333-015-0090; and

(c) The transportation provider shall comply with appropriate local, state, and federal transportation safety standards regarding passenger safety and comfort. The vehicle shall include, but is not limited to, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) First aid kit;

(C) Fire extinguisher;

(D) Roadside reflective or warning devices;

(E) Flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to transport members using wheelchairs or stretchers, if the member is using a wheelchair or stretcher.

(3) A preventative maintenance schedule shall be followed for each vehicle that incorporates at least all of the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to, the following equipment:

(a) Side and rear view mirrors;

(b) Horn; and

(c) Working turn signals, headlights, taillights, and windshield wipers.

(4) Prior to hiring an NEMT driver, the CCO shall require the following:

(a) The driver must have a valid driver license. The license must be the class of license with any required endorsements that permits the driver to legally operate the vehicle for which they are hired to drive pursuant to ORS chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states; and

(b) The driver must pass a criminal background check in accordance with ORS 181.534, 181.537, and OAR chapter 257, division 10. If the driver is employed by a mass transit district formed under ORS Chapter 267, the driver must pass a criminal background check in accordance with ORS 267.237 as well as the mass transit district's background check policies. A CCO shall have an exception process to the criminal background check requirement that may allow approval of a driver with a criminal background under certain circumstances. The exception process must include review and consideration of when the crime occurred, the nature of the offense, and any other circumstances to ensure that the member is not at risk of harm from the driver. Any approvals made through the exception process must be documented and maintained for three calendar years, even if the CCO is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(5) Drivers authorized to provide NEMT services must receive training on their job duties and responsibilities including:

(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting, and the geographic area in which drivers will provide service;

(b) Completing the National Safety Council Defensive Driving course or equivalent within six months of the date of hire and at least every three years thereafter;

(c) Completing Red Cross-approved First Aid, Cardiopulmonary Resuscitation, and blood spill procedures courses or equivalent within six months of the date of hire and maintain the certification;

(d) Completing the Passenger Service and Safety course or equivalent course within six months of the date of hire and at least every three years thereafter; and

(e) Understanding the CCO's established procedures for responding to a member's needs for emergency care should they arise during the ride.

(6) For authorized out-of-state NEMT services in which the transportation provider solely performs work in the other state and for which the CCO has no oversight authority, the CCO is not responsible for requiring that the subcontractor's vehicle and standards meet the requirements set forth in this rule.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14; DMAP 88-2015, f. 12-29-15, cert. ef. 1-1-16

410-141-3445
Out-of-Service-Area and Out-of-State Transportation

(1) A CCO shall provide NEMT services outside the CCO's service area under the following circumstances:

(a) The member is receiving an OHP-covered health care service that is not available in the service area but is available in another area of the state;

(b) The member is receiving an OHP-covered service where the service location is no more than 75 miles from the Oregon border and contiguous to the CCO's service area;

(c) The CCO determines that no local medical provider or facility as outlined in OAR 410-141-3220 will provide OHP-covered medical services for the member; or,

(d) The member is receiving an OHP-covered service outside of Oregon that is not available in Oregon.

(2) Nothing in this rule prohibits a CCO from providing and paying for NEMT services to allow a client to access other services the CCO authorizes.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3450
Attendants for Child and Special Needs Transports

(1) This rule applies to NEMT for children under 12 years of age who are eligible for NEMT services to and from OHP-covered medical services. The rule also applies to children and young adults with special physical or developmental needs regardless of age.

(2) Parents or guardians must provide an attendant to accompany these members while traveling to and from medical appointments except when:

(a) The driver is a Department of Human Services (Department) volunteer or employee or an Authority employee;

(b) The member requires secured transport pursuant to OAR 410-141-3437 (Secured Transports); or

(c) An ambulance provider transports the member for non-emergent services, and the CCO reimburses the ambulance provider at the ambulance transport rate, per CCO contract or non-contracted rate policy.

(3) NEMT ambulance transports shall have an attendant when the CCO uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) The Department shall establish and administer written guidelines for members in the Department's custody including written guidelines for volunteer drivers. If the Department's requirements or administrative rules differ from this rule, the Department's requirements or administrative rules take precedence.

(5) An attendant may be the member's mother, father, stepmother, stepfather, grandparent, or guardian. The attendant may also be any adult the parent or guardian authorizes. An attendant may also be the member's brother, sister, stepbrother, or stepsister if the attendant is at least 18 years of age, and the parent or guardian authorizes it.

(6) CCOs may require the member's parent or guardian to provide written authorization for an attendant other than the parent or guardian to accompany the member.

(7) The CCO may not bill additional charges for a member's attendant.

(8) The attendant must accompany the member from the pick-up location to the destination and the return trip. The attendant must also remain with the member during their appointment.

(9) The member's parent, guardian, or adult caregiver shall provide and install safety seats as required by ORS 811.210–811.225. An NEMT driver may not transport a member if a parent or guardian fails to provide a safety seat that complies with state law.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3455
Secured Transports

(1) "Secured transport" means NEMT services for the involuntary transport of members who are in danger of harming themselves or others. Secured transports may be used when:

(a) The CCO verified that the secured transporter has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and the secured transporter is able to transport the member who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the member in crisis.

(2) One additional attendant may accompany the member at no additional charge when medically appropriate, such as to administer medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian, or escort is required during transport.

(3) The CCO shall authorize transports to and from OHP covered medical services for an eligible member for court ordered medical services with the following exceptions:

(a) The member is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The member is an inmate of a public institution as defined in OAR 461-135-0950 (Eligibility for Inmates); or

(c) The Authority has suspended the member's OHP eligibility pursuant to ORS 411.443 or 411.439.

(4) The CCO shall assume that a member returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a member to their place of residence, the CCO shall obtain written documentation signed by the treating medical professional stating the circumstances that required secured transport. The CCO shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The CCO may approve and pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing if there is no other source of funding for this transport.

(6) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3460
Ground and Air Ambulance Transports

(1) Transporting a member via ambulance is required when a medical facility or provider states the member's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the CCOs shall authorize the transport.

(3) CCOs shall provide ambulance transports with a medical technician when:

(a) A member's medical condition requires a stretcher;

(b) The length of transport would require a personal care attendant; and

(c) The member does not have an attendant who can assist with personal care during the ride.

(4) When a member's medical condition is an emergency as defined in OAR 410-120-0000, emergency ambulance transportation must be used. The ambulance must transport the member to the nearest appropriate facility able to meet the member's medical needs.

(5) CCOs shall verify that the Authority has licensed providers of ground or air ambulance services to operate ground or air ambulances. If the ambulance service provider is located in a contiguous state and regularly provides rides to OHP members, the CCO must ensure that both the Authority and the contiguous state have licensed the ambulance service provider.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3465
Modifications for Individuals with Disabilities

(1) For the purposes of this rule, "direct threat" means a significant risk to the health or safety of others. A direct threat is one that:

(a) Cannot be eliminated or reduced to an acceptable level through the provision of auxiliary aids and services or through reasonably modifying policies, practices, or processes.

(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence that shows:

(A) The nature, duration, and severity of the risk;

(B) The probability that a potential injury will actually occur; and

(C) Whether reasonable modification of policies, practices, or processes will lower or eliminate the risk.

(2) CCO's may not apply criteria, standards, or practices that screen out or tend to screen out individuals in a protected class from fully and equally enjoying any goods, services, programs, or activities unless:

(a) The criteria can be shown to be necessary for providing those goods and services; or

(b) The CCO determines the screening or exclusion identifies a direct threat to the health and safety of others.

(3) CCOs and their subcontractors shall comply with the Authority's non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.

(4) CCO members may use the processes and rights specified in OAR 410-141-3260 through 3264 (Grievance System and Contested Case Hearings Rules).

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3470
Service Modifications

(1) CCOs shall draft policies and procedures describing passenger rights and responsibilities including the right to file a complaint and request reconsideration and provide this information in all general information materials such as handbooks.

(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles and provide the information to contractors, subcontractors, and members receiving NEMT services.

(3) A CCO may modify or a member may request modification of NEMT services when the member:

(a) Threatens harm to the driver or others in the vehicle.

(b) Has a health condition that creates a health or safety concern to the driver, others in the vehicle, or the member as described in OAR 410-141-3439.

(c) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm.

(d) Engages in behavior that, in the CCO's judgment, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services.

(e) Frequently does not show up for scheduled rides.

(f) Frequently cancels the ride on the day of the scheduled ride time.

(4) Reasonable modifications include, but are not limited to, requiring members to:

(a) Use a specific transportation provider;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive or locate someone to drive the member and receive mileage reimbursement;

(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

(5) Before modifying services, the NEMT provider, a CCO representative, and the member shall:

(a) Communicate about the reason for imposing a modification;

(b) Explore options that are appropriate to the member's needs;

(c) Address health and safety concerns;

(d) The CCO or member may include the member's care team in the discussion;

(e) The member may include another individual of their choosing in the discussion.

(6) Responses to requests for modification or auxiliary aids based on disability or other protected class status under state or federal rule or law must comply with the Americans with Disabilities Act and all other applicable state and federal laws and rules.

(7) A CCO may not modify NEMT services under this rule due solely to a request for modification or auxiliary aid based on disability or other protected class status.

(8) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.

(9) A CCO shall make all reasonable efforts to offer an appropriate alternative to meet a member's needs under the circumstances.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3475
Contested Case Hearings

As required by 42 CFR 431, the CCO shall comply with OAR 410-141-3264 pertaining to contested case hearings when it denies a ride with the following exceptions:

(1) Prior to mailing a notice of action to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.

(2) The CCO shall mail a notice of action to a member denied a ride within 72 hours of denial.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3480
Member Reimbursed Mileage, Meals, and Lodging

(1) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.

(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.

(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. See the Division's fee schedule, available at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(4) The member must return any documentation a CCO requires before receiving reimbursement.

(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.

(6) A CCO shall reimburse members for meals when a member travels:

(a) Out of their local area as outlined in OAR 410-141-3220(4)(a) and (b); and

(b) For a minimum of four hours round-trip.

(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:

(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The member's health care provider documents a medical need.

(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.

(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:

(a) The member is a minor child and unable to travel without an attendant;

(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;

(c) The member is mentally or physically unable to reach his or her medical appointment without assistance; or

(d) The member is or would be unable to return home without assistance after the treatment or service.

(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCOs discretion.

(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:

(a) For mileage, meals, and lodging, and another resource also paid:

(A) The member; or

(B) The ride, meal, or lodging provider directly;

(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;

(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.

(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

410-141-3485
Reports and Documentation

(1) CCOs shall maintain documentation of rides denied and rides provided to members.

(2) For NEMT services provided to members, this documentation shall include:

(a) All encounter data required in the current CCO contract;

(b) Names of the company and driver transporting the member.

(3) For NEMT services denied to members, this documentation shall include:

(a) The name of the member and the individual requesting the ride on behalf of the member, if applicable;

(b) The member's OHP medical care identification number;

(c) The date and time of the request for transportation;

(d) The name of the employee who denied a ride;

(e) The name of the employee who performed the secondary review before denying the ride;

(f) The reason for the denial and the applicable OAR supporting the denial;

(g) The date on the notice of action the brokerage mailed to the member;

(h) Documentation on the review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and

(i) Notations of oral and written communications with the member.

(4) The CCO shall retain the documentation on NEMT service denials for three calendar years, even if the CCO, its brokerage, or subcontractor that denied the service is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(5) The Authority may request and the CCO shall provide other reports or information not specified in sections (1-4) of this rule.

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14

DIVISION 142

HOSPICE SERVICES

410-142-0020
Definitions

(1) Accredited/Accreditation: A designation by an accrediting organization that a hospice program has met standards that have been developed to indicate a quality program.

(2) Ancillary staff: Staff that provides additional services to support or supplement hospice care.

(3) Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

(4) Attending physician: A physician who is a doctor of medicine or osteopathy and is identified by the client, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care.

(5) Bereavement counseling: Counseling services provided to the client's family before and after the client's death. Bereavement counseling is required to be offered per the Conditions of Participation and is a non-reimbursable hospice service.

(6) Bundled Rate: the Nursing Facility (NF) rate as defined in 411-070-0085.

(7) Client-family unit includes a client who has a life threatening disease with a limited prognosis and all others sharing housing, common ancestry or a common personal commitment with the client.

(8) Conditions of Participation (CoPs): The applicable federal regulations that hospice programs are required to comply with in order to participate in the federal Medicare and Medicaid programs.

(9) Coordinated: When used in conjunction with the phrase "hospice program," means the integration of the interdisciplinary services provided by client-family care staff, other providers and volunteers directed toward meeting the hospice needs of the client.

(10) Coordination of Care (COC): The federal regulations for coordination of client care between the hospice and the nursing facility that hospice programs are required to comply with in order to serve hospice clients in a nursing facility and participate in the federal Medicare and Medicaid programs.

(11) Coordinator: A registered nurse designated to coordinate and implement the care plan for each hospice client.

(12) Counseling: A relationship in which a person endeavors to help another understand and cope with problems as a part of the hospice plan of care.

(13) Curative: Medical intervention used to ameliorate the disease.

(14) Dying: The progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.

(15) Family: The relatives and/or other significantly important persons who provide psychological, emotional, and spiritual support of the client. The "family" need not be blood relatives to be an integral part of the hospice care plan.

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

(17) Hospice continuity of care: Services that are organized, coordinated and provided in a way that is responsive at all times to client/family needs, and which are structured to assure that the hospice is accountable for its care and services in all settings according to the hospice plan of care.

(18) Hospice routine home care: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to client/family in the place of residence. The hospice will deliver at least 80 percent of the care in the place of residence.

(19) Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, clients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

(20) Hospice Program: A coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel trained to provide palliative and supportive services to a client-family unit experiencing a life threatening disease with a limited prognosis. A hospice program is an institution for purposes of ORS

(21) Hospice Program registry: A registry of all licensed hospice programs maintained by the Authority, Public Health Division.

(22) Hospice services: Items and services provided to a client/family unit by a hospice program or by other clients or community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include home care, inpatient care for acute pain and symptom management or respite, and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of the client/family unit during the final stages of illness, dying and the bereavement period.

(23) Illness: The condition of being sick, diseased or with injury.

(24) Interdisciplinary team: A group of individuals working together in a coordinated manner to provide hospice care. An interdisciplinary team includes, but is not limited to, the client-family unit, the client's attending physician or clinician and one or more of the following hospice program personnel: Physician, nurse practitioner, nurse, hospice aide (nurse's aide), occupational therapist, physical therapist, trained lay volunteer, clergy or spiritual counselor, and credentialed mental health professional such as psychiatrist, psychologist, psychiatric nurse or social worker.

(25) Medical director: The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's client care program.

(26) Medicare certification: Licensed and certified by the Authority, Public Health Division as a program of services eligible for reimbursement.

(27) Nursing facility: A facility licensed and certified by the Department of Human Services (Department) as a nursing facility and defined in OAR 411-070.

(28) Nursing facility services: The bundled rate of services which incorporates all services, including room and board, for which the nursing facility is paid per OAR 411-070.

(29) Pain and Symptom Management: For the hospice program, the focus of intervention is to maximize the quality of the remaining life through the provision of palliative services that control pain and symptoms. Hospice programs recognize that when a client/family is faced with terminal illness, stress and concerns may arise in many aspects of their lives. Symptom management includes assessing and responding to the physical, emotional, social and spiritual needs of the client/family.

(30) Palliative services: Comfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness. Palliative therapy:

(a) Active: Is treatment to prolong survival, arrest the growth or progression of disease. The person is willing to accept moderate side-effects and psychologically is fighting the disease. This person is not likely to be a client for hospice;

(b) Symptomatic: Is treatment for comfort, symptom control of the disease and improves the quality of life. The person is willing to accept minor side-effects and psychologically wants to live with the disease in comfort. This person would have requested and been admitted to a hospice.

(31) Period of crisis: A period in which the client requires continuous care to achieve palliation or management of acute medical symptoms.

(32) Physician designee: Means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

(33) Primary caregiver: The person designated by the client or representative. This person may be family, a client who has personal significance to the client but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. The primary caregiver assumes responsibility for care of the client as needed. If the client has no designated primary caregiver the hospice may, according to client program policy, make an effort to designate a primary caregiver.

(34) Prognosis: The amount of time set for the prediction of a probable outcome of a disease.

(35) Representative: An individual who has been authorized under state law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill client who is mentally or physically incapacitated.

(36) Terminal illness: An illness or injury which is forecast to result in the death of the client, for which treatment directed toward cure is no longer believed appropriate or effective.

(37) Terminally Ill means that the client has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(38) Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; DMAP 18-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 40-2011, f. 12-15-11, cert. ef. 1-1-12; DMAP 18-2013(Temp), f. 4-11-13, cert. ef. 5-1-13 thru 10-28-13; DMAP 30-2013, f. & cert. ef. 6-27-13

410-142-0040
Eligibility for the Hospice Services

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

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

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

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

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 40-2011, f. 12-15-11, cert. ef. 1-1-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14

410-142-0060
Certification of Terminal Illness

(1) In order to receive reimbursement from the Division of Medical Assistance Programs (Division), the hospice must obtain and retain a physician's written certification of a client's terminal illness in accordance with the following procedures. Division will not pay for services provided prior to certification.

(2) The attending physician is a doctor of medicine or osteopathy or a nurse practitioner and is identified by the client at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care. A nurse practitioner serving as the attending physician may not certify or re-certify the terminal illness.

(3) Certifications may be completed up to two weeks before hospice care is elected.

(4) The certification of a client who elects hospice is based on the physician's or medical director's clinical judgment regarding the normal course of the client's illness and must include:

(a) The statement that the client's medical prognosis indicates a life expectancy of six months or less if the terminal illness runs its normal course; and

(b) Clinical information and other documentation which support the medical prognosis must accompany the certification and be filed in the medical record with the certification.

(5) A written certification signed by the physician(s) must be on file in the hospice client's record prior to submission of a claim to Division for all benefit periods.

(6) For the initial period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the client's attending physician (if the client has an attending physician). If the written certification is not dated, a notarized statement or some other acceptable documentation may be obtained to verify the actual certification date.

(7) For any subsequent periods, the hospice must obtain, no later than two calendar days after the first date of each period, a written certification from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days.

(8) The requirements specified in this rule also apply to clients who had been previously discharged during a benefit period and are again being certified for hospice care.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 58-2002, f. & cert. ef. 10-1-02; OMAP 34-2006, f. 9-15-06

410-142-0080
Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form has been obtained for every individual, either from the individual or representative as defined in OAR 410-142-0020. The form must specify the type of care and services that may be provided as hospice care during the course of the illness.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-142-0100
Election of Hospice Care

(1) An individual who meets the eligibility requirements of OAR 410-142-0040 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative may file the election statement.

(2) The election statement must include the following:

(a) Identification of the particular hospice that will provide care to the individual;

(b) The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;

(c) Except for children (see 410-124-0110), acknowledgment that certain otherwise covered services are waived by the election. Election of a hospice benefit means that the Division of Medical Assistance Programs (Division) will only reimburse the hospice for those services included in the hospice benefit;

(d) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement;

(e) The signature of the individual or representative.

(3) Re-election of hospice benefits. If an election has been revoked in accordance with OAR 410-142-0160, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

(4) File the election statement in the medical record.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0110
Concurrent Care for Children

(1) Under Section 2302 of the Affordable Care Act, Medicaid or Children's Health Insurance Program (CHIP) eligible children are eligible to receive curative treatment upon the election of the hospice benefit.

(2) The criteria for receiving hospice services does not change for children eligible for Medicaid and CHIP programs. However these children may now receive hospice services without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition.

(3) All other eligibility, coverage, and hospice rules for the Division of Medical Assistance Programs apply.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0120
Duration of Hospice Care

(1) An eligible individual may elect to receive hospice care during one or more of the following election periods:

(a) An initial 90-day period;

(b) A subsequent 90-day period;

(c) An unlimited number of subsequent 60-day periods.

(2) An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(a) Remains in the care of a hospice; and

(b) Does not revoke the election under the provisions of OAR 410-142-0160.

(3) For the duration of an election of hospice care, an individual waives all rights to the Division of Medical Assistance Programs (Division) payments for the following services:

(a) Hospice care provided by a hospice other than the hospice designated by the individual, unless provided under arrangements made by the designated hospice;

(b) Any covered services related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services equivalent to hospice care.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98

410-142-0140
Changing the Designated Hospice

(1) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

(2) The change of the designated hospice is not a revocation of the election for the period in which it is made.

(3) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following:

(a) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care;

(b) The date the change is to be effective.

(4) The statement shall be kept on file in the medical record.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95

410-142-0160
Revoking the Election of Hospice Care

(1) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(2) Revocation Procedure: To revoke the election of hospice care, the individual or representative must file with the Hospice a statement to be placed in the medical record that includes the following information:

(a) A signed statement that the individual or representative revokes the individual's election for coverage of hospice care for the remainder of that election period;

(b) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made.)

(3) An individual, upon revocation of the election of coverage of hospice care for a particular election period:

(a) Is no longer covered for hospice care;

(b) Resumes eligibility for all covered services as before the election to hospice; and

(c) May at any time elect to receive hospice coverage for any other hospice election periods he or she is eligible to receive, in accordance with OAR 410-142-0120.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00

410-142-0180
Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan:

(1) Establishment of Plan. The plan is established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(2) Content of Plan. The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(3) Review of Plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0200
Interdisciplinary Group

The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice:

(1) Composition of group. The hospice must have an interdisciplinary group or groups composed of or including at least the following individuals who are employees of the hospice, or, in the case of a doctor, be under contract with the hospice:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A social worker;

(d) A pastoral or other counselor.

(2) Role of interdisciplinary group. Members of the group interact on a regular basis and have a working knowledge of the assessment and care of the patient/family unit by each member of the group. The interdisciplinary group is responsible for:

(a) Participation in the establishment of the plan of care;

(b) Provision or supervision of hospice care and services;

(c) Periodic review and updating of the plan of care for each individual receiving hospice care; and

(d) Establishment of policies governing the day-to-day provision of hospice care and services.

(3) If a hospice has more than one interdisciplinary group, it must document in advance the group it chooses to execute the functions described in section (2) of this rule;

(4) Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0220
Requirements for Coverage

To be covered, hospice services must meet the following requirements:

(1) They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

(2) The individual must elect hospice care in accordance with OAR 410-142-0100 and a plan of care must be established as set forth in 410-142-0180 before services are provided.

(3) The services must be consistent with the plan of care.

(4) A certification that the individual is terminally ill must be completed as set forth in OAR 410-142-0060.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0225
Signature Requirements

(1) The Division of Medical Assistance Programs (Division) requires practitioners to sign for services they order. This signature shall be handwritten or electronic, (or facsimiles of original written or electronic signatures for terminal illness for hospice) and it must be in the client's medical record.

(2) The ordering practitioner is responsible for the authenticity of the signature.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0240
Hospice Core Services

The following services are covered hospice services when consistent with the plan of care and must be provided in accordance with recognized standards of practice:

(1) Nursing services. The hospice must provide nursing care and services by or under the supervision of a registered nurse:

(a) Nursing services must be directed and staffed to assure that the nursing needs of the patient are met;

(b) Patient care responsibilities of nursing personnel must be specified;

(c) Services must be provided in accordance with recognized standards of practice.

(2) Medical social services. Medical social services must be provided by a qualified social worker, under the direction of a physician;

(3) Physician services. In addition to palliative and management of terminal illness and related conditions, physician employees, contractors or volunteers of the hospice, including the physician member(s), of the interdisciplinary group, must also meet the general medical needs of the patient to the extent these needs are not met by the attending physician:

(a) Reimbursement for physician or nurse practitioner supervisory and interdisciplinary group services for those physicians or nurse practitioners employed by the hospice agency is included in the rate paid to the agency;

(b) Reimbursement of attending physician or nurse practitioner services for those physicians not employed by the hospice agency is according to the Division of Medical Assistance Programs (Division) fee schedule. These physicians or nurse practitioners must bill the Division for their services;

(c) Reimbursement of attending physician or nurse practitioner services (not including supervisory and interdisciplinary group services) for those physicians or nurse practitioners employed by the hospice agency is according to the Division fee schedule. These physicians or nurse practitioners must bill the Division for their services;

(d) Reimbursement of the hospice for consulting physician services furnished by hospice employees or by other physicians under arrangements by the hospice is included in the rate paid to the agency.

(4) Counseling services. Counseling services must be available to both the patient and the family. Counseling includes bereavement counseling provided after the patient's death as well as dietary, spiritual and any other counseling services for the patient and family provided while the individual is enrolled in the hospice;

(5) Short-term inpatient care. Inpatient care must be available for pain control, symptom management and respite purposes;

(6) Medical appliances and supplies:

(a) Includes drugs and biologicals as needed for the palliation and management of the terminal illness and related conditions;

(b) Drugs prescribed for conditions other than for the palliation and management of the terminal illness are not covered under the hospice program.

(7) Hospice aide and homemaker services;

(8) Physical therapy, occupational therapy, and speech-language pathology services;

(9) Other services. Other services specified in the plan of care that are covered by the Oregon Health Plan (OHP).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0260
Hospice Level of Care

(1) Each day of hospice care is classified into one of five levels of care. The level of care determines the payment for each day of hospice benefit:

(a) Routine Home Care. A routine home care day is a day on which a patient who has elected to receive hospice care is in a place of residence and is not receiving continuous home care;

(b) Continuous Home Care. A continuous home care day is a day on which a patient who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aid or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as necessary to maintain the terminally ill individual at home. Nursing care must be provided by a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care must be provided during a 24-hour day, which begins and ends at midnight. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care;

(c) In-Home Respite Care. An in-home respite care day is a day on which short-term in-home care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the patient's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Home health aide/CNA or homemaker services or both may be utilized for providing in-home respite care;

(d) Inpatient Respite Care. An inpatient respite care day is a day on which short-term inpatient care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth, and any subsequent days, is to be made at the routine home care rate. Respite care may not be provided when the hospice patient is a nursing home resident;

(e) General Inpatient Care. A general inpatient care day is a day on which a hospice patient receives care in an inpatient facility for pain control, acute or chronic symptom management, or other procedures which cannot be managed or provided in any other setting.

(2) Inpatient care must be provided by a facility that has an agreement with the hospice:

(a) A hospice capable of providing inpatient care;

(b) A hospital; or

(c) A nursing facility.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 58-2002, f. & cert. ef. 10-1-02

410-142-0280
Recipient Benefits

An individual who has elected to receive hospice care remains entitled to receive other services not included in the hospice benefit. These services are subject to the same rules as for non-hospice clients. Typical services used that are not covered by the hospice benefit include:

(1) Attending physician care (e.g. office visits, hospital visits, etc.);

(2) Medical transportation;

(3) Any services, drugs or supplies for a condition other than the recipient's terminal illness or a related condition (e.g. broken leg, pre-existing diabetes).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0290
Hospice Services in a Nursing Facility

(1) Pursuant to Title XIX, Section 1902 and 1905, federal statute prohibits the state from paying nursing facility (NF) providers directly for NF services when their Medicaid residents elect hospice care. In these instances, the Centers for Medicare and Medicaid Services (CMS) require the state to pay the hospice provider the additional amount equal to at least 95% of the per diem rate the state would have paid to the NF for NF services for that client in that facility.

(2) When a client resides in a NF and elects hospice care, the hospice provider and the NF must have a written contract which addresses the provision of hospice care and the method upon which the hospice will pay the NF. The hospice and the NF must maintain

a copy of the completed and signed contract on file and it must be available upon request.

(3) Reimbursement when a client resides in a NF and elects hospice care:

(a) In accordance with CMS 4308.2, "when hospice care is furnished to an individual residing in a NF, the state will pay hospice an additional amount on routine home care or continuous home care days to take into account the room and board furnished by the NF. In this context, the term 'room and board' includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a residents' room, and supervision and assisting in the use of durable medical equipment and prescribed therapies," as well as any other services considered under the bundled rate for which the NF is paid pursuant to OAR 411-070.

(b) The hospice shall bill the Division of Medical Assistance Programs (Division) directly for the hospice care provided (under routine home care, Revenue code 651, or continuous home care, Revenue code 652) and for the cost of NF services at their usual and customary rate for NF services delivered in that NF for that client;

(c) The Division shall pay the hospice provider for the hospice care provided and not to exceed 100% of the current NF basic, complex medical, pediatric, or special contract rate according to the rate schedule for NF services delivered in that NF for that client;

(d) The hospice provider must reimburse the nursing facility according to their contract and after the hospice receives payment from the Division for that NF for that client; and

(e) Reimbursement for services provided under this rule is available only if the recipient of the services is Medicaid-eligible, hospice-eligible, and been found to need NF care through the Pre-Admission Screening process under OAR 411-070-0040.

(4) NF Services Overpayment: Any payment received from the Division by a NF for services delivered after a client has elected hospice care shall adjust their claims from the day the client first elected hospice care. Failure to submit an adjustment subjects the NF to potential sanctions and all means of overpayment recovery authorized under OAR chapter 410, division 120.

(5) Coordination of Care (COC) must be provided according to CMS Conditions of Participation (CoPs), 42CFR418.112 for hospice and nursing facilities.

(6) Coordinated Care Organization (CCO) and Prepaid Health Plan (PHP) clients who reside in a NF and elect hospice care shall remain in the CCO and PHP for all care other than hospice services in the NF. Hospice services for a resident in a NF shall be excluded from CCO and PHP capitation and the hospice must bill the Division directly for payment of hospice and NF services.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: DMAP 34-2012, f. & cert. ef. 7-20-12; DMAP 18-2013(Temp), f. 4-11-13, cert. ef. 5-1-13 thru 10-28-13; DMAP 30-2013, f. & cert. ef. 6-27-13

410-142-0300
Hospice Reimbursement and Limitations

(1) The Division of Medical Assistance Programs (Division) recalculates its hospice rates annually. When billing for hospice services, the provider must bill the usual charge or the rate based upon the geographic location in which the care is furnished, whichever is lower. See hospice rates on the Oregon Health Authority (Authority) website at: http://www.oregon.gov/OHA/healthplan/pages/hospice.aspx.

(2) Rates:

(a) The Division bases its rates on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts;

(b) Under the Medicaid hospice benefit regulations, the Division cannot impose cost sharing for hospice services rendered to Medicaid recipients;

(c) The Division sets rates no lower than the rates used under Part A of Title XVIII of the Social Security Act (Medicare);

(d) The Division uses prospective hospice rates;

(e) The Division makes no retroactive adjustments other than the optional application of the cap on overall payments and the limitation on payments for inpatient care, if applicable.

(3) With the exception of payment for physician services, the Division reimburses providers of hospice services for each day of care at one of five predetermined rates. Rates are based on intensity and type of care, which the Division defines as:

(a) Routine home care. The Division pays the hospice the routine home care rate for each day that the client is under the care of the hospice and that the Division does not reimburse at another rate. The Division pays this rate without regard to the volume or intensity of services provided on any given day;

(b) Continuous home care. The Hospice must provide a minimum of eight hours of continuous home care per day to receive the continuous home care rate:

(A) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate;

(B) The Division pays the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

(c) Inpatient respite care. The Division pays the hospice at the Inpatient Respite Care rate for each day on which the client is in an approved inpatient facility and is receiving respite care:

(A) The Division pays for inpatient respite care for a maximum of five days at a time, including the date of admission but not counting the date of discharge;

(B) The Division pays for the sixth and any subsequent days at the routine home care rate.

(d) General inpatient care. The Division pays providers at the general inpatient rate when general inpatient care is provided;

(e) In-home respite care. An in-home respite care day is a day on which short-term in-home care is provided to the client only when necessary to relieve the family members or other persons caring for the client at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the client's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Hospice aide/CNA or homemaker services or both may be utilized for providing in-home respite care.

(4) On the day of discharge from an inpatient unit, the Division pays the appropriate home care rate unless the client dies as an inpatient. When the client is discharged deceased, the Division pays the appropriate inpatient rate (general or respite) for the discharge date.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 47-1998, f. & cert. ef. 12-1-98; OMAP 40-1999, f. & cert. ef. 10-1-99; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 55-2001(Temp) f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02; OMAP 65-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 41-2002(Temp), f. & cert. ef. 10-1-02 thru 3-15-03; OMAP 15-2003, f. & cert. ef. 2-28-03; OMAP 80-2003(Temp), f. & cert. ef. 10-10-03 thru 3-15-04; OMAP 86-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 66-2004, f. 9-13-04, cert. ef. 10-1-04; OMAP 79-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; OMAP 90-2004, f. 11-24-04 cert. ef. 12-16-04; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 34-2006, f. 9-15-06; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11

410-142-0380
Death With Dignity

(1) Death with dignity services are defined in the Division of Medical Assistance Programs (Division) Medical-Surgical Services and Pharmaceutical Services program rules.

(2) All death with dignity services must be billed directly to Division, even if the client is in a prepaid health plan (PHP).

(3) Death with dignity services are not included in the hospice care per diem payment.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

Hist.: OMAP 40-1999, f. & cert. ef. 10-1-99; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

DIVISION 145

COOPERATIVE TRANSPLANT PROGRAM APPROVAL AND MONITORING

410-145-0000
Definitions

As used in this division unless the context requires otherwise:

(1) "Board of governors" means the governors of a cooperative program as described in OAR 410-145-0020.

(2) "Cooperative program" means a program among two or more health care providers for the purpose of providing heart and kidney transplant services including, but not limited to, the sharing, allocation and referral of physicians, patients, personnel, instructional programs, support services, facilities, medical diagnostic, laboratory or therapeutic services, equipment, devices or supplies, and other services traditionally offered by health care providers.

(3) "Director" means the Director of the Department of Human Services.

(4) "Health care provider" means a hospital, physician or entity, a significant part of whose activities consist of providing hospital or physician services in this state. For purposes of the immunities provided under ORS 442.700 to 442.760 and 646.740, "health care provider" includes any officer, director, trustee, employee, or agent of, or any entity under common ownership and control with, a health care provider.

(5) "Hospital" means a health care facility defined in ORS 442.015(14)(a) to (d) and licensed under 441.015–441.097 and includes community health programs established under 430.610–430.700. In other words, as used in this division the term "hospital" includes health care facilities licensed as hospitals, special inpatient care facilities, skilled and intermediate long-term care facilities, and ambulatory surgical centers. It also includes community mental health and developmental disabilities programs established under ORS 430.610 to 430.700. It does not include establishments furnishing primarily domiciliary care.

(6) "Order" means a decision issued by the director under OAR 410-145-0010 either approving or denying an application for a cooperative program and includes modification of an original order under 410-145-0040(3)(b) and orders under 410-145-0060(1) and (4).

(7) "Party to a cooperative agreement" or "party" means an entity that enters into the principal agreement to establish a cooperative program and applies for approval under this division and any other entity that, with the approval of the director, becomes a member of the cooperative program.

(8) "Physician" means a physician defined in ORS 677.010(12) and licensed under ORS Chapter 677.

(9) "Urban area" means a Metropolitan Statistical Area as defined by the federal Bureau of the Census.

Stat. Auth.: ORS 413.042, 442.700 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0010
Application Procedures

(1) The Oregon Health Sciences University and one or more entities, each of which operates at least three hospitals in a single urban area in this state, may apply to the director for approval of a cooperative program.

(2) The application must include all of the following information, in the order specified:

(a) The names and addresses of each of the entities to be involved in the cooperative program, with a narrative describing how each entity meets the eligibility requirements set out in section (1) of this rule;

(b) A list of the names of all health care providers who propose to provide heart and kidney transplant services under the cooperative program, together with appropriate evidence of compliance with any licensing or certification requirements for those health care providers to practice in this state. The services to be provided by each provider and the location where these services are to be provided should be identified. In the case of employed physicians, the list and the information to be submitted may be limited to the employer or organizational unit of the employer;

(c) A description of the activities to be conducted by the cooperative program;

(d) A description of proposed anticompetitive practices listed in paragraphs (A) through (E) of this subsection, any practices that the parties anticipate will have significant anticompetitive effects and a description of practices of the cooperative program affecting costs, prices, personnel positions, capital expenditures and allocation of resources. As provided in ORS 442.715(1), practices which may be authorized by an order issued under this rule include:

(A) Setting prices for heart and kidney transplants and all services directly related to heart and kidney transplants;

(B) Refusing to deal with competitors in the heart and kidney transplant market;

(C) Allocating product, service, geographic and patient markets directly relating to heart and kidney transplants;

(D) Acquiring and maintaining a monopoly in heart and kidney transplant services; and

(E) Engaging in other activities that might give rise to liability under ORS 646.705–646.836 or federal antitrust laws.

(e) A list of the goals identified in paragraphs (A) through (H) of this subsection that the cooperative agreement expects to achieve, together with an explanation, including documentation as necessary, of the way in which such goals will be achieved and the anticipated time schedule for meeting these goals. The phrase "Reduction of, or protection against," as used in paragraphs (A), (B) and (D) of this subsection, means that the applicants have two options for demonstrating accomplishment of these goals. The application may compare the projected results for the cooperative program to the existing situation, in which case a reduction in price, cost and duplication of resources compared to present conditions must be demonstrated. Alternatively, the application may compare the projected results for the cooperative program to the situation that would have existed if there were separate, competing transplant programs. In this latter case, the application must demonstrate that the proposed cooperative program will result in protection against the rising costs, rising prices and duplication of resources that might result if there were competing programs. As provided in ORS 442.705(2), goals which might be achieved through cooperative transplant programs include:

(A) Reduction of, or protection against, rising costs of heart and kidney transplant services;

(B) Reduction of, or protection against, rising prices for heart and kidney transplant services;

(C) Improvement or maintenance of the quality of heart and kidney transplant services provided in this state;

(D) Reduction of, or protection against, duplication of resources including, without limitation, expensive medical specialists, medical equipment and sites of service;

(E) Improvement or maintenance of efficiency in the delivery of heart and kidney transplant services;

(F) Improvement or maintenance of public access to heart and kidney transplant services;

(G) Increase in donations of organs for transplantation; and

(H) Improvement in the continuity of patient care.

(f) A description of the proposed places and manner of providing heart and kidney transplant services and services related to heart and kidney transplants under the cooperative program. This description should include a discussion of whether service sites have or will receive membership in the United Network for Organ Sharing (UNOS). If the cooperative program will not initially include both heart and kidney transplant services, the application shall identify which services will not initially be included, and will describe what will be done by the parties to work towards inclusion of such services in the future. The application must describe the ongoing efforts being made and any planned efforts for including

both heart and kidney transplant services in the cooperative program;

(g) Projections of the number of heart transplants and the number of kidney transplants which the cooperative program expects to perform in each of its first three years of operation. These projections should be accompanied by a discussion of the methodology by which they were derived. A description of the expected service area(s) for the cooperative program's services should also be included;

(h) If the application claims that the program will achieve the goal in paragraph (e)(G) of this section, or if the application projects an increase in the total number of heart or kidney transplants in the state, the application should discuss how donor organ availability would change as a result of the cooperative program's operations, and explain the reasons why such changes are anticipated;

(i) If the applicants intend to demonstrate that the cooperative program will result in a reduction of costs, prices and duplication of resources compared to present conditions, the application must include a budget for the most recently completed fiscal year for each existing heart and kidney transplant program, as well as a proposed budget for operating the cooperative program for its first three years. The budget for the cooperative program must account for all applicable services listed in OAR 410-145-0000(2). Both the budgets for existing programs and the projected budget for the proposed cooperative program must include the following information:

(A) Gross revenues;

(B) Direct expenses, including a breakdown into salaries, payroll taxes and fringe benefits, any compensation to physicians to be paid by the program, supplies, bad debts, depreciation and interest, and other direct expenses;

(C) Indirect expenses, identified by categories which should include operation and maintenance of plant, housekeeping, billing, insurance, another indirect expenses;

(D) Deductions from revenue by component, including charity care;

(E) Net operating income (or loss) after the allocation of indirect expenses from non-revenue producing departments;

(F) Anticipated gross and net operating revenue per case for heart transplants and for kidney transplants;

(G) If either existing programs or the proposed cooperative programs charge or anticipate charging any flat fees for any transplant services, the amount of such fees (projected for the first three years of operation, in the case of the cooperative program);

(H) For the cooperative program only, any proposed capital expenditures; and

(I) Projected cost savings or cost increases to the health care system of the proposed cooperative program, compared to the costs of existing transplant services.

(j) If the applicants intend to demonstrate that the cooperative program will result in protection against rising costs, rising prices and duplication of resources compared to the situation that would have existed if there were separate, competing transplant programs, the application must include a proposed budget for operating the cooperative program for its first three years. This budget must account for all applicable services listed in OAR 410-145-0000(2) which will be delivered at a new transplant program site, and for all new services which will be delivered through the cooperative program at an existing site. The budget must also separately account for any existing services that will be included in or provide support to the cooperative program, but the application may provide a lesser level of detail for the budget information on existing services. The applicant must also provide a projected three year budget for new transplant service sites and associated support services, showing what would occur if the services proposed to be delivered by the cooperative program were to be delivered through separate, competing programs. Both the cooperative program budget and the hypothetical budget for a competing program must include the following information:

(A) Gross revenues;

(B) Direct expenses (for services provided through a new transplant program site or for new services at an existing site, include a breakdown into salaries, payroll taxes and fringe benefits, any compensation to physicians to be paid by the program, supplies, bad debts, depreciation and interest, and other direct expenses);

(C) Indirect expenses (for services provided through a new transplant program site or for new services at an existing site, identified by categories which should include operation and maintenance of plant, housekeeping, billing, insurance, and other indirect expenses);

(D) Deductions from revenue (for services provided through a new transplant program site or for new services at an existing site, deductions should be broken out by component, including charity care);

(E) Net operating income (or loss) after the allocation of indirect expenses from non-revenue producing departments;

(F) Anticipated gross and net operating revenue per case for heart transplants and for kidney transplants;

(G) If it is anticipated that either the cooperative or competitive program would charge any flat fees for any transplant services, a projection of such fees for the first three years of operation;

(H) For services provided through a new transplant site or for new services at an existing site, any proposed capital expenditures; and

(I) Projected cost savings or cost increases to the health care system of cooperative vs. competitive programs for transplant services.

(k) Satisfactory evidence of financial ability to deliver heart and kidney transplant services in accordance with the cooperative program. Such evidence shall include:

(A) Financial statements for each party to the application for each of the three previous years;

(B) The anticipated sources or reimbursement for heart transplants and sources of reimbursement for kidney transplants during the first three years of cooperative program operations. The application should discuss whether the cooperative program anticipates receiving Medicare certification for any proposed new heart and kidney transplant sites and, if so, when such certification is expected. The application should also discuss any existing or anticipated contractual agreements with third party payers regarding cooperative program services, and any anticipated modifications of existing contractual agreements concerning cooperative program services between parties to the cooperative agreement and third party payers.

(l) The agreement that establishes the cooperative program and policies that shall govern it.

(3) A joint application must be submitted on behalf of all parties to the proposed cooperative agreement. Four copies of the application shall be submitted to the Office of the Director, Oregon Health Authority, Human Services Building, Salem, Oregon 97310. The application must be accompanied by an application fee of $30,000. Checks should be made payable to the Oregon Health Authority.

(4) An application shall be considered filed as of the date that a complete application is received by the director. A complete application must meet all the requirements of sections (2) and (3) of this rule. Within 14 days of the receipt of an application, the director shall determine whether the application is complete, and notify the applicants if the application is complete or incomplete. If the application is incomplete, this notification shall include a detailed description of the additional information that is needed. The applicants may provide the additional information requested to make the application complete, or the applicants may elect to proceed with the review process without providing this information. The applicants should notify the director of their choice in this matter in writing within seven days of the director's finding in regard to completeness. If the applicants elect to submit additional information, the notification to the director should include an acknowledgment by the applicants that the application as originally submitted was incomplete. If such notification and acknowledgment is not received by the director within seven days, it will be assumed that the applicants do no intend to submit additional information

and wish to proceed immediately with the review. If the applicants elect to provide the additional information requested, a complete application shall not be considered to have been submitted until such information is received by the director. If the applicants elect not to provide such information, a complete application will be considered to have been submitted as of the date that the initial application was received by the director. In such an instance, however, the director may make negative findings concerning any areas that were found to be incomplete.

(5) The director shall review the application in accordance with the provisions of this rule and shall grant, deny or request modification of the application within 90 days of the date the application is filed. The director shall hold one or more public hearings on the application, which shall conclude no later than 80 days after the date the application is filed. Hearings shall be held in the applicants' urban area. At least 14 days notice of any hearing will be provided. Notice of hearings shall be provided to the applicants; to all other hospitals located in the applicant's urban area(s); to all wire services, daily newspapers and TV stations serving the state; and to any other persons who have requested notice of such hearings or who the director believes may have any interest in such hearings. The decision of the director shall be considered an order in a contested case for the purposes of ORS 183.310 to 183.550.

(6) The director shall approve an application made under this rule after:

(a) The applicants have demonstrated they will achieve at least six of the goals of subsection (2)(e) of this rule, including at least the goals listed in paragraphs (2)(e)(A) to (2)(e)(D); and

(b) The director has reviewed and approved the specifics of the anticompetitive activity expected to be conducted by the cooperative program.

(7) In evaluating the application, the director shall consider whether a cooperative program will contribute to or detract from achieving the goals listed under subsection (2)(e) of this rule. The director may weigh goals relating to circumstances that are likely to occur without the cooperative program, and relating to existing circumstances. The director may also consider whether any alternative arrangements would be less restrictive of completion while achieving the same goals.

(8) An order approving a cooperative program shall identify and define the limits of the permitted activities for the purposes of granting antitrust immunity under ORS 442.700 to 442.760.

(9) An order approving a cooperative program shall include:

(a) Approval of specific activities listed in subsection (2)(d) of this rule;

(b) Approval of activities the director anticipates will have substantial anticompetitive effects;

(c) Approval of the proposed budget of the cooperative program;

(d) The goals listed in subsection (2)(e) of this rule that the cooperative program is expected to achieve; and

(e) Approval of the cooperative program as described in the application and a finding that the cooperative program is in the public interest.

(10) An order denying the application for a cooperative program shall identify the findings of fact and reasons supporting denial.

(11) Either the director or all parties to the cooperative program may request an modification of an application made under this section. A request for a modification shall result in one extension of 30 days after submission of the modified application. The director shall issue an order under this section within 30 days after receipt of the modified application.

Stat. Auth.: ORS 413.042, 442.705, 442.710, 441.715 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0020
Board of Governors

(1) If the director issues an order approving an application for a cooperative program under OAR 410-145-0010, the director shall establish a board of governors to govern the cooperative program. The board of governors shall not constitute, for any purpose, a governmental agency.

(2) The board of governors shall consist of the president or other chief executive officer of each health care provider that is a party to the cooperative program agreement and the director or a designee of the director. The designee shall serve at the pleasure of the director. The designee shall not have any economic or other interest in any of the health care providers associated with the cooperative program.

(3) In governing the cooperative program, the board of governors shall develop policy and approve budgets for the implementation of the cooperative program.

(4) The director or designee of the director may reject any operating or capital budget of the cooperative program upon a finding by the director that the budget is not consistent with the goals listed in OAR 410-145-0010(2)(E) that the cooperative program is expected to achieve.

Stat. Auth.: ORS 413.042, 442.720 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0030
Annual Report

Not later than 60 days following each anniversary date of the director's approval of a cooperative program, the board of governors of the cooperative program shall deliver four copies of an annual report to the director, accompanied by a review fee of $16,000. The report shall specifically describe:

(1) How heart and kidney transplant services and related services of the cooperative program are being provided in accordance with the order;

(2) Which of the goals identified in the order are being achieved and to what extent; and

(3) Any substantial changes in the cooperative program.

(4) If the cooperative program does not include both heart and kidney transplant services, the annual report will describe any efforts that have been made by the parties over the previous year to provide for inclusion of both heart and kidney transplants in the cooperative program, and will describe what the parties will do to work towards inclusion of such services in the future. The annual report must describe the ongoing efforts being made and any planned efforts for including both heart and kidney transplant services in the cooperative program.

Stat. Auth.: ORS 413.042, 442.725 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0040
Review and Evaluation of Annual Report

(1) The director shall review and evaluate the annual report delivered under OAR 410-145-0030. The director shall:

(a) Determine the extent to which the cooperative program is achieving the goals identified in the order;

(b) Review the activities being conducted to achieve the goals; and

(c) Determine whether each of the activities is still necessary and appropriate to achieve the goals.

(2) If the director determines that additional information is needed for the review described in section (1) of this rule, the director may order the board of governors to provide the information within a specified time. Such an order shall be issued no later than 14 days after receipt of the cooperative program's annual report.

(3) Within 60 days after receiving the annual report or any additional information ordered under section (2) of this rule, the director shall:

(a) Approve the report if the director determines that the cooperative program is operating in accordance with the order and that the goals identified in the order are being adequately achieved by the cooperative program;

(b) Modify the order as appropriate to adjust to changes in the cooperative program approved by the director and approve the report as provided in subsection (a) of this section;

(c) Order the board of governors to make remedial changes in anticompetitive activities not in compliance with the order and request the board of governors to report on progress not later than a deadline specified by the director;

(d) Revoke approval of the cooperative program; or

(e) Take any of the action set forth in OAR 410-145-0060.

Stat. Auth.: ORS 413.042, 442.730 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0050
Complaint Procedure

(1) Any person may file a complaint with the director requesting that a specific decision or action of a cooperative program supervised by the director be reversed or modified, or that approval for all or part of the activities permitted by the order be suspended or terminated. The complaint shall allege the reasons for the requested action and shall include any evidence relating to the complaint.

(2) The director on the director's own initiative may at any time request information from the board to governors concerning the activities of the cooperative program to determine whether the cooperative program is in compliance with the order.

Stat. Auth.: ORS 413.042, 442.735 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0060
Action on Complaints

(1) During the review of the annual report described in OAR 410-145-0040, after receiving a complaint under 410-145-0050, or on the director's own in initiative, the director may take one or more of the following actions:

(a) If the director determines that a particular decision or action is not in accordance with the order, or that the parties are engaging in anticompetitive activity not permitted by the order, the director may direct the board of governors to identify and implement corrective action to insure compliance with the order or may modify the order.

(b) If the director determines that the coopera-tive program is engaging in unlawful activity not permitted by the order or is not complying with the directive given under subsection (a) of this section, the director may serve on the cooperative program a proposed order directing the cooperative program to:

(A) Conform with the directive under sub-section (a) of this section; or

(B) Cease and desist from engaging in the activity.

(2) The cooperative program shall have up to 30 days to comply with a proposed order under subsection (1)(b) of this rule, counted from the order's date of issuance, unless the board of governors demonstrates to the director's satisfaction that additional time is need for compliance.

(3) If the director determines that the participants in the cooperative program are in substantial noncompliance with the cease and desist directive, the director may seek an appropriate injunction in the circuit courts of Marion or Multnomah Counties.

(4) If the director determines that a sufficient number of goals set forth in OAR 410-145-0010(2)(e) are not being achieved or that the cooperative program is engaging in activity not permitted by the order, the director may suspend or terminate approval for all or part of the activities approved and permitted by the order.

(5) A proposed order to be entered under subsection (1)(b) or section (4) of this rule may be served upon the cooperative program without prior notice. The cooperative program may contest the proposed order by filing a written request for a contested case hearing with the director not later than 20 days following the date of the proposed order. The proposed order shall become final if no request for a hearing is received. Unless inconsis-tent with this section, the provisions of ORS 183.310–183.550, as applicable, shall govern the hearing procedure and any judicial review.

(6) The only effect of an order suspending or terminating approval under ORS 442.700–442.760 shall be to withdraw the immunities granted under 442.715(3) for anticompetitive activity permitted by the order and taken after the effective date of the order.

Stat. Auth.: ORS 442.740 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0070
Confidentiality of Information

(1) If parties to a cooperative program agreement provide the director with written or oral information that is confidential or otherwise protected from disclosure under Oregon law, the disclosures shall not be considered a waiver of any right to protect the information from disclosure in other proceedings.

(2) The parties to a cooperative agreement shall specifically identify to the director any information that meets the requirements of section (1) of this rule, and the director shall considered only information that has been so identified by the parties to be confidential. The director will make the decision as to whether such information is in fact protected from disclosure under Oregon law. The director shall inform the party who submitted the information of any decisions regarding its confidentiality. Information which has been found to be subject to disclosure under Oregon law may be released by the director to any requesting persons subject to the provisions of ORS 192.410–192.505.

Stat. Auth.: ORS 413.042, 442.750 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0080
Reconsideration and Judicial Review

(1) Orders, modifications of orders, findings and directives issued under OAR 410-145-0010, 410-145-0040(3), or 410-145-0060(1)(a) are subject to reconsideration and stay under the procedures provided in 137-003-0080 through 137-003-0092.

(2) Notwithstanding the provisions of ORS 183.310(6) and 183.480, only a party to a cooperative program agreement or the director shall be entitled to a contested case hearing, reconsideration, or judicial review of an order issued pursuant to 442.700 to 442.760.

(3) The director may recover any expenses incurred in the conduct of any hearing under this rule, including hearing officer and court reporter fees and the director's legal expenses, through an assessment on other parties to the hearing.

Stat. Auth.: ORS 413.042, 442.710, 442.730, 442.740 & 442.755
Stats. Implemented: ORS 413.042
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

DIVISION 146

AMERICAN INDIAN/ALASKA NATIVE

410-146-0000
Foreword

(1) The Division of Medical Assistance Programs (Division) American Indian/Alaska Native (AI/AN) Oregon Administrative Rules are designed to assist the following providers to prepare claims for services provided to clients with Medical Assistance Program coverage:

(a) Indian Health Service (IHS) facilities; and

(b) Tribal 638 facilities, defined as Tribally–operated health care clinics owned or operated by a Tribe or Tribal organization with funding authorized by Title I or Title V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), and recognized by the Centers for Medicare and Medicaid Services (CMS) under the 1996 Memorandum of Agreement (MOA);

(2) Health care facilities not designated an IHS or Tribal 638 facility should refer to Oregon Health Plan (OHP) General Rules (OAR 410 division 120) and other applicable program-specific rules to enroll and operate as any other provider type recognized under the state plan.

(3) CMS does not recognize Urban Indian Health Program (UIHP) clinics as eligible for reimbursement of services under the MOA. UIHP Clinics should refer to:

(a) Federally Qualified Health Centers (FQHC) and Rural Health Clinics administrative Rules (OAR 410 division 147) to enroll as a FQHC if the clinic is an urban Indian organization under the Indian Health Care Improvement Act, Public Law 94-437; or

(b) OHP General Rules (OAR 410 division 120) and other applicable program-specific rules to enroll and operate as any other provider type recognized under the state plan.

(4) The AI/AN administrative rules include important information about general program policy, provider enrollment, maintenance of financial records, special programs, and billing. Unless specifically directed by the AI/AN rules, do not use other Division administrative rules to determine appropriate action.

(5) AI/AN Division-enrolled providers must use the OHP General Rules (OAR 410 division 120) and the OHP Administrative Rules (OAR 410 division 141) as directed in the AI/AN rules and in conjunction with applicable program-specific rules including the AI/AN administrative rules.

(6) The Health Services Commission's Prioritized List of Health Services defines Medicaid-covered services under Division. For more information, refer to the OHP Administrative Rules (OAR 410-141-0520).

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08

410-146-0020
Memorandum of Agreement Reimbursement Methodology

(1) In 1996, a Memorandum of Agreement (MOA) between the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS) established the roles and responsibilities of CMS and IHS regarding the Division of Medical Assistance Programs' (Division) American Indian/Alaska Native (AI/AN) Program individuals. The MOA addresses payment for Medicaid services provided to AI/AN individuals on and after July 11, 1996, through health care facilities owned and operated by AI/AN tribes and tribal organizations, which are funded through Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

(2) The IHS and CMS, pursuant to an agreement with the Office of Management and Budget (OMB), developed an all-inclusive rate to be used for billing directly to and reimbursement by Medicaid. This rate is sometimes referred to as the "OMB," "IHS," "All-Inclusive" (AIR), "encounter," or "MOA" rate and is referenced throughout these rules as the "IHS rate." The IHS rate is updated and published in the Federal Register each fall:

(a) The rate is retroactive to the first of the year;

(b) The Division automatically processes a retroactive billing adjustment each year to ensure payment of the updated rate.

(3) IHS direct health care service facilities, established, operated, and funded by IHS; enroll as an AI/AN provider and receive the IHS rate.

(4) Under the MOA, tribal 638 health care facilities can choose to be designated a certain type of provider or facility for enrollment with Division. The designation determines how the Division pays for the Medicaid services provided by that provider or facility. Under the MOA, a tribal 638 health care facility may do one of the following:

(a) Operate as a Tribal 638 health care facility. The health center would enroll as AI/AN provider and choose reimbursement for services at either:

(A) The IHS rate; or

(B) A cost-based rate according to the Prospective Payment System (PPS). Refer to OARs 410-147-0360, Encounter Rate Determinations, 410-147-0440, Medicare Economic Index (MEI), 410-147-0480, Cost Statement (DMAP 3027) Instructions, and 410-147-0500, Total Encounters for Cost Reports; or

(b) If it so qualifies, operate as any other provider type recognized under the State Plan, and receive that respective reimbursement methodology.

(5) AI/AN and the Division's Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC) Program providers may be eligible to receive the supplemental/wraparound payment for services furnished to clients enrolled with a Prepaid Health Plan (PHP). Refer to AI/AN OAR 410-146-0420 and FQHC/ RHC administrative rules OAR chapter 410, division 147.

(6) AI/AN providers may be eligible for an administrative match contract with the Division. AI/AN providers are not eligible to participate in the Medicaid Administrative Claiming (MAC) Program if they:

(a) Receive reimbursement for services according to the cost-based PPS rate methodology; or

(b) Receive financial compensation for out-stationed outreach worker activities.

(7) An AIAN clinic that chooses to participate in the Patient Centered Primary Care Home Program (PCPCH) must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through 409-055-0080 Office for Oregon Health Policy and Research and OAR 410-141-0860 Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment.The PCPCH program is outside the Prospective Payment system and the IHS/MOA rate. Providers who choose to participate and meet all PCPCH related requirements shall receive a separate reimbursement per the per member per month (PMPM) payment established by OAR 410-141-0860.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 28-2011, f. 9-30-11, cert. ef. 10-1-11; DMAP 14-2012, f. & cert. ef. 3-22-12

410-146-0021
American Indian/Alaska Native (AI/AN) Provider Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (Division) requirements for Indian Health Service (IHS) and Tribal 638 clinics to enroll as American Indian/Alaska Native (AI/AN) providers (refer to OAR 410-120-1260, Provider Enrollment).

(2) An IHS or Tribal 638 clinic that operates a retail pharmacy, provides durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS and/or TCM provider. For specific information, refer to OAR chapter 410, division 121, Pharmaceutical Services Program; OAR chapter 410, division 122, DMEPOS Program; and OAR chapter 410, division 138, TCM Program.

(3) To enroll with the Division as an AI/AN provider, a health center must be one of the following:

(a) An IHS direct health care services facility established, operated, and funded by IHS; or

(b) A Tribally-owned and operated facility funded by Title I or V of the Indian Self Determination and Education Assistance Act (Public Law 93-638, as amended) and is referenced throughout these rules as a "Tribal 638" provider;

(A) A Tribal 638 facility that has administrative control, operation, and funding for health programs transferred to AI/AN tribal governments under a Title I contract with IHS;

(B) A Tribal 638 facility that assumes autonomy for the provision of the tribe's own health care services under a Title V compact with IHS.

(4) Eligible IHS and Tribal 638 providers who want to enroll with the Division as an AI/AN provider must submit the following information:

(a) Completed Oregon Health Authority (Authority) provider enrollment forms with attachments as required in OAR 407-0120-0300 through -0320;

(b) A Tribal facility must submit documentation verifying they are a 638 provider:

(A) A letter from IHS, applicable-Area Office or Central Office, indicating that the facility (identified by name and address) is a 638 facility;

(B) A written assurance from the Tribe that the facility (identified by name and site address) is owned or operated by the Tribe or a Tribal organization with funding directly obtained under a 638 contract or compact. A copy of the relevant provision of the Tribe's current 638 contract or compact must accompany the written assurance;

(c) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, licensed professional counselor or licensed marriage and family therapist is providing mental health services;

(d) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services;

(e) A list of all Prepaid Health Plan (PHP) contracts;

(f) A list of all practitioners contracted with or employed by the IHS or Tribal 638 Facility including names, legacy Division provider numbers, National Provider Identifier (NPI) numbers and associated taxonomy codes; and

(g) A list of all clinics affiliated or owned by the IHS or Tribal 638 Facility including business names, legacy Division provider numbers, National Provider Numbers (NPI) and associated taxonomy codes.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065, 430.010
Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 46-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 37-2010, f. 12-15-10, cert. ef. 1-1-11

410-146-0040
ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes

(1) The Division of Medical Assistance Program (Division) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The appropriate ICD-10-CM code must be used to identify:

(a) Diagnoses;
(b) Symptoms;
(c) Conditions;
(d) Problems;
(e) Complaints; or
(f) Other reasons for the encounter/visit.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-10-CM. The Division considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) The Division requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(a) For dental services, use codes that are in effect for the date the services(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the services(s) was provided. These services include, but are not limited to, the following:

(A) Physician services;
(B) Physical and occupational therapy services;
(C) Radiology procedures;
(D) Clinical laboratory tests;
(E) Other medical diagnostic procedures;
(F) Hearing and vision services.

(6) The Division maintains unique coding and claim submission requirements for administrative exams and Death With Dignity services. Refer to OAR 410 division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services for specific requirements.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 41-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-146-0060
Prior Authorization

(1) Some covered services or items require prior authorization (PA) by the Division before the service can be provided or before payment will be made. Refer to OAR 410-120-1320 Authorization of Payment.

(2) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a prepaid health plan (PHP). Refer to OAR 410-120-1140 Verification of Eligibility.

(3) An OHP client who is a Native American or Alaska Native with proof of Indian heritage is exempt from mandatory enrollment in a PHP, and can request disenrollment from a PHP if mandatorily enrolled. An American Indian/Alaska Native Program OHP client can choose to remain in the Medicaid fee-for-service (FFS) delivery system for physical, dental and/or mental (including alcohol and chemical dependency) health care and receive services from an Indian Health Service facility, tribal health clinic/program or urban clinic. Refer to OAR 410-141-0060(4).

(4) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. It is the AI/AN providers' responsibility to contact the PHP prior to providing services to any:

(a) Non-AI/AN OHP client enrolled in a PHP and with whom the AI/AN provider has a contract, to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP. The AI/AN provider needs to contact the client's PHP for specific instructions;

(b) AI/AN OHP client enrolled in a PHP with whom the AI/AN provider does not have a contract, to comply with PA requirements in these rules, the General Rules and applicable Division program rules.

(5) If a client receives services on a FFS basis or is an AI/AN PHP-enrolled client with whom the AI/AN provider does not have a contract and plans to bill the Division directly FFS, a PA may be required from the Division for certain services. An AI/AN provider assumes full financial risk in providing services to a client prior to receiving authorization, or in providing services that are not in compliance with Oregon administrative rules.

(6) If the service or item is subject to prior authorization, the AI/AN provider must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to

adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with the services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0075
Client Copayments

(1) Division American Indian/Alaska Native (AI/AN) program clients who are members of a Federally recognized Indian Tribe or Tribal Organization and receive Medicaid-covered services rendered through an AI/AN provider or an Urban Tribal Health Clinic are exempt from copayments. Refer to OAR 410-120-1230 Client Copayment.

(2) AI/AN providers may not charge copayments to eligible non-AI/AN Division clients receiving care at their facility.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 89-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08

410-146-0080
Professional Ambulatory Services

(1) Professional Ambulatory services for AI/AN providers include Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services.

(2) Providers must use the following guidelines in conjunction with all individual program-specific Division administrative rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages:

(a) American Indian/Alaska Native (AI/AN) Services administrative rules (OAR 410 division 146),

(b) General Rules (OAR 410 division 120);

(c) OHP Administrative Rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520), and

(d) The Health Services Commission's (HSC) Prioritized List of Health Services (List).

(3) IHS and Tribal 638 facilities are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also AI/AN OAR 410-146-0085(13).

(4) The date of service determines the appropriate version of the AI/AN Services Rules, General Rules, and the HSC Prioritized List that AI/AN providers should use to determine coverage.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0085
Encounter and Recognized Practitioners

(1) The Division of Medical Assistance Programs (Division) will reimburse enrolled American Indian/Alaska Native (AI/AN) providers as follows:

(a) For services, items and supplies that meet the criteria of a valid encounter in sections (5) through (7) of this rule;

(b) Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Division.

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon administrative rule (OAR) 410-147-0120, Encounter and Recognized Practitioners, in the Division's Federally Qualified Health Centers and Rural Health Clinics Program.

(3) AI/AN providers reimbursed according to the IHS rate are subject to the requirements of this rule.

(4) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) and Qualified Medicare Beneficiary (QMB) only clients are not billed according to encounter criteria and not reimbursed at the IHS encounter rate (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System).

(5) For the provision of services defined in Titles XIX and XXI, and provided through an IHS or Tribal 638 facility, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (7) of this rule outlines limitations for telephone contacts that qualify as encounters.

(6) An encounter includes all services, items and supplies provided to a client during the course of an office visit, and "incident-to" services (except as excluded in section (15) of this rule). The following services are inclusive of the visit with the core provider meeting the criteria of a reimbursable valid encounter and are not reimbursed separately:

(a) Drugs or medication treatments provided during the clinic visit, with the exception of contraception supplies and medications as costs for these items are excluded from the IHS encounter rate calculation (refer to OAR 410-146-0200, Pharmacy);

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace); and

(c) Venipuncture for laboratory tests.

(7) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and OAR 410-130-0190, Tobacco Cessation (refer to OAR 410-120-1200). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(8) The following services may be Medicaid-covered services according to an OHP client's benefit package as a stand-alone service; however, when furnished as a stand-alone service, are not reimbursable:

(a) Case management services for coordinating care for a client;

(b) Sign language and oral interpreter services;

(c) Supportive rehabilitation services including, but not limited to, environmental intervention, supported employment, or skills training and activity therapy to promote community integration and job readiness.

(9) AI/AN providers may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment and that require separate enrollment (see OAR 410-146-0021, AI/AN Provider Enrollment). These services include:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (DMEPOS) (e.g. diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS);

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to the Division through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services);

(c) Targeted case management (TCM) services. For specific information, refer to OAR chapter 410, division 138, TCM.

(10) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, see OAR 410-146-0086 for reporting multiple encounters.

(11) For claims that require a procedure and diagnosis code the provider must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure Code Set established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided (refer to OARs 410-120-1280, Billing and 410-146-0040, ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes).

(12) Services furnished by AI/AN enrolled providers that may meet the criteria of a valid encounter (refer to individual program administrative rules for service limitations.):

(a) Medical (OAR chapter 410, division 130);

(b) Diagnostic: The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Oregon Health Evidence Review Commission's Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-130-0190);

(d) Dental (OAR 410-146-0380 and OAR chapter 410, division 123);

(e) Vision (OAR chapter 410, division 140);

(f) Physical Therapy (OAR chapter 410, division 131);

(g) Occupational Therapy (OAR chapter 410, division 131);

(h) Podiatry (OAR chapter 410, division 130);

(i) Mental Health (refer to the Division of Addiction and Mental Health (AMH) for appropriate OARs);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 410-146-0021). Requires a letter or licensure of approval by AMH (refer to AMH for appropriate OARs);

(k) Maternity Case Management (OAR 410-146-0120);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) The Division considers a home visit for assessment, diagnosis, treatment or maternity case management (MCM) as an encounter. The Division does not consider home visits for MCM as home health services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid and CHIP State Plan Amendments and the Division's administrative rules.

(13) The following practitioners are recognized by the Division:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed physician assistants;

(c) Nurse practitioners;

(d) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon's Board of Nursing OARs;

(e) Nurse midwives;

(f) Dentists;

(g) Dental hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits in Oregon Revised Statute (ORS) 680.200 and the appropriate Oregon Board of Dentistry OARs;

(h) Pharmacists;

(i) Psychiatrists;

(j) Licensed Clinical Social Workers;

(k) Clinical psychologists;

(l) Acupuncturists — refer to OAR chapter 410, division 130 for service coverage and limitations;

(m) Licensed professional counselor;

(n) Licensed marriage and family therapist; and

(o) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(A) Their individual provider's certification or license; or

(B) A clinic's mental health certification or alcohol and other drug program approval or licensure by AMH (see OAR 410-146-0021).

(14) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (including drugs and biologicals) furnished on a part-time or intermittent basis to home-bound AI/AN clients residing on tribal land and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-146-0080).

(15) The Division reimburses the following services fee-for-service outside of the IHS all-inclusive encounter rate and according to the physician fee schedule:

(a) Laboratory and/or radiology services;

(b) Contraception supplies and medications (see OAR 410-146-0200, Pharmacy);

(c) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);

(d) Death with Dignity services (refer to OAR 410-130-0670); and

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).

(16) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140, Verification of Eligibility).

(17) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280, Billing and 410-120-1340, Payment).

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05; Renumbered from 410-146-0080, DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 21-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 46-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 37-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-146-0086
Multiple Encounters

(1) An "encounter" is defined in Oregon Administrative Rule (OAR) 410-146-0085.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (see OAR 410-146-0085 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (section (3) of this rule, and OAR chapter 410, division 130);

(b) Dental (OAR 410-146-0380 and chapter 410, division 123);

(c) Mental Health — f a client is also seen for a medical office visit and receives a mental health diagnosis, then the client contacts are a single encounter (refer to the Division of Addictions and Mental Health (AMH) for the appropriate OARs);

(d) Addiction, Alcohol and Chemical Dependency — If a client is also seen for a medical office visit and receives an addiction diagnosis, then the client's contacts are a single encounter (refer to the Division of Addictions and Mental Health (AMH) for the appropriate OARs);

(e) Ophthalmology — fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR chapter 410, division 140);

(f) Maternity Case Management (MCM) (OAR 410-146-0120);

(g) Physical or occupational therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR chapter 410, division 131);

(h) Immunizations — if no other medical office visit occurs on the same date of service; and

(i) Tobacco cessation — if no other medical, dental, mental health or addiction service encounter occurs on the same date of service (OAR 410-130-0190).

(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in section (2) of this rule.

(4) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(5) Similar services, even when provided by two different health care practitioners are considered a single encounter, and not multiple encounters. Services that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist; and

(f) Any time a client receives only a partial service with one provider and partial service from another provider.

(6) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service.

(7) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

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

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05; Renumbered from 410-146-0080, DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 37-2010, f. 12-15-10, cert. ef. 1-1-11

410-146-0100
Vaccines for Children

(1) The Vaccines for Children (VFC) program supplies federally purchased free vaccines for immunizing eligible client's ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Oregon Health Authority (Authority) Immunization Program. Refer to the AI/AN Supplemental Information for instructions and OAR 410-130-0255(4) VFC Program.

(2) The Division of Medical Assistance Programs (Division) will reimburse for the administration of vaccines to eligible clients according to the AI/AN provider's IHS or cost-based rate.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0120
Maternity Case Management Services

(1) The Division of Medical Assistance Programs (Division) will reimburse American Indian/Alaska Native (AI/AN) providers for maternity case management (MCM) services according to their encounter rate.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill the Division directly per the clinic's encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, and services were furnished to a:

(A) Non-AI/AN client, the provider needs to request the necessary authorizations from the PHP;

(B) AI/AN client enrolled with a PHP with which the AI/AN provider does not have an agreement, the AI/AN provider can bill the Division directly.

(3) Clients records' must clearly document all MCM services provided including all mandatory topics. For specific requirements, refer to the Medical-Surgical Services Program OAR 410-130-0595, Maternity Case Management.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation prior to the day of delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day do not qualify as multiple encounters.

(6) A medical/prenatal visit encounter and an MCM encounter can qualify as two separate encounters when furnished on the same day only when the MCM service is:

(a) The initial evaluation to receive MCM services; or

(b) A nutritional counseling MCM service provided after the initial evaluation visit. See section (7) of this rule for limitations.

(7) MCM Services limitations:

(a) The Division reimburses the initial evaluation one time per pregnancy per provider;

(b) The Division reimburses nutritional counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(c) The Division will reimburse a maximum of ten MCM services/visits in addition to (a) and (b) above, providing visits/services are furnished in compliance with OAR 410-130-0595.

(8) Case management services must not duplicate services for case management activities or direct services provided under the State Plan or the Oregon Health Plan (OHP), through fee for service, managed care, or other contractual arrangement, that meet the same need for the same client at the same point in time. This includes the Division's Maternity Case Management Program (OAR chapter 410, division 130) and any Targeted Case Management (TCM) Program outlined in OAR chapter 410, division 138.

(9) Community health representatives may be eligible to provide specific MCM services, with the exclusion of the initial assessment (G9001), while working under the supervision of a licensed health care practitioner listed in OAR 410-130-0595(7)(a). Refer to OAR 410-130-0595(7)(d).

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 37-2010, f. 12-15-10, cert. ef. 1-1-11

410-146-0130
Modifiers

(1) The Division of Medical Assistance Programs (Division) uses HIPAA compliant modifiers for many services.

(2) The following services require the use of a modifier for all services for all procedures:

(a) Family planning service — FP, Refer to OAR 410-130-0585 Family Planning Services;

(b) Vaccine for children — SL or 26, Refer to OAR 410-130-0255(4).

(3) When billing for services that are reimbursed outside an AI/AN provider's cost-based or IHS rate, a clinic must use the required modifier(s) listed in the individual program-specific administrative rules.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0160
Administrative Medical Examinations and Reports

(1) The Division of Medical Assistance Programs (Division) does not reimburse administrative medical examinations and reports at an AI/AN provider's IHS encounter rate. Administrative medical examinations and reports are not eligible under the Memorandum of Agreement (MOA). The Division reimburses providers for administrative examinations and reports on a fee-for-service basis outside the IHS or cost-based encounter rate.

(2) AI/AN health care facilities can be reimbursed for administrative medical examinations and reports when requested by a Department of Human Services' branch office, or approved by the Division. The branch office may request an Administrative Medical Examination/Report Authorization (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) Refer to OAR 410 division 150, Administrative Examination and Report Billing Services, for specific requirements. See Administrative Exams Supplemental Information guide for more detailed information on procedure codes and descriptions.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08

410-146-0200
Pharmacy

(1) As defined by the Division of Medical Assistance Programs (Division), a valid encounter excludes pharmaceutical or biologicals not generally provided during a clinic visit. Refer to OAR 410-146-0085 Division Encounter and Recognized Practitioners:

(a) Because the Division includes the costs for drugs or medication treatments dispensed by a clinic to treat a client during an office visit in the calculation of the all-inclusive encounter rate for the office visit, providers cannot bill separately for the cost of drugs or medication treatments;

(b) Because pharmacy services are not eligible under the Memorandum of Agreement (MOA) for reimbursement at the IHS or a cost-based encounter rate prescriptions are not included in the calculation of the encounter rate. To bill for filled prescriptions, the AI/AN facility's qualified enrolled pharmacy must bill the Division through the pharmacy program.

(2) AI/AN providers may directly bill the Division only for contraceptive supplies and contraceptive medications outside of the pharmacy program:

(a) For clients enrolled with a prepaid health plan (PHP): AI/AN providers must bill the PHP first. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill the Division fee-for-service at the clinic's acquisition cost. See also OAR 410-130-0585, Family Planning Services;

(b) For clients not enrolled with a PHP: AI/AN providers can directly bill the Division fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications. See also OAR 410-130-0585, Family Planning Services.

(3) Refer to OAR 410 division 121, Pharmaceutical Services Program Rulebook for specific information.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 59-2002, f. & cert. ef. 10-1-02; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 24-2008, f. 6-13-08, cert. ef. 7-1-08

410-146-0220
Death With Dignity

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) All Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a prepaid health plan. Death With Dignity services are not part of the AI/AN encounter rate.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 22-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 28-1999, f. & cert. ef. 6-4-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 59-2002, f. & cert. ef. 10-1-02; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08

410-146-0240
Transportation

(1) The Division of Medical Assistance Programs (Division) may reimburse American Indian/Alaska Native (AI/AN) providers for medically appropriate sedan car or wheelchair van transportation services to Oregon Health Plan (OHP) AI/AN clients who receive medical services through an AI/AN provider. (Refer to OAR 410 division 136, Medical Transportation).

(2) Federal regulations in 42 CFR 431.53 require the State to ensure necessary transportation for Medicaid recipients to and from providers. The AI/AN provider must ensure that:

(a) The service to be provided is the most cost-effective method that meets the medical needs of the client; and

(b) The service to be provided at the point of origin and/or destination is a Division Medicaid-covered service according to a client's Oregon Health Plan (OHP) benefit package.

(c) In addition, AI/AN OHP clients may be transported to the nearest Tribal health facility, and are not restricted to the nearest (non-tribal) facility able to meet the client's medical needs.

(3) For the purpose of this rule the most "cost effective" method is a transportation service that cannot, in the judgment of

the Division, be provided through a less expensive alternative while meeting the medical needs of the client. Reimbursement by the Division to an AI/AN provider will not exceed the most cost-effective method and is the lesser of:

(a) The providers costs for furnishing transportation services; or

(b) The amount reimbursed by the Division to non-emergency transportation providers under OAR 410 division 136 Medical Transportation Program.

(4) The Division reimburses transportation services fee-for-service, and outside of the IHS encounter rate, when the AI/AN provider meets the following conditions:

(a) The AI/AN provider owns or leases the sedan car or wheelchair van; and

(b) The individual providing the service is an employee of the AI/AN provider.

(5) AI/AN providers do not need to enroll separately as a transportation provider if they furnish either sedan car or wheelchair van transportation. As used in this rule transportation services by AI/AN providers are defined as follows:

(a) Sedan car transport: Transportation provided by a 4-door sedan or mini-van motor vehicle having a seating capacity of not less than 4 and not more than 7 passengers;

(b) Wheelchair van transport: Transportation provided by a wheelchair lift equipped vehicle for a client who uses a wheelchair. Transportation is generally a "door to door" service. At times, an individual being transported must be picked up inside their residence and taken inside their destination (escort by the driver);

(6) Under the following conditions, an AI/AN provider is required to separately enroll with the Division as a provider of medical transportation services:

(a) The AI/AN provider serves all clients as a whole, and does not limit services to the AI/AN community (e.g. Native American clients);

(b) The AI/AN provider owns and operates a taxi service; or

(c) The AI/AN provider owns and operates an ambulance service.

(7) Non-emergency ambulance, air ambulance, commercial air, bus, or train are not reimbursed under this rule to AI/AN providers and requires advance arrangement and prior authorization (PA) through the local Aging and People with Disabilities Division (APD) or Children, Adults and Families (CAF) branch office.

(8) For all claims submitted to the Division, the provider records must contain completed documentation (pertinent to the service provided) that includes but is not limited to:

(a) Trip information including:

(A) Date of service;

(B) If one way, round trip, or three-way and if transportation needs are ongoing;

(C) Physical address of the point of origin, e.g., client address, nursing home name and address, etc.;

(D) Number of actual patient miles traveled; and

(E) Physical address and name of the destination point, e.g., hospital name, doctor name, address, etc.;

(b) Client information including:

(A) Client name;

(B) ID number; and

(C) Medical assistance needs (e.g. for example, requires wheelchair, walker, cane, needs assistance, requires portable oxygen, etc.); and

(c) Justification for extra attendant beyond one if wheelchair van;

(9) All required documentation must be retained in the provider files for the period of time specified in the General Rules (OAR 410 Division 120).

(10) Medical transportation services must be billed in the professional claim format using the billing instructions and procedure codes in this rule and in conjunction with OAR 147 Division 136 Medical Transportation Program.

(11) Additional client transport. If two or more Medicaid clients are transported by the same mode (e.g., wheelchair van) at the same time, the Division will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more Division clients are transported by mixed mode (e.g., wheelchair van and ambulatory) at the same time, the Division will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client. Reimbursement will not be made for duplicated miles traveled. If more than one client is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. The first 10 miles is included in the Base Rate and should be included in the total number of miles on the CMS-1500 (OAR 410-136-0080, Additional Client Transport).

(12) Tribal facility owned/leased sedan car:

(a) S0215 — Non-emergency transportation; mileage, per mile;

(b) Not eligible for base rate or extra attendant reimbursement;

(13) Tribal facility owned/leased Wheelchair Car/Van. the Division's reimbursement of the first ten miles of a transport is included in the payment for the base rate. A service from point of origin to point of destination (one-way) is considered a "transport."

(14) Tribal facility owned/leased wheelchair van:

(a) If a client is able to transfer from wheelchair to car/van, the Division will not make payment for wheelchair services for transportation of ambulatory (capable of walking) clients (e.g. base rate, extra attendant);

(b) Wheelchair van — Bill using the following procedure codes:

(A) A0130 — Non-emergency transportation, wheelchair car/van base rate;

(B) S0209 — Wheelchair van, ground mileage, per statute mile;

(C) T2001 — Extra attendant (each).

(15) When billing transportation services use the appropriate place of service (POS) codes and modifiers as listed in the Medical Transportation Services Supplemental Information guidebook to indicate the type of transportation service, and point(s) of origin and destination.

(16) The Division may recoup such payments if, on subsequent review, it is found that the provider did not comply with Division administrative rules. Non-compliance includes, but is not limited to, failure to adequately document the service and the need for the service.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 14-2002, f. & cert. ef. 4-1-02; OMAP 59-2002, f. & cert. ef. 10-1-02; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 46-2009, f. 12-15-09, cert. ef. 1-1-10

410-146-0440
Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (Division) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP). American Indian/Alaska Native (AI/AN) Program providers that are not FQHCs, and that elect to receive payment under Title XIX and XXI according to the Indian Health Services (IHS) rate under the Memorandum of Agreement (MOA) effective July 11, 1996 will also be eligible to receive supplemental payments in the same manner as an FQHC under 1902(bb)(5).

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon administrative rule (OAR) 410-147-0460, Prepaid Health Plan Supplemental Payments.

(3) The PHP supplemental payment represents the difference, if any, between the payment received by the AI/AN provider from the PHP for treating the PHP enrollee and the payment to which the AI/AN provider would be entitled if they had billed the Division

directly for these encounters according to the clinic's IHS rate (refer to OAR 410-146-0020).

(4) In accordance with federal regulations, the provider must take all reasonable measures to ensure that in most instances, with the exception of IHS, Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP (refer to OAR 410-120-1140, Verification of Eligibility).

(5) When any other coverage is known to the provider, the provider must bill the other resource prior to billing the PHP. When a provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field (see OAR 410-120-1280, Billing and 410-120-1340, Payment).

(6) Supplemental payment by the Division for encounters submitted by AI/AN providers for purposes of this rule is reduced by any and all payments received by the AI/AN provider from outside resources, including Medicare, private insurance or any other coverage. AI/AN providers are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third party resources (TPR).

(7) The Division shall calculate the PHP supplemental payment in the aggregate of the difference between total payments received by the AI/AN provider, to include payments as listed in section (6) of this rule and the payment to which the AI/AN provider would have been eligible to claim as an encounter if they had billed the Division directly according to the IHS encounter rate.

(8) AI/AN providers must submit their clinic's data using the Managed Care Data Submission Template developed by the Division to report all PHP encounter and payment activity.

(9) To facilitate the Division processing PHP supplemental payments, the AI/AN must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The AI/AN National Provider Identifier (NPI) number and applicable associated taxonomy code registered with the Division for the health center must be used when submitting all claims to the PHPs;

(b) To the Division:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template coversheet;

(C) Payments must be reported at the detail line level on the Managed Care Data Submission Template worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (medical, dental, mental health, or alcohol and chemical dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the IHS or Tribal 638 facility or the total detail lines submitted on the Managed Care Data Submission Template worksheet;

(E) A list of individual practitioners with active Division enrollment including, names, legacy Division provider number and NPI number assigned to practitioners associated with the IHS or Tribal 638 facility. "Associated" refers o a practitioner who is either subcontracted or employed by the AI/AN provider.

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to the Division no later than October 31 of each year.

(10) PHP supplemental payment process:

(a) The Division processes PHP supplemental payments on a quarterly basis. The quarterly settlement includes a final reconciliation for the reported time period.

(b) Upon processing a clinic's data and the PHP supplemental payment, the Division shall:

(A) Send a check to the AI/AN provider for PHP supplemental payment calculated from clinic data the Division was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by the Division;

(c) The AI/AN provider is responsible for reviewing the data the Division was unable to process for accuracy and completeness. The clinic has 30 days, from the date of the Division's cover letter under section (9) of this rule, to make any corrections to the data and resubmit to the Division for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by the Division prior to expiration of the 30 days, and must:

(A) Be in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing the Division the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of the Division's receipt of the resubmitted data, the Division shall:

(A) Review the data and issue a check for all encounters the Division verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The AI/AN provider must submit data to the Division within the timelines provided by the Division.

(11) Clinics must carefully review in a timely fashion the data that the Division was unable to process and returns to the AI/AN provider. If clinics do not bring any incomplete, inaccurate or missing data to the Division's attention within the time frames outlined, Division may not process an adjustment.

(12) The Division encourages AI/AN providers to request PHP supplemental payment in a timely manner.

(13) Clinics must exclude from a clinic's data submission for PHP supplemental payment, services provided to a PHP-enrolled non-AI/AN client denied by the PHP because the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP supplemental payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP supplemental payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to the Division (see OAR 410-146-0060).

(14) If a PHP denies payment to a contracted AI/AN provider for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-146-0085, for the reason that all services, items and supplies are non-covered by the plan, the Division may or may not make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(15) The Division will not reimburse some Medicaid-covered services that are only reimbursed by PHPs, and are not reimbursed by the Division. The Division will not make PHP supplemental payment for these services, as the Division does not reimburse these services when billed directly to the Division.

(16) It is the responsibility of the AI/AN provider to refer PHP-enrolled non-AI/AN clients back to their PHP if the AI/AN provider does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The provider assumes full financial risk in serving a person not confirmed by the Division as eligible on the date of service. See OAR 410-120-1140, Verification of Eligibility. The provider must verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an "open card" or fee-for-service basis.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 24-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 7-2011, f. 6-6-11, cert. ef. 7-1-11

410-146-0460
Compensation for Outstationed Eligibility Workers

(1) The Division of Medical Assistance Programs (Division) may provide reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices.

(2) The Division may provide reasonable compensation to eligible AI/AN providers for outreach activities performed by Outstationed Outreach Workers (OSOW) equal to 100% of direct costs.

(3) American Indian/Alaska Native (AI/AN) Program providers must submit a budget each December 1st to the Division for review of the clinic OSOW costs for approval before any OSOW compensation is made each January 1st.

(4) AI/AN providers must be compliant with OAR 410-120-0045 Applications for Medical Assistance at provider locations, to be eligible for compensation under this rule.

(5) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percent of time spent performing OSOW services and maintain adequate documentation to support the percentage of time claimed. The percent must be used to calculate personnel expenses incurred by an AI/AN provider as outlined in section (7) of this rule and that are directly attributed to outreach activities performed by the employee.

(6) Case management is excluded from OSOW reimbursement. If an OSOW also does case management, calculate the OSOW expense as outlined in section (5) above.

(7) Direct cost expenses allowed for OSOW reimbursement:

(a) Personnel costs for OSOWs:

(A) Salary/wages;

(B) Taxes;

(C) Fringe benefits provided to OSOW;

(D) Premiums paid by the AI/AN Program provider for private health insurance;

(b) Travel expenses incurred by the AI/AN provider for the Division training on OSOW activities;

(c) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(d) Reasonable equipment necessary to perform outreach activities. A Tribal 638 provider reimbursed according to a cost-based rate will not include expenses for replacing equipment if the original cost of the equipment was reported on the cost statement when the clinic's initial cost-based encounter rate was calculated;

(e) Rent or space costs. A Tribal 638 provider reimbursed according to a cost-based rate will not include rent or space costs if 100% of facility costs were reported on the cost statement when the clinic's initial cost-based encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(8) The Division excludes indirect costs relating to OSOW activities to Tribal 638 providers reimbursed according to a cost-based rate. Excluded indirect costs include and are not limited to the following:

(a) Any costs included in the initial calculation of a Tribal 638 clinic's cost-based encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs; and

(d) Operating expenses including utilities, building maintenance and repair, and janitorial services

(9) IHS and Tribal 638 Facilities that have a Medicaid Administrative Match contract that includes outreach costs are not eligible for separate outreach payments. IHS and Tribal 638 facilities cannot participate in the Medicaid Administrative Claiming (MAC) program if they are receiving OSOW compensation according to this rule.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 7-2011, f. 6-6-11, cert. ef. 7-1-11

DIVISION 147

FQHC AND RHC SERVICES

410-147-0000
Foreword

(1) The Division of Medical Assistance Programs" (Division) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage.

(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.

(3) It is the clinic's responsibility to understand and follow all Division rules that are in effect on the date services are provided.

(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All provider rules can be found on the Division website.

(5) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other provider rules unless specifically directed in rules contained in the FQHC and RHC rules. Division General Rules and the Oregon Health Plan (OHP) Administrative Rules are intended to be used in conjunction with all program rules including the FQHC and RHC provider rules.

(6) The Health Services Commission's Prioritized List of Health Services is found in the OHP Administrative Rules (OAR 410-141-0520) and defines the services covered under Division.

(7) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.

(8) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065

Hist.: Hist.: AFS 20-1988, f. 3-8-88, cert. ef. 4-1-88; AFS 16-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 29-1991(Temp), f. & cert. ef. 7-1-91; HR 33-1991, f. & cert. ef. 8-16-91, Renumbered from 461-014-0415; HR 12-1992, f. & cert. ef. 4-1-92; HR 24-1992, f. & cert. ef. 7-3-92; HR 13-1996(Temp), f. & cert. ef. 7-1-96; HR 24-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00;OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0000; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0000; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 47-2005, f. 9-9-05, cert. ef. 10-1-05

410-147-0020
Professional Ambulatory Services

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 division 147), General Rules (410 division 120), OHP Administrative Rules (410-141-0480, 410-141-0500, and 410-141-0520), and the Health Services Commission's (HSC) Prioritized List of Health Services (List), and the Oregon Health Authority (Authority) rules related to provider enrollment and claiming (943-120-0300 through 0380).

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:

(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and

(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).

(3) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and HSC Prioritized List to determine coverage.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0500; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0140; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0040
ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The appropriate ICD-10-CM diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;
(b) Symptoms;
(c) Conditions;
(d) Problems;
(e) Complaints; or
(f) Other reasons for the encounter/visit.

(2) The Division of Medical Assistance Program (DMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-10-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. DMAP considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided:

(a) For dental services, use codes that are in effect for the date the service(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the service(s) was provided. These services include, but are not limited to, the following:

(A) Physician services;
(B) Physical and occupational therapy services;
(C) Radiology procedures;
(D) Clinical laboratory tests;
(E) Other medical diagnostic procedures;
(F) Hearing and vision services.

(6) DMAP maintains unique coding and claim submission requirements for Administrative Exams and Death with Dignity services. Refer to OAR 410 division 150, Administrative Examination and Billing Services, and 410-130-0670, Death with Dignity Services, for specific requirements.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert, ef, 4-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0020; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0060; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 42-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-147-0060
Prior Authorization

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a prepaid health plan (PHP). client's who are not enrolled in a PHP, receive services on an "open card" or "fee-for-service" (FFS) basis.

(2) It is the responsibility of the Provider to verify whether a PHP or Division is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) If a client is enrolled in a PHP there may be Prior Authorization (PA) requirements for some services that are provided through the PHP. It is the Federally Qualified Health Center (FQHC) or Rural Health Clinic(RHC) responsibility to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP client enrolled in a PHP. The FQHC or RHC needs to contact the client's PHP for specific instructions.

(4) Clients who are enrolled in a PHP can receive family planning services, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without

PA from the PHP as provided under the terms of Oregon's Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with a PHP, and the PHP denies payment, the Division of Medical Assistance Programs (Division) will reimburse for these services per a clinic's encounter rate (see OAR 410-147-0120(12)(b)).

(5) If a client receives services on a FFS basis, a PA may be required by Division for certain covered services or items before the service can be provided or before payment will be made. An FQHC or RHC assumes full financial risk in providing services to a FFS client prior to receiving authorization, or in providing services that are not in compliance with OARs. See OAR 410-120-1320 Authorization of Payment and any applicable program rules.

(6) If the service or item is subject to Prior Authorization, the FQHC or RHC must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0640; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0080; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0080
Prepaid Health Plans (PHPs)

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a prepaid health plan (PHP). Clinics serving eligible OHP clients who are enrolled in a PHP must secure authorization from the PHP prior to providing PHP-covered services or case management services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or referral from the PHP before providing any services to clients enrolled in a PHP unless the FQHC or RHC have contracted with the PHP to provide PHP-covered services. If an FQHC or RHC has an arrangement or contract with a PHP, the clinic is responsible to follow PHP rules and prior authorization requirements. See OAR 410 division 141 for OHP Program Rules and; 410-147-0060, Prior Authorization.

(2) The Division of Medical Assistance Programs (Division) encourages FQHCs and RHCs to contact each PHP in their local service area for the purpose of requesting inclusion in their panel of providers.

(3) PHPs contracting with FQHCs or RHCs, for the provision of providing services to their members, are required by 42 USC 1396b(m)(2)(A)(ix) to provide payment to the FQHC or RHC that is not less than the level and amount of payment which the PHP would make for services furnished by a non-FQHC/RHC provider.

(4) Payment for services provided to PHP-enrolled clients (PHP members) is a matter between the FQHC or RHC and the PHP authorizing the services except as otherwise provided in OAR 410-141-0410, OHP primary care managers. If a PHP denies payment to an FQHC or RHC because arrangements were not made with the PHP prior to providing the service, Division will not reimburse the FQHC or RHC under the encounter rate, except as outlined in Section (5) of this rule (see OAR 410-141-0120, OHP PHP Provision of Health Care Services).

(5) FQHCs and RHCs can provide family planning services or Human Immunodeficiency Virus and Acquired Immune deficiency Sydrome prevention services to eligible PHP members without authorization or a referral from the PHP. The FQHC and RHC must bill the PHP first. If the PHP will not reimburse for the service, then the clinic may bill Division. Refer to ORS 414.153, Authorization for payment for certain point of contact services.

(6) PHPs will execute agreements with publicly funded providers, unless cause can be demonstrated to Division's satisfaction why such an agreement is not feasible for authorization of payment for point of contact services in the following categories (refer to ORS 414.153):

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(7) PHPs are responsible to ensure the provision of qualified sign language and oral interpreter services for covered medical, mental health or dental care visits, for their enrolled PHP Members with a hearing impairment or who are non-English speaking. Services must be sufficient for the FQHC or RHC provider to be able to understand the PHP Member's complaint; to make a diagnosis; respond to the PHP Member's questions and concerns; and to communicate instructions to the PHP Member. See OAR 410-141-0220(7), Oregon Health Plan prepaid health plan Accessibility.

(8) The provider assumes full financial risk in serving a person not confirmed by Division as eligible on the date(s) of service. It is the responsibility of the provider to verify a client's eligibility. Refer to OAR 410-120-1140 Verification of Eligibility:

(a) That the individual receiving medical services is eligible on the date of service for the service provided;

(b) Whether an OHP client receives services on a fee-for-service (open card) basis or is enrolled with a PHP; and

(c) Whether the service is covered by a third party resource (TPR), a PHP, or if Division reimburses on a fee-for-service basis.

(9) Division requires the following of a FQHC or RHC under contract with a PHP:

(a) Clinic must maintain reimbursement and documentation records that will permit calculation of supplemental payments according to OAR 410-147-0460. According to OAR 410-141-0180, Oregon Health Plan prepaid health plan Record Keeping, a PHP's participating providers shall maintain a clinical record keeping system with sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the PHP Member. See also OAR 410-120-1360, Requirements for Financial, Clinical and Other Records;

(b) Clinics are subject to ongoing performance review by the PHP. According to OAR 410-141-0200, Oregon Health Plan prepaid health plan Quality Improvement (QI) System, PHPs must maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division Members. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(c) Clinics are subject to program review by Division, the Department of Human Services' Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity and:

(A) Compliance with Oregon Revised Statutes, Oregon Administrative Rules and Federal laws and regulations;

(B) Use of accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation, for calculating PHP supplemental payments and compensation for outstationed outreach workers;

(C) Adequate records maintenance for cost reimbursed services to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99;

OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0155; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0100; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08

410-147-0085
Client Copayments

(1) The Division of Medical Assistance Programs (Division) Medical Care Identification will indicate which Oregon Health Plan (OHP) clients are responsible for copayments for services.

(2) Division requires copayments from clients with certain benefit packages. See OAR 410-120-1230, Client Copayment, and Table 120-1230-1 for specific details.

(3) A client may owe more than one copayment during a 24-hour period. Division may require copayments for each medical, dental, mental health or alcohol and chemical dependency encounter on the same date of service. Refer to OAR 410-147-0140, Multiple Encounters.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 90-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0120
Division Encounter and Recognized Practitioners

(1) The Division of Medical Assistance Programs (Division) reimburses Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services according to the Prospective Payment System (PPS) as follows:

(a) When the service(s) meet the criteria of a valid encounter as defined in Sections (2) through (4) of this rule;

(b) Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Division.

(2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (4) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) An encounter includes all services, items and supplies provided to a client during the course of an office visit (except as excluded in Sections (6) and (12) of this rule) and those services considered "incident-to." These services are inclusive of the visit with the core provider meeting the criteria a valid encounter and reimbursed at the PPS all-inclusive encounter rate. These services include:

(a) Drugs or medication treatments provided during a clinic visit are inclusive of the encounter, with the exception of contraception supplies and medications as costs for these items are excluded from the PPS encounter rate calculation (see OAR 410-147-0280 Drugs and OAR 410-147-0480 Cost Statement (DMAP 3027) Instructions);

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) are inclusive of an office visit;

(c) Laboratory and/or radiology services (even if performed on another day);

(d) Venipuncture for lab tests. The Division does not deem a visit for lab test only to be a clinic encounter;

(4) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and 410-130-0190, Tobacco Cessation (see also OAR 410-120-1200). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(5) Extended care services furnished under a contract between a county Community Mental Health Program (CMHP) of the FQHC and Addictions and Mental Health Division (AMH) are reimbursed outside of the PPS. Extended care services are those services provided under AMH's licensure requirements and reimbursed under AMH's terms and conditions.

(6) Some Division Medicaid-covered services are not reimbursable when furnished according to Oregon Health Plan (OHP) client's benefit package as a stand alone service. Although costs incurred for furnishing these services are inclusive of the PPS all-inclusive rate calculation, visits where these services were furnished as a stand-alone service were excluded from the denominator for the PPS rate calculation (see OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions). The following services when furnished as a stand-alone service are not reimbursable:

(a) Sign language and oral interpreter services;

(b) Supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job.

(7) FQHCs and RHCs may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment, and requires separate enrollment (see OAR 410-147-0320(1)(b) Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment). These services include:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (DMEPOS) (e.g. diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS);

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to DMAP through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services);

(c) Targeted case management (TCM) services (refer to OAR chapter 410, division 138).

(8) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single encounter. For exceptions to this rule, see OAR 410-147-0140 for reporting multiple encounters.

(9) Providers are advised to include all services that can appropriately be reported using a procedure code on the claim and bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ICD-10-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual provider rules (refer to OAR 410-120-1280 Billing and see OAR 410-147-0040 ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes).

(10) FQHC and RHC services that may meet the criteria of a valid encounter are (refer to individual program administrative rules for service limitations.):

(a) Medical (OAR chapter 410, division 130);

(b) Diagnostic: The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-130-0190);

(d) Dental (see to OAR 410-147-0125, and refer to OAR chapter 410, division 123);

(e) Vision (OAR chapter 410, division 140);

(f) Physical Therapy (OAR chapter 410, division 131);

(g) Occupational Therapy (OAR chapter 410, division 131);

(h) Podiatry (OAR chapter 410, division 130);

(i) Mental Health (Refer to the Division of Addiction and Mental Health (AMH) for appropriate OARs);

(j) Alcohol, Chemical Dependency, and Addiction services (see also OAR 410-147-0320). Requires a letter or licensure of approval by AMH (refer to AMH for appropriate OARs);

(k) Maternity Case Management (MCM) (OAR 410-147-0200);

(l) Speech (OAR chapter 410, division 129);

(m) Hearing (OAR chapter 410, division 129);

(n) The Division considers a home visit for assessment, diagnosis, treatment or MCM as an encounter. The Division does not consider home visits for MCM as home health services;

(o) Professional services provided in a hospital setting; and

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid and CHIP State Plan Amendments and the Division's administrative rules.

(11) The following practitioners are recognized by the Division:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits, ORS 680.200 and the appropriate Oregon Board of Dentistry OARs;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon's Board of Nursing OARs;

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists — Refer to OAR chapter 410, division 130 for service coverage and limitations;

(n) Licensed professional counselor;

(o) Licensed marriage and family therapist; or

(p) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(A) Their individual provider's certification or license; or

(B) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH) (see OAR 410-147-0320).

(12) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies — Code of Federal Regulations 42 ¦ 405.2417), and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(13) FQHCs and RHCs may furnish services that are reimbursed outside of the PPS all-inclusive encounter rate and according to the physician fee schedule. These services include:

(a) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);

(b) Death with Dignity services (refer to OAR 410-130-0670);

(c) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients (refer to OARs 410-120-1210, 461-135-1070 and 410-130-0240);

(d) Services provided to Qualified Medicare Beneficiary (QMB) only clients (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). Specific billing information is located in the FQHC and RHC Supplemental Information billing guide; and

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).

(14) OHP benefit packages and delivery system are described in OAR 410-120-1210. Most OHP clients have prepaid health services, contracted for by the Authority through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or "fee-for-service" (FFS) basis.

(a) The Division is responsible for making payment for services provided to open card clients. The provider will bill the Division the clinic's encounter rate for Medicaid-covered services provided to these clients according to their OHP benefit package (see OAR 410-147-0360, Encounter Rate Determination).

(b) A PHP is responsible to provide, arrange and make reimbursement arrangements for covered services for their Division members (refer to OAR 410-120-0250, and OAR chapter 410, division 141, OHP administrative rules governing PHPs). The provider must bill the PHP directly for services provided to an enrolled client (See also OARs 410-147-0080, Prepaid Health Plans, and 410-147-0460, PHP Supplemental Payment). Clinics must not bill the Division for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(A) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(B) HIV/AIDS prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(15) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140 Verification of Eligibility).

(16) When a provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280 Billing and 410-120-1340 Payment).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 71-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0390; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0150; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 22-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 47-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 38-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-147-0140
Multiple Encounters

(1) An encounter is defined in OAR 410-147-0120.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (see OAR 410-147-0120 and individual program rules listed below for specific service requirements and limitations):

(a) Medical section (3) of this rule and OAR chapter 410, division 130);

(b) Dental (OAR 410-147-0125, and OAR chapter 410, division 123);

(c) Mental Health — If a client is also seen for a medical office visit and receives a mental health diagnosis, then the client contacts are a single encounter (Refer to the Division of Addictions and Mental Health (AMH) for the appropriate OARs);

(d) Addiction and Alcohol and Chemical Dependency — If a client is also seen for a medical office visit and receives an addiction diagnosis, then the client contacts area single encounter (Refer to AMH's OARs);

(e) Ophthalmologic services — fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR chapter 410, division 140);

(f) Maternity Case Management MCM (OAR 410-147-0200);

(g) Physical or occupational therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR chapter 410, division 131);

(h) Immunizations — if no other medical office visit occurs on the same date of service; and

(i) Tobacco cessation — if no other medical, dental, mental health or addiction service encounter occurs on the same date of service (refer to OAR 410-130-0190).

(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in section (2) of this rule.

(4) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(5) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist;

(f) Any time a client receives only a partial service with one provider and partial service from another provider, this would be considered a single encounter.

(6) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service. A recipient may obtain medical, dental or other health services from any provider approved by the Division, and/or contracts with the recipient's PHP, if the Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) is not the recipient's primary care manager.

(7) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0520; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0155; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 22-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 38-2010, f. 12-15-10, cert. ef. 1-1-11

410-147-0160
Modifiers

(1) The Division of Medical Assistance Programs (Division) uses HIPAA compliant modifiers for many services.

(2) The following conditions require the use of a modifier for all codes:

(a) Family Planning Service — FP, Refer to OAR 410-130-0585 Family Planning Services

(b) Vaccine for Children — SL or 26, Refer to OAR 410-130-0255(4)

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in the individual program Administrative Rules.

(a) Enhanced Care Services (including extended care) — HK, Refer to OAR 410-147-0120;

(b) Assist surgeon for cesarean deliveries for Citizen Alien Waived Emergency Medical (CAWEM) clients — 80, 81, 82 or AS.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0180
Vaccines for Children (VFC) Program

(1) The Division of Medical Assistance Programs (Division) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible clients.

(2) The VFC program supplies federally purchased free vaccines for immunizing eligible client's ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Oregon Health Authority (Authority) Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0540; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0160; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0200
Maternity Case Management Services

(1) The Division of Medical Assistance Programs (Division) will reimburse federally qualified health centers (FQHCs) and rural health clinics (RHCs) for maternity case management (MCM) services.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to a client enrolled in a PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill the Division directly per the clinic's Prospective Payment System (PPS) encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, the provider needs to request the necessary authorizations from the PHP.

(3) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management for specific requirements.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes, including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation the day before delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day do not qualify as multiple encounters.

(6) A medical/prenatal visit encounter and an MCM encounter can qualify as two separate encounters when furnished on the same day only when the MCM service is:

(a) The initial evaluation to receive MCM service; or

(b) A nutritional counseling MCM service provided after the initial evaluation visit. See Section (7) of this rule for limitations.

(7) MCM services limitations:

(a) The Division reimburses the initial evaluation one time per pregnancy per provider;

(b) The Division reimburses nutritional counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(c) The Division will reimburse a maximum of ten MCM services/visits in addition to (a) and (b) above, providing visits/services are furnished in compliance with OAR 410-130-0595.

(8) Case management services must not duplicate services for case management activities or direct services provided under the State Plan or the Oregon Health Plan (OHP), through fee for service, managed care, or other contractual arrangement, that meet the same need for the same client at the same point in time. This includes Maternity Case Management, and any Targeted Case Management (TCM) Programs outlined in OAR chapter 410, division 138.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0560; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0180; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 38-2010, f. 12-15-10, cert. ef. 1-1-11

410-147-0240
Administrative Medical Examinations and Reports

(1) The Division of Medical Assistance Programs (Division) does not reimburse Administrative Medical Examinations and Reports at a clinic's encounter rate. Division reimburses providers for Administrative Examinations and Reports on a fee-for-service basis.

(2) Refer to OAR 410 division 150, Administrative Examination and Billing Services, for specific requirements. See Administrative Exams Supplemental Information for more detailed information on procedure codes and descriptions.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-620; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0220; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0260
Death With Dignity

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) All claims for Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a managed care plan. Death With Dignity services are not part of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter rate.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 16-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 27-1999, f. & cert. ef. 6-4-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0035; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0260

410-147-0280
Drugs

(1) As defined by the Division of Medical Assistance Programs (Division), a valid Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter excludes pharmaceutical or biologicals not generally provided during a clinic visit. Refer to OAR 41-147-0120 Division Encounter and Recognized Practitioners.

(a) Because Division includes the costs of drugs or medication treatments administered by a clinic to treat a client during an office visit in the PPS all-inclusive encounter rate for the office visit, providers cannot bill separately for the costs of the drugs or treatments;

(b) Prescriptions are not included in the Prospective Payment System (PPS) encounter rate. To bill for filled prescriptions, the FQHC or RHC's qualified enrolled pharmacy must bill Division using its pharmacy provider number.

(2) Clinics may directly bill Division using their clinic provider number for contraceptive supplies and contraceptive medications only for:

(a) Clients enrolled in a prepaid health plan (PHP): Clinics must bill the PHP first. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill Division fee-for-service at the clinic's acquisition cost. See also OAR 410-130-0585, Family Planning Services;

(b) Fee-for-service clients: Clinics can directly bill Division fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications. See also OAR 410-130-0585, Family Planning Services.

(3) Refer to OAR 410 division 121, Pharmaceutical Services Program Rulebook for specific information.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0600; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0240; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08

410-147-0320
Federally Qualified Health Center Rural Health Clinics Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (Division) enrollment requirements for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) (Refer also to OAR 410-120-1260 and 943-120-0320, Provider Enrollment).

(a) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act (Public Law 93-638), providers should refer to the program rules for American Indian/Alaska Native (AI/AN) Services, OAR chapter 410, division 146, for enrollment details;

(b) An FQHC or RHC that operates a retail pharmacy; provides durable medical equipment, prosthetics, orthotics, and

supplies (DMEPOS); or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS and/or TCM provider. For specific information, refer to OAR chapter 410, division 121, Pharmaceutical; OAR chapter 410, division 122, DMEPOS; and OAR chapter 410, division 138, TCM.

(c) A county Community Mental Health Program (CMHP) furnishing extended care services under contract with the Oregon Health Authority (Authority) Addictions and Mental Health Division (AMH) should refer to AMH for licensure and reimbursement requirements.

(2) To enroll with the Division as an FQHC, a health center must comply with one of the following:

(a) Receive Public Health Service (PHS) grant funds under the authority of Section 330;

(b) Have received FQHC Look-Alike designation from the Centers for Medicare and Medicaid Services (CMS), based on the recommendation of the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC); or

(c) Be an Urban Indian Health Program (UIHP) clinic (under Title V of the Indian Health Care Improvement Act, Public Law 94-437). In the Omnibus Reconciliation Act (OBRA) of 1993, Title V programs were added to the list of specific programs automatically eligible for FQHC designation.

(3) Eligible FQHCs who want to enroll with the Division as an FQHC, and receive reimbursement under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed Authority provider enrollment forms with attachments as required in OAR 943-120-0300 through 943-120-0320;

(b) National Provider Identifier (NPI) number and associated taxonomy code(s) obtained for the FQHC with the provider enrollment form (refer to OAR 943-120-0320);

(c) Completed Cost Statement(s) (DMAP 3027):

(A) One each for medical, dental and mental health (including addiction, alcohol and chemical dependency) (see also OAR 410-147-0360);

(B) One for each FQHC-designated site, unless specifically exempted in writing by the Division to file a consolidated cost report (see also OAR 410-147-0340 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)/provider numbers);

(d) Completed copy of the grant proposal submitted to HRSA/BPHC detailing the clinic's service and geographic scope;

(e) Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC;

(f) A copy of the clinic's trial balance (see OAR 410-147-0500, Total Encounters for Cost Reports);

(g) Audited financial statements (refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations");

(h) Depreciation schedules;

(i) Overhead cost allocation schedule;

(j) A copy of the clinic's AMH certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, licensed professional counselor or licensed marriage and family therapist is providing mental health services;

(k) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services;

(l) A list of all Prepaid Health Plan (PHP) contracts;

(m) A list including names and NPI numbers of individual practitioners enrolled with the Division and contracted with or employed by the FQHC; and

(n) A list including business names, addresses and facility NPI numbers for all Division-enrolled clinics affiliated or owned by the FQHC including any clinics that do not have FQHC status.

(4) For enrollment with the Division as an RHC, a clinic must:

(a) Be designated by CMS as an RHC.

(b) Maintain Medicare certification and be in compliance with all Medicare requirements for certification.

(5) Eligible RHCs who want to enroll with the Division as an RHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed the Authority provider enrollment forms with attachments as required in OAR 943-0120-0300 through 943-120-0320;

(b) National Provider Identifier (NPI) number and any associated taxonomy codes obtained for the RHC with the provider enrollment form (refer to OAR 943-120-0320);

(c) Copy of Medicare's letter certifying the clinic as an RHC;

(d) Medicare Cost Report for RHC or completed Cost Statement(s) (DMAP 3027) (see OAR 410-147-0360). Complete a cost statement for each RHC-designated site, unless specifically exempted in writing by the Division to file a consolidated cost report (see OAR 410-147-0340):

(A) The Division will accept an uncertified Medicare Cost Report;

(B) If the clinic's Medicare Cost Report, provided to the Division, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. The Division will include these costs when determining the PPS encounter rate;

(C) An RHC can submit the Cost Statement (DMAP 3027) as a substitute to the Medicare Cost Report.

(e) A copy of the clinic's trial balance (see OAR 410-147-0500, Total Encounters for Cost Reports only if completing Cost Statement DMAP 3027);

(f) Audited financial statements (refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" if completing Cost Statement DMAP 3027);

(g) Depreciation schedules (only if completing Cost Statement DMAP 3027);

(h) Overhead cost allocation schedules (only if completing Cost Statement DMAP 3027);

(i) A copy of the clinic's AMH certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, licensed professional counselor or licensed marriage and family therapist is providing mental health services;

(j) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services;

(k) A list of all Prepaid Health Plan (PHP) contracts;

(l) A list including names and NPI numbers of individual practitioners enrolled with the Division and contracted with or employed by the RHC; and

(m) A list including business names, addresses and facility NPI numbers for all Division-enrolled clinics affiliated or owned by the RHC including any clinics that do not have RHC status.

(6) The FQHC/RHC Program Manager, upon receipt of the required items as listed in section (3) of this rule for FQHCs and Section (5) of this rule for RHCs, will review all documents for compliance with program rules, completeness and accuracy.

(7) The Division prohibits an established, enrolled FQHC or RHC that adds or opens a new clinic site from submitting claims for services rendered at the new site under their FQHC or RHC Division enrollment, and according to the PPS encounter rate, prior to the Division's acknowledgment. An FQHC or RHC is required to immediately submit to the attention of the FQHC/RHC Program Manager, Division:

(a) For FQHCs only, a copy of the recent HRSA Notice of Grant Award including the new site under the main FQHC's scope;

(b) For RHCs only, a copy of Medicare's letter certifying the new clinic as an RHC;

(c) A recent list of all PHP contracts; and

(d) A recent list of names and NPI numbers for all individual practitioners enrolled with the Division and contracted with or employed by the new FQHC or RHC site.

(8) If an established and enrolled RHC or FQHC changes ownership, the new owner must submit:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated; or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership (see OAR 410-147-0360);

(b) Notice of a change in tax identification number;

(c) A recent list of all PHP contracts;

(d) A recent list of names and NPI numbers for all individual practitioners enrolled with the Division and contracted with or employed by the FQHC or RHC; and

(e) A recent list including business names, addresses, NPI numbers and associated taxonomy codes for all Division-enrolled clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status.

(9) FQHCs that are involved with a sub-recipient must provide documentation. Sub-recipient contracts with an FQHC must enroll as an FQHC and submit the same required documentation as outlined under the enrollment sections of this rule.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0010; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 47-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 38-2010, f. 12-15-10, cert. ef. 1-1-11

410-147-0340
Federally Qualified Health Centers and Rural Health Clinics Provider Numbers

(1) Pursuant to National Provider Identifier (NPI) requirements in 45 CFR Part 162 providers must use a NPI, and in specific situations associated taxonomy code(s), when billing the Division of Medical Assistance Programs (Division).

(2) A Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) shall register the NPI number and associated taxonomy code, obtained for the FQHC or RHC at the time of enrollment. Multiple sites are not separately enrolled, unless each site has a different tax identification number.

(3) The Division may grant an exception to section (2) of this rule upon written request to the Division of Medical Assistance Programs — Attn: FQHC/RHC Program Manager. The request must include a detailed explanation describing the:

(a) Need for separate enrollment of an additional site; and

(b) Mechanisms in place to assure no duplication of billings.

(4) If the Division finds evidence of duplicate or inappropriate billing resulting from provider misuse under multiple enrollments, the Division may terminate the exception upon written notice to the clinic.

(5) If the Division grants an exception to section (2) of this rule, the Division shall separately enroll each clinic site. When granted multiple provider enrollments, clinics must register:

(a) A separate NPI number for each clinic; or

(b) One NPI number and separate taxonomy codes for each clinic.

(6) If an FQHC or RHC has several clinic sites and one or more of the clinics are not designated as an FQHC or RHC, the non-FQHC or non-RHC (each individual clinic) must:

(a) Enroll as a billing provider; and

(b) Each practitioner must individually enroll.

(7) Upon enrollment and each October thereafter, FQHCs and RHCs must submit to the Division:

(a) A list including names and NPI numbers of individual practitioners associated with the FQHC/RHC; and

(b) A list including business names, addresses and facility NPI numbers for all Division-enrolled clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status

(8) An FQHC or RHC that operates a retail pharmacy, provides durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS), must enroll separately as a pharmacy and/or DMEPOS provider. Refer to OAR chapter 410, division 121, Pharmaceutical and OAR chapter 410, division 122, DMEPOS; for specific information. These services are not billed under FQHC or RHC enrollment.

(9) The Division shall coincide registration of a clinic's NPI number and associated taxonomy codes if applicable, effective the date of enrollment with the Division as an FQHC or RHC, and after the encounter rate is established.

(10) Prepaid Health Plans (PHP) are required to report all PHP encounters using the FQHC/RHC's NPI and associated taxonomy code, if required, and not individual practitioner NPI numbers and taxonomy codes.

Stat. Auth.: ORS 413.042, 414.065

Stat. Implemented: ORS 414.065

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 8-2011, f. 6-6-11, cert. ef. 7-1-11

410-147-0360
Encounter Rate Determination

(1) The Division of Medical Assistance Programs (Division) will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:

(a) DMAP will enroll a clinic as an FQHC or RHC effective the date DMAP determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with the Division and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled providers can submit claims to the Division for providing specific care, item(s), or service(s) to Division clients. A clinic or individual provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with DMAP, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical, Dental and Mental Health/Substance Use Disorder Services.

(a) Effective October 1, 2004, for FQHCs only, the Division will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with the Division:

(i) Medical;

(ii) Dental; and

(iii) Mental Health/Substance Use Disorder services.

(b) FQHCs enrolled with the Division prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate calculated if the clinic adds a service category listed in either Section (2)(a)(ii) or (iii) of this rule. Refer also to Section (16) of this rule.

(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.

(a) The Division will accept an uncertified Medicare Cost Report;

(b) If the clinic's Medicare Cost Report, provided to the Division, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. The Division will include these costs when determining the PPS encounter rate.

(c) The Division will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;

(d) An RHC can submit the Division cost statement form 3027 as a substitute to the Medicare Cost Report.

(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by the Division. If exempted from this requirement by the Division, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding separate enrollment for multiple sites.

(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.

(6) FQHCs and RHCs cannot include costs associated with non-covered Medicaid services. The Division does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.

(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid covered services provided at clinic sites serving Division clients when completing the Cost Statement (DMAP 3027). For RHCs only, the Medicare Cost Report can only include financial documents for Medicaid-covered services provided at clinic sites that see Division clients. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve Division clients in the Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs.

(8) At any time, if the Division determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, the Division may:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate(s); and

(b) Impose sanctions as defined in OARs 410-120-1400 Provider Sanctions, 410-120-1460 Type and Conditions of Sanctions; and 943-120-0360 Consequences of Non-Compliance and Provider Sanctions.

(9) Effective January 1, 2001, DMAP determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid covered services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.

(10) Clinics existing in 1999 and 2000, and enrolled with the Division as a FQHC or RHC as of January 1, 2001, receive payment from the Division for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.

(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from the Division for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC. Coinciding with enrollment as an FQHC or RHC with the Division, a clinic will have a PPS encounter rate:

(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or

(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.

(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).

(13) For established, enrolled clinics with a change of ownership, the new owner can submit:

(a) A Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by the Division to determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic's tax identification number;

(c) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.

(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to the Division for review.

(15) The Division may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health/Substance Use Disorder services. A separate PPS encounter rate will be calculated by the Division for the added service element if:

(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;

(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;

(c) The FQHC is certified by the Addictions and Mental Health Division (AMH) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by Addictions and Mental Health Division (AMH) former Office of Mental Health and Addictions Services (OMHAS) to provide substance use disorder services;

(i) Certification by AMH of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements

(iii) A letter of licensure or approval by AMH is required for FQHCs providing substance use disorder services. Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(16) If an FQHC meets the criteria as outlined in Section (15) of this rule for the addition of Dental or Mental Health/Substance Use Disorder services, after the initial encounter rate determination, the Division will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

(17) When an FQHC shares the same space for multiple services, then the Division will use square footage to determine the percent of the indirect cost associated with each encounter rate.

(18) A clinic may be exempt from this requirement if an FQHC has minimal utilization for a particular service such as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to the Division FQHC Program Manager for consideration.

(19) For an FQHC approved by the Division to participate in an Alternate Payment Methodology (APM) pilot, the following will apply:

(a) APM converts the clinics current PPS rate into an equivalent per member per month (PMPM) rate using the clinic's historical patient utilization and the clinic's PPS cost base rate. The purpose of APM is to reimburse clinics an amount no less than what the clinic would have received if paid with PPS. The Division shall process quarterly reconciliations and if the APM issued is less than what the clinic would have received if paid using PPS, the Division shall reimburse the clinic the difference. The Division will perform a final annual reconciliation and remit payment within 120 days after the close of the calendar year.

(b) The Division shall have a memorandum of understanding to establish an effective date with each participating clinic.

(c) A clinic may request to return to its PPS rate by submitting written request to the Division. The Division shall return the clinic to their PPS rate within 30 business days after a clinics request has been received.

Stat. Auth.: ORS 413.042 & 414.065
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 8-2013(Temp), f. & cert. ef. 3-1-13 thru 8-27-13; DMAP 45-2013, f. & cert. ef. 8-26-13

410-147-0362
Change in Scope of Services

(1) As required by 42 USC § 1396a(bb)(3)(B), the Division of Medical Assistance Programs (Division) must adjust Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payment System (PPS) encounter rates based on any increase or decrease in the scope of FQHC or RHC services, as defined by 42 USC § 1396d(a)(2)(B)–(C).

(2) The Centers for Medicare and Medicaid Services (CMS) defines a "change in scope of services" as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS' broad definition of change in scope of services allows the Division the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the elements "type," "intensity," "duration," and "amount" and procedures for implementing these adjustments. This rule defines the Division's policy for implementing FQHC and RHC PPS rate adjustments based on a change in scope of services.

(3) A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC § 1396d(a)(2)(B)–(C).

(4) A change in the cost of a service is not considered in and of itself a change in the scope of services. An FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers' services.

(5) The following examples are offered as guidance to FQHCs and RHCs to facilitate understanding the types of changes that may be recognized as part of the definition of a change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

(a) A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples of eligible changes in scope of services include, but are not limited to:

(A) Changes within medical, dental or mental health (including addiction, alcohol and chemical dependency services) service areas (e.g. vision, physical/occupation therapy, internal medicine, oral surgery, podiatry, obstetrics, acupuncture, or chiropractic);

(B) Services that do not require a face-to-face visit with an FQHC or RHC provider will be recognized (e.g. laboratory, radiology, case-management, supportive rehabilitative services, and enabling services.)

(b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of services does not constitute an eligible change. Examples of eligible changes include but are not limited to:

(A) A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center;

(B) The addition or removal of specialty providers (e.g., pediatric, geriatric or obstetric specialists) with a corresponding change in scope of services provided by the health center (e.g. delivery services);

(i) If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services;

(ii) If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services;

(c) A change in service intensity or service delivery model attributable to a change in the types of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the health center;

(d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services. (e.g. the addition of a radiology department);

(e) A change in applicable technologies or medical practices:

(A) Maintaining electronic medical records (EMR);

(B) Updating or replacing obsolete diagnostic equipment (which may also necessitate personnel changes); or

(C) Updating practice management systems;

(f) A change in overall health center costs due to changes in state or federal regulatory or statutory requirements. Examples include but are not limited to:

(A) Changes in laws or regulations affecting health center malpractice insurance;

(B) Changes in laws or regulations affecting building safety requirements; or

(C) Changes in laws or regulations relating to patient privacy.

(6) The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as described in sections (3)–(5):

(a) A change in office hours;

(b) Adding staff for the same service-mix already provided;

(c) Adding a new site for the same service-mix provided;

(d) A change in office location or office space; or

(e) A change in the number of patients served.

(7) Threshold change in cost per visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over the course of several years (e.g. health centers would use the cost report for the year in which all changes were implemented and the 5% cost/visit was met, as described in sections (13) and (14) of this rule). A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a health center, as defined in sections (3)–(5) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

(8) If a FQHC or RHC has experienced an increase or decrease in the health center's scope of services, as described in sections (3)–(5) of this rule and that meets the threshold requirement of section (7) of this rule, the FQHC or RHC must submit to the Division a written application as outlined below. The Division may also initiate a review of whether a change in scope of services has occurred at a health center:

(a) A written narrative describing the specific changes in health center services, and how these changes relate to a change in the health center's overall picture of services;

(b) An estimate of billable Medicaid encounters for the forthcoming 12-month period so the financial impact to the Division can be accounted for;

(c) A cost statement. All costs and expenses reported must be in agreement with the principles of reasonable cost reimbursement as found at 42 CFR 413, Centers for Medicare and Medicaid Services Publication 15-1 (Provider Reimbursement Manual), and

any other regulations mandated by the Federal government. Any situations not covered will be based on Generally Accepted Accounting Principals (GAAP). See Change in Scope Cost Report Instructions;

(d) Certification by the Addiction and Mental Health Division (AMH) of a health center's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements; and

(e) A letter of licensure or approval by AMH is required for health centers providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320(3)(j) and (5)(i); and

(f) The clinic is responsible for providing complete and accurate copies of the above documentation. Health centers may submit a maximum of one change in scope application per year.

(9) Upon receipt of a health center's written change in scope of services request, the FQHC/RHC Program manager will:

(a) Review all documents for completeness, accuracy and compliance with program rules. An incomplete application will result in a delay in the Division's review until the complete application is received; and

(b) Respond to the health center with a decision within 90 days of receipt of a complete application.

(10) Providers may appeal this decision in accordance with the provider appeal rules set forth in OAR 410-120-1560.

(11) Approved change in scope of service requests will result in PPS rate adjustments:

(a) A separate mental health or dental PPS encounter rate will be calculated if a FQHC or RHC adds dental or mental health (including addiction, and alcohol and chemical dependency) services, and costs associated with these service categories were not included in the original cost statements used to determine the baseline PPS encounter rate;

(b) If costs associated with dental or mental health services were included in the original cost statements, whether negligible or significant, health centers have the option of having an adjusted single encounter rate, or requesting a separate dental or mental health rate.

(12) The new rate will be effective beginning the first day of the quarter immediately following the date the Division approves the change in scope of services adjustment (e.g. January, April, July, or October 1):

(a) The Division will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;

(b) It is a health center's responsibility to request a timely change in scope of service rate adjustment.

(13) For changes occurring on or after October 1, 2008, the effective date of this policy, FQHCs and RHCs are required to:

(a) For anticipated changes, health centers should submit prospective costs for the Division to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by the Division. Health centers may later request a subsequent rate adjustment based on actual costs;

(b) For gradual or unanticipated changes, health centers must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met, or beginning in the calendar year of the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met. For example, a health center implements a change in scope of services in 2008, but the additional costs incurred do not meet the 5% threshold criteria. In 2009 the health center implements additional scope of service changes. Additional costs incurred in 2009 together with the costs incurred for 2008 meet the 5% threshold. The health center would report costs for 2009;

(c) Health centers may submit both actual costs (for prior changes) as well as projected costs (for anticipated changes). Prior to submitting both actual and projected costs, health centers should work with the Division's FQHC/RHC Program manager to confirm the appropriate time periods of costs to submit.

(14) For changes that occurred prior to the effective date of this policy, October 1, 2008, FQHCs and RHCs are required to:

(a) Submit cost reports for either:

(A) The first year of actual costs beginning the date on which a change in the cost per visit threshold is met; or

(B) The calendar year or the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met;

(b) For changes that occurred over multiple and overlapping time periods, FQHC/RHCs will submit actual costs for the time period beginning when all changes were in effect. For example, if changes occurred in 2003 and 2004, health centers would submit their 2004 cost report that would include costs for changes implemented in both 2003 and 2004;

(c) Rate adjustments calculated using costs from prior fiscal years will be adjusted by the Medicare Economic Index (MEI) to present.

(15) FQHC and RHCs clinics that choose to participate in the Patient Centered Primary Care Home (PCPCH) Program must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through 409-055-0080 and 410-141-0860, Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment:

(a) The PCPCH Program is outside the Prospective Payment system. Providers who choose to participate and meet all related requirements shall receive a separate payment per the PMPM payment established by OAR 410-141-0860;

(b) If a provider has a PPS rate that includes costs for operating a medical home or health home but would like to participate as a PCPCH, then they must submit a change in scope for a change in service delivery method.

(c) Becoming a PCPCH does not qualify as a change in scope.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042, 414.065, 413.032

Stats. Implemented: ORS 414.065, 413.032

Hist.: DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 28-2011, f. 9-30-11, cert. ef. 10-1-11; DMAP 14-2012, f. & cert. ef. 3-22-12

410-147-0365

Rural Health Clinic Obstetrics Care Delivery Procedures Reimbursement

Reimbursement for obstetric delivery procedures by the Division of Medical Assistance Programs (Division) to eligible Medicare-certified Independent RHCs will be according to the physician fee schedule and outside of the Prospective Payment System (PPS).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 18-2005(Temp), f. 3-15-05, cert. ef. 3-18-05 thru 9-1-05; OMAP 26-2005, f. 4-20-05, cert. ef. 6-1-05; OMAP 48-2005(Temp), f. & cert. ef. 9-15-05 thru 2-15-06; OMAP 64-2005, f. 11-29-05, cert. ef. 1-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 20-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 9-2010(Temp), f. 4-13-10, cert. ef. 5-1-10 thru 10-26-10; DMAP 20-2010, f. 6-23-10, cert. ef. 7-1-10

410-147-0380

Accounting and Record Keeping

(1) General Requirements:

(a) The following rules and regulations apply to clinics reimbursed under the Federally Qualified Health Center (FQHC) and Rural Health Clinic Program;

(b) In cases of conflict between the rules contained in section (2) and (3) of this rule, section (2) will prevail over section (3);

(c) FQHCs and RHCs must use the cost principles contained in Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. Use the circular appropriate to your clinic;

(d) Must adhere to acceptable accounting standards.

(2) Rules and Regulations:

(a) FQHC and RHC Administrative Rules;

(b) The Division of Medical Assistance Programs (Division) General Rules;

(c) Oregon Health Plan (OHP) Administrative Rules;

(d) All other applicable Division provider rules.

(3) Cost Principles for State and Local Governments, OMB Circular A-87 and A-122.

(4) Each FQHC and RHC shall:

(a) Maintain internal control over and accountability for all funds, property and other assets;

(b) Maintain complete client documentation;

(c) Adequately safeguard from duplicate billings or other routine billing errors;

(d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;

(e) Prepare Cost Statements (Division 3027) or Medicare Cost Reports for RHCs in conformance with:

(A) Generally accepted accounting principles;

(B) The provisions of the FQHC and RHC Administrative Rules; and

(C) All other applicable rules listed in sections (2) and (3).

(f) Maintain for a period of not less than five years from the end of the fiscal the year:

(A) Cost Statement (Division 3027) or Medicare Cost Report for RHCs;

(B) Cost Statement Worksheet (Division 3032);

(C) A copy of the clinic's trial balance;

(D) Audited financial statements;

(E) Depreciation schedules;

(F) Overhead cost allocation schedules; and

(G) Financial and clinical records for the period covered by the Cost Statement (Division 3027) or Medicare Cost Report for RHCs.

(g) Maintain adequate records to thoroughly explain how the amounts reported on the Cost Statement (Division 3027) were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;

(h) Adequately document expenses reported as allowable costs in the records of the clinic or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee stating the purpose of the trip or activity, the dates, name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over $25;

(i) Prepare special work papers or reports to support or explain data reported on the Cost Statement (Division 3027) or Medicare Cost Report for RHCs for current or previous periods at Division's request. These work papers/reports must be completed within 30 days of the Division request. An extension of up to 30 days may be granted if the request is made before the end of the original 30 day period. Extensions must be requested in writing;

(j) Ensure that the Cost Statement (Division 3027) or Medicare Cost Report for RHCs is reconcilable to the audited financial records and encounters must be reconcilable to the Uniform Data Set (UDS) form or other reasonable data Division may request. If the Cost Statement (Division 3027) or Medicare Cost Report for RHCs cannot be reconciled, the UDS numbers will be used or other appropriate data sets as determined by Division;

(k) Do not submit financial documentation to Division for FQHC or RHC sites that:

(A) Are not designated as an FQHC or RHC, and/or;

(B) Do not serve Medical Assistance Program clients.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0080; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03

410-147-0400

Compensation for Outstationed Outreach Activities

(1) This rule provides reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices.

(2) A federally qualified health center (FQHC) eligible in accordance with OAR 410-120-0045, will be eligible for compensation under this rule.

(3) ''Initial processing'' includes the following activities:

(a) Taking applications;

(b) Assisting applicants in completing the application;

(c) Providing information as outlined in OAR 410-120-0045;

(d) Obtaining required documentation to complete processing of the application;

(e) Ensuring that the information contained on the application form is complete; and

(f) Conducting any necessary interviews.

(4) "Initial processing" does not include evaluating the information contained on the application and the supporting documentation or making a determination of eligibility or ineligibility.

(5) At locations that are infrequently used by the designated low-income eligibility groups, the Division may use the following resources:

(a) Volunteers, provider or contractor employees; or

(b) Its own eligibility staff, or

(c) Telephone assistance by:

(A) The FQHC as outlined in section (12); or

(B) Prominently displaying a notice that includes the telephone number for the state OHP Application Center or the local branch office that applicants may call for assistance.

(6) Eligible FQHCs may be able to receive reasonable compensation for outreach activities performed by Outstationed Outreach Workers (OSOW) that is equal to 100% of direct costs.

(7) Allowable direct cost expenses for OSOW reimbursement include:

(a) Travel expenses incurred by the FQHC for Division training on OSOW activities;

(b) Phone bills, if a dedicated line is used. Otherwise an estimate of telephone usage and resulting costs;

(c) OSOW personnel costs:

(A) Wages shall be the lesser of:

(i) Wages reported by the FQHC; or

(ii) Wages paid by the State of Oregon to an employee of the state providing enrollment assistance to individuals applying for OHP;

(iii) Wage reimbursement may not exceed the highest salary issued by the State of Oregon to a Human Services Specialist 2;

(B) Taxes;

(C) Fringe benefits provided to OSOW;

(D) Premiums paid by the FQHC for private health insurance.

(d) Reasonable costs for equipment necessary to perform outreach activities, which does include expenses for replacing equipment if the original equipment cost was reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(e) Rent or space costs only if 100% of facility costs were not reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(8) The Division may not include indirect costs in the OSOW reimbursement rate. Indirect costs include but are not limited to the following:

(a) Any costs included in the initial calculation of a clinic's PPS encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs;

(d) Supervision costs; and

(e) Operating expenses including utilities, building maintenance and repair, and janitorial services.

(9) Clinics must submit to the Division a cost statement for the preceding calendar year between October 1, and October 31, of each year for Division review and approval of the clinic's OSOW direct costs.

(10) If a clinic fails to submit the OSOW cost statement by October 31 of the required year, the clinic may not be eligible for

reimbursement of OSOW costs as of January 1 for the following year.

(11) Any change to the OSOW rate, based on the October cost statement submission, shall be effective January 1 of the following year; The Division shall make payment to the clinic for the reviewed and accepted OSOW costs in four equal installments at the beginning of each calendar quarter; January 1, April 1, July 1, and October 1.

(12) Clinic locations with limited operating hours, or that limit access to the general public during their regular operating hours must calculate the actual time an OSOW meets face-to-face with the general public for receipt and the initial processing of applications. For example, if a clinic employs an OSOW at a satellite school-based health center (SBHC), and the SBHC can only be accessed by the general public outside of the school's normal hours of operation, use the percent of time an OSOW is available to meet face-to-face with potential applicants when reporting compensation as outlined in section (11)(c) of this rule.

(a) Clinics must display a notice in a prominent place that advises potential applicants when an OSOW will be available;

(b) The notice must include a telephone number that applicants may call for assistance.

(13) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percentage of time spent performing OSOW activities and maintain adequate documentation to support the time claimed. The percentage must be used to calculate personnel expenses incurred by an FQHC that are directly attributed to outreach activities performed by the employee. Outreach activities:

(a) May include assisting individuals with completing applications for other Department of Human Services (Department) and Authority-administered programs where eligibility is determined by staff at local branch offices;

(b) Does not include assisting individuals with applying for non-Department and non-Authority-administered programs.

(14) A clinic shall not claim reimbursement for costs associated with personnel positions where 100% of costs were included in the FQHC's PPS encounter rate calculation.

(15) A Public Health Department designated as an FQHC or a School Based Health Center (SBHC) within the scope of an FQHC designation cannot participate in the Medicaid Administrative Claiming (MAC) program.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0330; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 47-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 8-2011, f. 6-6-11, cert. ef. 7-1-11; DMAP 64-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 9-2013(Temp), f. & cert. ef. 3-1-13 thru 6-29-13; DMAP 35-2013, f. & cert. ef. 6-27-13

410-147-0420
Rebasing

(1) Determination of encounter rates effective January 1, 2001 as directed by the Balanced Budget Act (BBA) of 1997 and the Budget Refinement Act of 1999 Prospective Payment System (PPS) was changed for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) clinics. PPS eliminates annual cost reports and retrospective settlements except for managed care organization (MCO) Supplemental Payments.

(2) As directed by the BBA and PPS, the federal government will notify states when clinics can re-base clinic rates. No specific date has been determined by the federal government at this time.

Stat. Auth.: ORS 413.042 & 414.065, 42 USC 1396a(bb), CFR Title 42 Public Health
Stats. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03

410-147-0440
Medicare Economic Index (MEI)

Effective January 1, 2001, as directed by the Balanced Budget Act of 1997, the Budget Refinement Act of 1999 Prospective Payment System (PPS), and BIPA all encounter rates must be adjusted annually by the Medicare Economic Index (MEI) for the current year. The encounter rate will be adjusted by the MEI effective January 1st of the current year.

Stat. Auth.:ORS 413.042 & 414.065 42 USC 1396a(bb), CFR Title 42 Public Health
Stats. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

410-147-0460
Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (Division) is required by 42 USC 1396a(bb), to make supplemental payments to eligible federally qualified health centers (FQHC) and rural health clinics (RHC) that contract with Prepaid Health Plans (PHP).

(2) The PHP Supplemental Payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP(s) for treating the PHP enrollee and the payment to which the FQHC/RHC would be entitled if they had billed Division directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.

(3) In accordance with federal regulations the Provider must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP. Refer to OAR 410-147-0120(14).

(4) When any other coverage is known to the provider, the provider must bill the other resource(s) prior to billing the PHP. When a Provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120-1280 Billing and 410-120-1340 Payment.

(5) Supplemental payment by Division for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third Party Resource(s) (TPR).

(6) Division will calculate the PHP Supplemental Payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in Section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed Division directly per their PPS encounter rate.

(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with dates of service January 1, 2006 and after, using the Managed Care Data Submission Template developed by Division to report all PHP encounter and payment activity.

(8) To facilitate Division processing PHP supplemental payments, the FQHC or RHC must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The National Provider Identifier (NPI) number and associated taxonomy code, registered by the FQHC or RHC clinic with Division must be used when submitting all claims to the PHPs;

(b) To Division:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template Coversheet;

(C) Payments are to be reported at the detail line level on the Managed Care Data Submission Template Worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (Medical, Dental, Mental Health, or Alcohol and Chemical Dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the FQHC or RHC or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) All individual NPI numbers and taxonomy codes assigned to practitioners associated with the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain individual active enrollment with Division in limited situations. Refer to OAR 410-147-0340(3).

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to Division no later than October 31 of each year.

(9) PHP Supplemental Payment process:

(a) Division will process PHP Supplemental Payments on a quarterly basis:

(A) Quarterly processing of PHP Supplemental Payments includes a final reconciliation for the reported time period;

(B) For an FQHC or RHC approved by Division to participate in a pilot project, PHP Supplemental Payments will be processed at the discretion of Division in collaboration with health centers;

(b) Upon processing a clinic's data and the PHP Supplemental Payment, Division will:

(A) Send a check to the clinic for PHP Supplemental Payment calculated from clinic data Division was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by Division;

(c) The FQHC or RHC is responsible for reviewing the data Division was unable to process for accuracy and completeness. The clinic has 30 days, from the date of Division's cover letter under Section (9)(b) of this rule, to make any corrections to the data and resubmit to Division for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by Division prior to expiration of the 30 days, and must:

(A) Be requested in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing Division the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of Division's receipt of the re-submitted data, Division will:

(A) Review the data and issue a check for all encounters Division verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The FQHC or RHC should submit data to Division within the timelines provided by Division.

(10) Clinics must carefully review in a timely fashion the data that Division was unable to process and returns to the FQHC or RHC. If clinics do not bring any incomplete, inaccurate or missing data to Division's attention within the time frames outlined, Division will not process an adjustment.

(11) Division encourages FQHCs and RHCs to request PHP Supplemental Payment in a timely manner.

(12) Clinics must exclude from a clinic's data submission for PHP supplemental payment, clinic services provided to a PHP-enrolled client when the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) prevention services. Family Planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP Supplemental Payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP Supplemental Payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to Division. (See also OAR 410-147-0060).

(13) If a PHP denies payment to an FQHC or RHC for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-147-0120, for the reason that all services, items and supplies are non-covered by the plan, Division is not required to make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(14) If an FQHC or RHC has been denied payment by a PHP because the clinic does not have a contract or agreement with the PHP, Division is not required to make a supplemental payment to the clinic. Division is only required to make a PHP supplement payment when the FQHC or RHC has a contract with a PHP.

(15) Division will not reimburse some Medicaid covered services that are only reimbursed by PHPs, and are not reimbursed by Division. Division will not make PHP supplemental payment for these services, as Division does not reimburse these services when billed directly to Division.

(16) It is the responsibility of the FQHC or RHC to refer PHP-enrolled clients back to their PHP if the FQHC or RHC does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The Provider assumes full financial risk in serving a person not confirmed by Division as eligible on the date(s) of service. See OAR 410-120-1140. It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an "open card" or "fee-for-service" basis.

Stat. Auth.: ORS 413.042 & 414.065
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0480
Cost Statement Instructions

(1) The Division of Medical Assistance Programs (Division) requires federally qualified health centers (FQHC) to submit Cost Statements (DMAP 3027).

(2) Rural health clinics (RHCs) can choose to submit either their Medicare Cost Report or the Cost Statement (DMAP 3027). If the RHC files a Medicare Cost Report, the Division may request additional information.

(3) The Division reimburses some services, items and supplies fee-for-service, outside of a FQHC or RHC's Prospective Payment System (PPS) encounter rate. For this reason, clinics must exclude the costs for the following items from the cost statement:

(a) Contraceptive supplies and contraceptive medications (see OAR 410-147-0280);

(b) Pharmacy. Requires separate enrollment, refer to OAR chapter 410, division 121, Pharmaceutical Services Program Rulebook for specific information;

(c) Durable medical equipment and supplies. Requires separate enrollment, refer to OAR chapter 410, division 122, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS);

(d) Targeted case management (TCM) services. Requires separate enrollment, see OAR 410-147-0610, and refer to OAR chapter 410, division 138, Targeted Case Management for specific information; and.

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).

(4) Payment for services provided by FQHCs and RHCs is in accordance with 42 USC 1396a (bb). In general, a Prospective Payment System (PPS) encounter rate is calculated on a per visit basis that is equal to the average of reasonable and allowable costs incurred by a clinic for furnishing services included in the State Plan under Title XIX and XXI of the Social Security Act. The rate is calculated by dividing the total costs incurred by an FQHC or RHC for furnishing services by the total number of clinic encounters as defined in OAR 410-147-0500. A clinic must submit a Cost Statement (DMAP 3027) to the Division:

(a) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinic services (see OAR 410-147-0360);

(b) For new clinics (see OAR 410-147-0360); or

(c) If there is a change of ownership, the new owner can submit the Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated (see also OAR 410-147-0320 (8).

(5) The Cost Statement (DMAP 3027) must include all documents required by OAR 410-147-0320.

(6) Each section must be completed if applicable.

(7) Page 1 — Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, legacy Division provider number, current National Provider Identifier (NPI) numbers and associated taxonomy code(s); the name of the persons or organizations having legal ownership of the FQHC or RHC; and all provider and health care practitioners as defined on the DMAP 3027 Cost Statement.

(b) The Cost Statement (DMAP 3027) must be prepared, signed and dated by both the FQHC or RHC accountant and an authorized responsible officer.

(8) Page 2 — Part A — FQHC or RHC Practitioner Staff and Visits:

(a) Full Time Equivalent (FTE) Personnel: List the total number of staff by position;

(b) Encounters: List the number of on-site and off-site encounters by staff (see OAR 410-147-0500, Total Encounters for Cost Reports). Exclude the following types of encounters from your total encounters:

(A) Out-stationed outreach workers;

(B) Administration; and

(C) Support staff, or any staff members who do not meet the criteria of OAR 410-147-0120(6) or the qualification or certification requirements under a clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH) (see OAR 410-147-0320).

(9) Pages 3-4 — Reclassification and adjustment of trial balance of expenses:

(a) Record the expenses for covered health care costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs:

(A) Covered health care (program) costs include all necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Whether the Division allows the costs is subject to the regulations prescribing the treatment of specific items under the Medicaid program (see OAR 410-147-0020 Professional Services). Covered health care (program) and direct health care costs include but are not limited to:

(i) Personnel costs, including Medical record and medical receptionist costs;

(ii) Administrative costs;

(iii) Employee pension plan costs;

(iv) Normal standby costs;

(v) Medical practitioner salaries; and

(vi) Malpractice insurance costs;

(B) Non-reimbursable program costs are costs that are not related to patient care and which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs that are not necessary include costs that usually are not common or accepted occurrences in the field of the provider's activity. Non-reimbursable program costs include, but are not limited to:

(i) Women, Infants and Children (WIC);

(ii) Community services/housing projects (refer to OAR 410-120-1200);

(iii) Environmental external maintenance costs (e.g. landscaping, pesticide application);

(iv) Research;

(v) Public education; and

(vi) Outside services;

(C) Allowable overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs:

(i) Administrative costs;

(ii) Billing department expenses;

(iii) Audit costs;

(iv) Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

(v) Space costs (rent and utilities); and

(vi) Liability insurance costs;

(D) Non-reimbursable overhead costs:

(i) Entertainment;

(ii) Fines and penalties;

(iii) Fundraising;

(iv) Goodwill;

(v) Gifts and contributions;

(vi) Political contributions;

(vii) Bad debts;

(viii) Other interest expense;

(ix) Advertising;

(x) Membership dues for public relations purposes, including country or fraternal club memberships;

(xi) Cost of personal use of motor vehicles;

(xii) Cost of travel incurred in connection with non-patient care related purposes; and

(xiii) Costs applicable to services, facilities, and supplies furnished by a related organization (related party transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity (see OAR 410-147-0540);

(b) Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used;

(c) Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC administrative rules on allowable costs. A schedule of any reported reclassification of trial balance expense, whether an increase or decrease, must include:

(A) A reference to the line number on either page 3 or 4;

(B) A description of the reclassification or adjustment;

(C) The amount of the debit or credit; and

(D) The total for each debit and credit;

(d) Net expenses must equal the combined reclassified trial balance taking into account the adjustment amount on each detail line;

(e) Enter the totals from each column in the "Total" fields.

(10) Page 5 — Determinations — Determination of overhead applicable to FQHC and RHC services:

(a) Parts A and B: Enter all totals from the previous pages of the Cost Statement (DMAP 3027) as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate;

(b) Part C: If applicable, complete by entering the wages for Out-stationed Outreach Workers on line C1, divide the wages by the number of billable Division encounters to determine the rate per encounter (see also OAR 410-147-0400).

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0400; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 38-2010, f. 12-15-10, cert. ef. 1-1-11

410-147-0500
Total Encounters for Cost Reports

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively.

(2) In general, the Division of Medical Assistance Programs (DMAP) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter.

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ALL:

(a) Encounters for all clients regardless of payor;

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, Third Party Payor or other party, but otherwise have an associated cost for providing the service whether billed to the client (e.g. uninsured, signed waiver on file) or absorbed by the clinic; and;

(c) Encounters regardless of line placement on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services. For the purpose of reporting encounters according to this rule, encounters are not subject to the HERC Prioritized List, or service limitations and benefit reductions implemented by the Division of Medical Assistance Programs (DMAP).

(4) FQHCs and RHCs must report all encounters furnished to all client populations irrespective of coverage or payor source. Examples of client populations include, but are not limited to:

(a) Oregon Health Plan (OHP) clients (includes both fee-for-service and prepaid health plan (PHP) clients). Refer to OAR 410-147-0120 for more information regarding OHP encounters;

(b) Citizen/Alien-Waived Emergency Medical (CAWEM) clients. Refer also to OAR 410-120-1210(3)(f).

(c) Family Planning Expansion Program (FPEP) Title X, clients;

(d) Uninsured and/or self-pay clients;

(e) Medicare clients;

(f) Third party or private pay insurance clients;

(g) County- and/or clinic-pay clients (services paid or funded by the county or clinic); and

(h) Clients funded by federal, state, local or other grants.

(5) FQHCs and RHCs must exclude from the total number of reported encounters:

(a) Encounters attributed to non-allowable costs:

(A) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract;

(B) Services performed and reimbursed under separate enrollment (e.g., Targeted Case Management);

(C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC; and

(E) Health services provided as part of a large-scale "free to the public" or "nominal fee" effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair);

(b) Encounters for specific services outlined in 42 USC 1396d(a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services is an allowed administrative program cost and should be reported on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to:

(A) Case management services for coordinating health care for a client;

(B) Enabling services, including but not limited to, sign language and oral interpreter services;

(C) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness;

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis);

(E) Prescription refills; and

(F) Services provided without the client present, except for telephone contacts as specified in this rule section (6)(c).

(6) FQHCs and RHCs are required to include encounters for services furnished by practitioners recognized by DMAP in OAR 410-147-0120(6). Examples of encounters that may be overlooked but should be included are:

(a) Encounters below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement;

(b) Encounters outside of the clinic by primary care practitioners (e.g. services furnished in a hospital or residential treatment setting);

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), 410-130-0595, programs. See also 410-120-1200(2)(y);

(d) Medication management-only encounters by a behavioral health practitioner;

(e) Encounters by Registered and Licensed Practical Nurses:

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of home health agencies (OAR 410-147-0120(10));

(B) Administration of immunizations/vaccinations encounters;

(C) "99211" encounters; and

(D) Maternity Case Management (MCM) encounters.

(7) Global procedures require attention for accurate reporting of encounters:

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter;

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-0040(5) ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information;

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information:

(A) Services within a surgical package and "included" in a given CPT surgical code are reported as a single encounter. Refer to OAR 410-130-0380, Surgical Guidelines, for more information; and

(B) The initial consultation or evaluation of the problem by the provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter.

(8) A surgical procedure furnished to an OHP client and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CAWEM client. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC, may be eligible as multiple encounters if medically necessary.

(9) When two or more services are provided on the same date of service:

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or

(b) With similar diagnoses, a clinic must report one encounter.

(10) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027):

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0380; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-147-0520
Depreciation

Office of Management and Budget (OMB) Circular A-87 and A-122, Section 13 is applicable with the following exception: depreciation and amortization must be calculated on a straight line basis less the estimated salvage value. The clinic must use the American Hospital Association guidelines "Estimated Useful Lives of Depreciable Hospital Assets" for determining asset lives when computing depreciation. For assets not covered by the guidelines and with costs of more than $500 individually and $500 aggregate, the lives established by the clinic are subject to approval by Division of Medical Assistance Programs (Division). Depreciation and amortization schedules must be maintained.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0260

410-147-0540
Related Party Transactions

(1) A "related party" is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the federally qualified health center (FQHC) or rural health clinic (RHC) furnishing the services, facilities, or supplies:

(a) "Common ownership" exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;

(b) "Control" exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(2) Division of Medical Assistance Programs (Division) allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent that they:

(a) Relate to Title XIX and Title XXI client care;

(b) Are reasonable, ordinary, and necessary; and

(c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.

(3) The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.

(4) Clinics must disclose a related party who is separately enrolled as a provider with Division and furnish the provider's National Provider Identifier (NPI) and associated taxonomy code(s).

(5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by Division. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(6) Division will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC Administrative Rules.

(7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0280; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0560
Sanctions

(1) Providers are directed to Division of Medical Assistance Programs' General Rules OARs 410-120-1400 Provider Sanctions and 410-120-1460 Type and Conditions of Sanctions and Oregon Health Authority OAR 943-120-0360 Consequences of Non-Compliance and Provider Sanctions.

(2) OAR 410-120-1510 and 943-120-0380 govern fraud and abuse. The Authority is authorized to take the actions necessary to investigate and respond to substantiated allegations of fraud and abuse, including but not limited to suspending or terminating the provider from participation in the medical assistance programs

Stat. Auth.: ORS 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0395; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

DIVISION 148

HOME ENTERAL/PARENTERAL NUTRITION AND IV SERVICES

410-148-0000
Foreword

(1) The Home Enteral/Parenteral Nutrition and IV Services rules are a user's manual designed to assist providers in preparing health claims for medical assistance program clients. The Home Enteral/Parenteral Nutrition and IV Services provider rules are to be used in conjunction with the General Rules for Oregon Medical Assistance Programs, the Oregon Health Plan administrative rules, the Pharmaceutical Services administrative rules, and other relevant provider rules and supplemental information.

(2) The Home Enteral/Parenteral Nutrition and IV Services provider rules include procedure codes with restrictions, and limitations. The Home EPIV code and fee schedule, which is not a part of these rules, is not an exhaustive list of OHP covered service codes. Please consult the Prioritized List of Health Services for the Oregon Health Plan and the Division's Maximum Allowable Table.

(3) The Division endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

(4) Providers should always follow the Division administrative rules in effect on the date of service.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 3-1995, f. & cer.t ef. 2-1-95; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0600 OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0020
Home Enteral/Parenteral Nutrition and IV Services

(1) The Division of Medical Assistance Programs (Division) will make payment for medically appropriate goods, supplies and services for home enteral/parenteral nutrition and IV therapy on written order or prescription. (a) The order or prescription must be dated and signed by a licensed prescribing practitioner, legible and specify the service required, the ICD-10-CM diagnosis codes, number of units and length of time needed.

(b) The prescription or written physician order for solutions and medications must be retained on file by the provider of service for the period of time specified in the Division's General Rules.

(c) An annual assessment and a new prescription are required once a year for ongoing services.

(d) Also covered are services for subcutaneous, epidural and intrathecal injections requiring pump or gravity delivery.

(2) All claims for enteral/parenteral nutrition and IV services require a valid ICD-10-CM diagnosis code. It is the provider's responsibility to obtain the actual diagnosis code(s) from the prescribing practitioner. Reimbursement will be made according to covered services on funded lines of the Health Services Commission's Prioritized List of Health Services, and these rules.

(3) The Division requires one initial nursing service visit to assess the home environment and appropriateness of enteral/parenteral nutrition or IV services in the home setting and to establish the client's treatment plan.

(a) This nursing service visit for assessment purposes does not require payment authorization.

(b) The nursing service assessment visit is not required when:

(A) The only service provided is oral nutritional supplementation;

(B) The services are performed in an Ambulatory Infusion Suite of the home infusion therapy provider.

(4) Nursing service visits specific to this Home Enteral/Parenteral and IV services program are provided in the home, or an Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS) and will be reimbursed by the Division only when prior authorized, and performed by a person who is licensed by the Oregon State Board of Nursing to practice as a Registered Nurse. All registered nurse delegated or assigned nursing care tasks must comply with the Oregon State Board of Nursing, Nurse Practitioner Act and Administrative Rules regulating the practice of nursing.

(5) Payment for services identified in the Home Enteral/Parenteral Nutrition and IV Services provider rules will be made only when provided in the client's place of residence (i.e., home or nursing facility) or an Ambulatory Infusion Suite (AIS).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 26-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0290; HR 9-1992, f. & cert. ef. 4-1-92; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0640; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 64-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15

410-148-0040
Requirements for Home Enteral/Parenteral Nutrition and IV Services

(1) Home Enteral/Parenteral Nutrition and IV Services:

(a) Home enteral/parenteral nutrition and IV services must include training and/or education of client or support person on nutritional supplement and /or equipment operation;

(b) When enteral/parenteral nutrition and IV services are initiated in a hospital setting, reimbursement for training is included in the hospital reimbursement and will not be made separately;

(c) Reimbursement for enteral/parenteral and IV services training when done in the home is included in the payment for the nursing visit(s);

(d) Per diem reimbursement includes: administrative service, pharmacy professional and cognitive services, including drug admixture, patient assessment, clinical monitoring, and care coordination, and all necessary infusion related supplies and equipment. Enteral/parenteral formula, drugs and nursing visits are not included in per diem rates and must be billed separately.

(2) Home enteral nutrition:

(a) Home enteral nutrition is considered medically appropriate to maintain body mass and prevent nutritional depletion, which occurs with some illnesses or pathological conditions;

(b) Home enteral therapy may be administered orally or by enteral tube feeding, i.e., nasogastric, jejunostomy or gastrostomy delivery systems.

(3) Home parenteral nutrition:

(a) Is considered medically appropriate for treatment of gastrointestinal dysfunction such as severe short bowel syndrome, chronic radiation enteritis, severe Crohn's disease, or other conditions where adequate nutrition by the oral and enteral routes is not possible:

(b) Initiation of home parenteral nutrition services must include client or support person education on catheter care, infusion technique, solution preparation, sterilization technique, and equipment operation;

(c) Parenteral nutrition is appropriate only when oral or enteral feeding is inadequate or contraindicated.

(4) Home intravenous (IV) services:

(a) Home intravenous (IV) services are covered by the Division for the administration of antibiotics, analgesics, chemotherapy, hydrational fluids or other intravenous medications in a client's residence, (i.e., home or nursing facility) or an Ambulatory Infusion Suite (AIS).

(b) In addition, the provision of all goods and services needed for maintaining venous or arterial access and required monitoring is covered.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 9-1992, f. & cert. ef. 4-1-92; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 34-1993(Temp), f. & cert. ef. 12-1-93; HR 11-1994, f. 2-25-94, cert. ef. 2-27-94; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0660; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07

410-148-0060
Authorization

(1) The Division of Medical Assistance Programs (Division) requires authorization of payment for the following items or services:

(a) All enteral/parenteral or IV infusion pumps. The provider is required to submit documentation with each request proving that other (non-pump) methods of delivery do not meet the client's medical need;

(b) All nursing service visits, except the assessment nursing visit, associated with home enteral/parenteral nutrition or IV services;

(c) All oral nutritional supplements;

(d) All drugs and goods identified as requiring payment authorization in the Pharmaceutical Services administrative rules (chapter 410, division 121). Contact the Division's Pharmacy Benefit Manager to determine those items that require prior authorization.

(2) The Division will approve payment for the above home enteral/parenteral nutrition and/or IV services entities when they are considered to be "medically appropriate."

(3) The Division requires authorization of payment for those services that require authorization even though the client has other insurance that may cover the service. Authorization of payment is not required for Medicare covered services.

(4) For services requiring authorization, providers must contact the Division's Medical Unit for authorization within five

working days following initiation of services. Authorization will be given based on medical appropriateness, appropriateness of level of care given, cost and/or effectiveness.

(5) How to obtain payment authorization:

(a) The Division's Medical Unit is responsible for authorization for services for clients identified as Medically Fragile Children's Unit clients;

(b) Contact the Division's Pharmacy Benefit Manager, prior authorization help desk to request oral nutrition supplements;

(c) Contact the Division's Medical Unit to request all other authorization;

(d) Payment authorization does not guarantee reimbursement.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 26-1984, f. & ef. 6-19-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 52-1986, f. & ef. 7-2-86; AFS 15-1987, f. 3-31-87, ef. 4-1-87; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0090; HR 26-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0220; HR 9-1992, f. & cert. ef. 4-1-92; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0680; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; DMAP 26-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2011, f. 12-13-11, cert. ef. 1-1-12

410-148-0080
Equipment Rental/Purchase/Repair

(1) The following equipment shall be authorized, if medically appropriate and when cost effective, on a rental basis only:

(a) IV infusion pumps;

(b) Enteral formulae pumps.

(2) The equipment provider is responsible for providing working equipment including replacement if repairs are necessary.

(3) Pump rental payment will not be made beyond the purchase price, but no more than 15 consecutive months when the period of use extends beyond 15 consecutive months:

(a) Consecutive months are defined as "any period of continuous use where no more than a 60-day break occurs";

(b) Division of Medical Assistance Programs (Division) considers that the maximum rental period toward purchase price is — 15 consecutive months of pump rental. The purchase price has been met at the earlier of the purchase price or 15 consecutive months;

(c) Having met the purchase price as described in this rule, the pump becomes property of the client, and the patient is responsible for all maintenance and repairs.

(A) The Division can still allow for medically necessary repairs on equipment that the patient owns.

(B) The provider may bill the Division for maintenance and servicing of the pump (as long as that maintenance and servicing is not covered under any manufacturer/supplier warranty) when a period of at least six months has elapsed since the final month of pump rental. Payment for the maintenance service will only be made one time during every six-month period.

(C) For a purchased pump, a rental pump may be prior authorized for up to one month during equipment repair for a client requiring medically necessary, continuous service.

(4) All other equipment for home enteral/parenteral nutrition and IV services will be authorized as either purchase or based on length of need and medical appropriateness.

(5) All rental or purchase of equipment, full services warranty, pickup, delivery, set-up, fitting and adjustments are included in the reimbursement. Individual consideration may be given in specific circumstances upon written request to the Division.

(6) Repair of rental equipment is the responsibility of the provider.

(7) The Division will not make payment for rental of pumps that are supplied by any manufacturer at no cost to the provider.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 20-1991, f. & cert. ef. 4-16-91; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0700; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 64-2004, f. 9-10-04, cert. ef. 10-1-04

410-148-0095
Client Copayments

Copayments may be required for non-American Indian/Alaska Native clients for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: OMAP 91-2002, f. 12-24-02, cert. ef. 1-1-03

410-148-0100
Reimbursement

(1) Drug ingredients (medications) shall be reimbursed as defined in the Division of Medical Assistance Programs (Division) Pharmaceutical Services administrative rules (chapter 410, division 121).

(2) The following service/goods will be reimbursed on a fee-for-service basis according to the Division EPIV Fee Schedule found in the Home Enteral/Parenteral Nutrition and IV Services on the Division website:

(a) Enteral formula;

(b) Oral nutritional supplements which are medically appropriate and meet the criteria specified in 410-148-0260;

(c) Parenteral nutrition solutions;

(3) Reimbursement for services will be based on the lesser of the amount billed, or the Division maximum allowable rate. When the service is covered by Medicare, reimbursement will be based on the lesser of the amount billed, Medicare's allowed amount, or the Division maximum allowable rate.

(4) Reimbursement for supplies that require authorization or services/supplies that are listed as Not Otherwise Classified (NOC) or By Report (BR) must be billed to the Division at the providers' acquisition cost, and will be reimbursed at such rate.

(a) For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item. Submit documentation identifying acquisition cost with your authorization request;

(b) Per diem, as it relates to reimbursement, represents each day that a given patient is provided access to a prescribed therapy. This definition is valid for per diem therapies of up to and including every 72 hours.

(c) Per diem reimbursement includes, but is not limited to:

(A) Professional pharmacy services:

(i) Initial and ongoing assessment/clinical monitoring;

(ii) Coordination with medical professionals, family and other caregivers;

(iii) Sterile procedures, including IV admixtures, clean room upkeep and all biomedical procedures necessary for a safe environment;

(iv) Compounding of medication/medication set-up.

(B) Infusion therapy related supplies:

(i) Durable, reusable or elastomeric disposable infusion pumps;

(ii) All infusion or other administration devices;

(iii) Short peripheral vascular access devices;

(iv) Needles, gauze, sterile tubing, catheters, dressing kits, and other supplies necessary for the safe and effective administration of infusion therapy.

(C) Comprehensive, 24-hour per day, seven days per week delivery and pickup services (includes mileage).

(5) Reimbursement will not be made for the following:

(a) Central catheter insertion or transfusion of blood/blood products in the client's home;

(b) Central catheter insertion in the nursing facility;

(c) Intradialytic parenteral nutrition in the client's home or Nursing Facility;

(d) Oral infant formula that is available through the Women's, Infant and Children (WIC) program;

(e) Oral nutritional supplements that are in addition to consumption of food items or meals.

(f) Tocolytic pumps for pre-term labor management;

(g) Home enteral/parenteral nutrition or IV services outside of the client's place of residence (i.e. home, nursing facility or AIS).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0720; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 64-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 23-2009, f. 6-12-09, cert. ef. 7-1-09

410-148-0120
Reimbursement Limitations for Clients in a Nursing Facility

(1) The Division of Medical Assistance Programs (Division) will not reimburse for the following services/supplies for clients residing in a nursing facility:

(a) Nursing service visits (including assessment visit). Refer to Aging and People with Disabilities (APD) administrative rule covering all-inclusive rate;

(b) Supplies and items covered in the nursing facility All-inclusive rate. Refer to the Supplemental Information section of the Home Enteral/Parenteral Nutrition and IV Services provider website (http://www.oregon.gov/oha/healthplan/pages/home-epiv.aspx) for a listing of those supplies and items;

(c) Oral nutritional supplements that are in addition to consumption of food items or meals.

(2) The Division will reimburse for the following:

(a) Oral nutritional supplements are covered by the Division for nursing facility clients when medically appropriate, i.e., the client cannot consume food items or meals;

(b) Tube fed enteral nutrition formula, when medically appropriate;

(c) Patient controlled pump for pain control medication (CADD).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 26-1993, f. & cert. ef. 10-1-93; HR 34-1993(Temp), f. & cert. ef. 12-1-93; HR 11-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0730; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0140
Billing Information

(1) For medications:

(a) Pharmacies billing electronically bill through the Division of Medical Assistance Program (Division) pharmacy benefit manager, point of sale. For more information on point of sale, contact the Division's pharmacy benefit manager's help desk;

(b) Only those pharmacies and Home Enteral/Parenteral Nutrition and IV (EPIV) providers billing manually for medications and home IV drug ingredients that are not billed through point of sale may use the CMS 1500 claim form or the 837P electronic claim form (instructions in home enteral/parenteral and IV services supplemental guide;

(c) Providers who bill by paper are required to complete a CMS 1500 claim form.

(2) For home enteral/parenteral and IV services other than medications:

(a) Providers must use the CMS 1500 form to bill for home enteral/parenteral nutrition and IV services identified with a five-digit Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT). Use the billing instructions found in the Home Enteral/Parenteral Nutrition and IV Services supplemental materials;

(b) See OAR 410-148-0160 for billing clients with Medicare coverage.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 9-1992, f. & cert. ef. 4-1-92; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0740; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; DMAP 26-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 23-2009, f. 6-12-09, cert. ef. 7-1-09

410-148-0160
Billing for Clients Who Have Both Medicare and Basic Health Care Coverage

(1) The Division of Medical Assistance Programs (Division) may be billed directly for services provided to a client when the provider has established and clearly documented in the client's record that the service provided does not qualify for Medicare reimbursement.

(2) When the service qualifies for Medicare reimbursement, bill as follows:

(a) When billing for home enteral/parenteral nutrition services:

(A) Bill in the usual manner to the local or designated Medicare Intermediary;

(B) After Medicare makes a payment determination, bill the Division on the DMAP 505 form following the billing instructions and using the procedure codes listed for the Home Enteral/Parenteral Nutrition and IV Services in the fee schedule and supplemental materials;

(b) When billing for Home EPIV services:

(A) Bill the local Medicare Intermediary in the usual manner;

(B) After Medicare makes payment determination, bill the Division following the billing instructions and using the procedure codes listed for the Home EPIV Services fee schedule and supplemental materials.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 9-1992, f. & cert. ef. 4-1-92; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0750; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03

410-148-0260
Home Enteral Nutrition

(1) Codes that have "PA" indicated require prior authorization. Codes with BR indicated are covered by report.

(2) Enteral nutrition formula. Use B4150 through B4156 when billing for tube fed nutritional formulae. If the product dispensed is not shown in Healthcare Common Procedure Coding System (HCPCS) description, select a category equivalent when billing the Division of Medical Assistance Programs (Division).

(3) Oral nutritional supplements:

(a) Prior authorization is required on all oral nutritional supplements;

(b) Oral nutritional supplements can be billed through the online point of sale pharmacy system, or by paper using the CMS 1500 claim form or the electronic 837P claim form. Use the product's National Drug Code (NDC) and Healthcare Common Procedure Coding System (HCPC) code when billing the CMS 1500 or electronic 837P claim form;

(c) If the product dispensed is not shown in one of the listed categories, select a category that is equivalent when billing the Division;

(d) Oral nutritional supplements may be approved when the following criteria has been met:

(A) Clients age 6 and above:

(i) Must have a nutritional deficiency identified by one of the following:

(I) Recent low serum protein levels; or

(II) Recent registered dietician assessment shows sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods;

(ii) The clinical exception to the requirements of (I) and (II) must meet the following:

(I) Prolonged history (i.e. years) of malnutrition, and diagnosis or symptoms of cachexia, and

(II) Client residence in home, nursing facility, or chronic home care facility, and

(III) Where (I) and (II) would be futile and invasive

(iii) Must have a recent unplanned weight loss of at least 10%, plus one of the following:

(I) Increased metabolic need resulting from severe trauma; or

(II) Malabsorption difficulties (e.g., short-gut syndrome, fistula, cystic fibrosis, renal dialysis); or

(III) Ongoing cancer treatment, advanced Acquired Immune Deficiency Syndrome (AIDS) or pulmonary insufficiency.

(iv) Weight loss criteria may be waived if body weight is being maintained by supplements due to patient's medical condition (e.g., renal failure, AIDS)

(B) Clients under age 6:

(i) Diagnosis of 'failure to thrive;

(ii) Must meet same criteria as above, with the exception of % of weight loss.

(4) Enteral nutrition equipment:

(a) All repair and maintenance is subject to rule 410-1480-0080;

(b) Procedure codes:

(A) S5036, Repair of infusion device (each 15 minutes = 1 unit) — PA;

(B) B9998, Enteral nutrition infusion pump replacement parts will be reimbursed at provider's acquisition cost (including shipping and handling);

(C) B9000, Enteral nutrition infusion pump, without alarm — rental (1 month = 1 unit) — PA;

(D) B9002, Enteral nutrition infusion pump, with alarm — rental (1 month = 1 unit) — PA;

(E) E0776, IV pole — purchase;

(F) E0776, modifier RR, IV pole — rental (1 day = 1 unit);

(G) S9342, Enteral nutrition via pump (1 day = 1 unit) — PA.

(5) Home infusion therapy:

(a) S9325, Home infusion, pain management (do not use with code S9326, S9327 or S9328) — PA

(b) S9326, Home infusion, continuous pain management — PA;

(c) S9327, Home infusion, intermittent pain management — PA;

(d) S9328, Home infusion, implanted pump pain management — PA.

(6) Not Otherwise Classified (NOC):

(a) B9998, NOC for enteral supplies;

(b) S9379, Home infusion therapy, NOC — PA/BR.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0840; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 52-2006, f. 12-28-06 cert. ef. 1-1-07; DMAP 23-2009, f. 6-12-09, cert. ef. 7-1-09

410-148-0280

Home Parenteral Nutrition

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Standard Total Parenteral Nutrition (TPN):

(a) Bill using Healthcare Common Procedure Coding System (HCPCS) codes S9365 through S9368;

(b) Home infusion for stand TPN includes the following drugs and products in the per diem rate:

(A) Non-specialty amino acids (e.g., aminosyn, freeamine, travasol)

(B) Concentrated dextrose (e.g., D10, D20, D40, D50, D60, D70)

(C) Sterile water;

(D) Electrolytes (e.g., CaC12, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4);

(E) Standard multi-trace elements (e.g., MTE4, MTE5, MTE7);

(F) Standard multi-vitamin solutions (e.g., MVI-13).

(c) The following items are not included in the per diem and should be billed separately:

(A) Specialty amino acids for renal failure, hepatic failure or for high stress conditions (e.g., aminess, aminosyn-RF, nephramine, RenAmin, HepatAmine, Aminosyn-HBC, BranchAmin, FreeAmine HBC, Trophamine);

(B) Specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted patients (e.g., Aminosyn 15%, Novamine 15%, Clinisol 15%);

(C) Lipids

(D) Added trace elements, vitamins not from standard multi-trace element or multivitamin solution;

(E) Products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran).

(2) Parenteral Nutrition Solutions:

(a) Bill using HCPCS codes B4164 through B5200. See HCPCS book for description.

(b) Note: Reimbursement for compounding, admixture and administrative fees is included in the unit price.

(3) Parenteral Supply Kits/Supplies — Procedure Codes

(4) Parenteral Nutrition Equipment — Procedure Codes — Table 0280-1.

(5) Not Otherwise Classified (NOC) — B9999, NOC For Parenteral Supplies — PA/BR.

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0860; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0300

Other Home IV and Enteral/ Parenteral Administration Services

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Catheter Care Kits. All catheter care kit allowable amounts are determined on a per diem basis (1 day = 1 unit):

(a) When performed as a stand alone therapy, or during days not covered under per diem by another therapy, bill using catheter care codes S5497 through S5521;

(b) The following supplies for non-routine catheter procedures may be billed separately from per diem reimbursement:

(A) S5517 Catheter declotting supply kit, 1 day = 1 unit;

(B) S5518 Catheter repair supply kit, 1 day = 1 unit;

(C) S5520 PICC insertion supply kit, 1 day = 1 unit;

(D) S5521 Midline insertion supply kit, 1 day = 1 unit.

(E) E0776 IV Pole — Purchase.

(F) E0776 with modifier RR IV Pole — Rental, 1 day = 1 unit

(3) Home Nursing Visits:

(a) When enteral/parenteral services are performed in the home, only a single provider of skilled home health nursing services may obtain authorization and/or bill for such services for the same dates of service;

(b) Requests made by providers for any intravenous or enteral/parenteral related skilled nursing services, either solely or in combination with any other skilled nursing services in the home are to be reviewed for prior authorization by the Division of Medical Assistance Programs (Division) Medical Unit;

(c) Procedure Codes:

(A) 99601, Home infusion/specialty drug administration, per visit (up to 2 hours). Modifier SS is used to indicate — Home infusion services provided in the infusion suite of the IV therapy provider — 1 visit = 1 unit — PA;

(B) 99602, each additional hour. List separately in addition to code for primary procedure). Modifier SS is used to indicate — Home infusion services provided in the infusion suite of the IV therapy provider. Use 99602 in conjunction with 99601 — PA;

(C) T1001, Home Nursing Visit for Assessment — 1 visit = 1 Unit.

(4) Not Otherwise Classified (NOC) — S9379, NOC for Home IV Supplies — PA/BR.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 46-1990, f. & cert. ef. 12-28-90; HR 26-1993, f. & cert. ef. 10-1-93; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0880; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07

410-148-0320
Billing Quantities, Metric Quantities and Package Sizes

(1) Use the following metric conversions when billing;

(a) Fluid Ounce — 30 ml;

(b) Pint — 480 ml;

(c) Quart — 960 ml;

(d) Gallon — 3,840 ml;

(e) Ounce (solids) — 30 gm;

(f) Pound (solids) — 454 gm.

(2) Use the following units when billing products:

(a) Solid substances (e.g., powders, creams, ointments, etc.), bill per gram;

(b) Solid substances that are reconstituted with a liquid (e.g., dry powder ampules and vials) such as antibiotic vials or piggybacks must be billed in metric quantity of one each;

(c) Tablets, capsules, suppositories, lozenges, packets bill per each unit. Oral contraceptives are to be billed per each table;

(d) Diagnostic supplies (e.g., chemstrips, clinitest tabs), bill per each unit;

(e) Injectables that are prepackaged syringe (e.g., tubex, carpujects), bill per ml;

(f) Medical Supplies (e.g., Testape, Cordran tape) bill in metric quantity of one each;

(g) Prepackaged medications and unit doses must be billed per unit (tablet or capsule). Unit dose liquids are to be billed by ml;

(h) Fractional ml liquid doses (e.g., flu vaccine, pneumovax, etc.) use unique codes and bill per each dose;

(i) Fractional units: If no unique codes are available, round quantity up to the next whole unit (e.g., 3.5 gm to 4.0 gm; 7.2 ml up to 8 ml).

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0900

DIVISION 150

ADMINISTRATIVE EXAMINATION AND BILLING SERVICES

410-150-0040
Request Requirements

(1) "Administrative Medical Examinations and Reports" is defined in Oregon Administrative Rule (OAR) 410-120-0000.

(2) A completed DMAP 729 Administrative Medical Examination/Report Authorization is authorization for the provider to furnish services.

(3) Only an employee of the Department of Human Services (Department), or Oregon Youth Authority (OYA) or the Division of Medical Assistance (Division) may request an administrative medical examination or report. Department, OYA and Division employees must request administrative medical examinations and reports in compliance with the policies outlined in the Division worker guide located at http://www.oregon.gov/oha/healthplan/tools/DMAP%20Worker%20Guide.pdf.

(4) Claims may only be submitted by a Division-enrolled provider who:

(a) Is contracted with the Department, OYA or the Division to provide Administrative Medical Examinations and Reports;

(b) Meets acceptable source criteria for the agency making the request; and

(c) Has received a completed DMAP 729 form.

(5) Providers may only perform the services included on the DMAP 729 as requested by a Department, OYA or Division employee. Providers must:

(a) Follow the instructions for all forms received in the DMAP 729 series, and

(b) Keep a copy of the DMAP 729 for seven years.

[ED. NOTE: Forms referenced rule are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; DMAP 46-2012, f. 10-11-12, cert. ef. 10-15-12

DIVISION 160

LAW ENFORCEMENT LIABILITY ACCOUNT (LEMLA)

410-160-0000
Definitions

For the purposes of OAR 410-160-0000 through 410-160-0100, the following definitions shall apply:

(1) LEMLA means the Law Enforcement Medical Liability Account.

(2) LEMLA Patient means a person who has suffered injuries related to law enforcement activity.

(3) Injuries Related to Law Enforcement Activity means injuries sustained prior to booking, citation in lieu of arrest or release instead of booking that occur during and as a result of efforts by a law enforcement officer to restrain or detain, or to take or retain custody of, the individual. Whether injuries related to law enforcement activity have occurred shall be determined by the law enforcement agency.

(4) Release Date means the date the LEMLA patient was released from actual physical custody, as determined by the law enforcement agency.

(5) Cost of Such Services means "usual charge" as defined in OAR 410-120-0000.

(6) Hospital means a hospital as defined in OAR 410-120-0000.

(7) Overpayment means payment made by LEMLA to a claimant in excess of the amount due for the covered services and items billed.

(8) Claimant means a Medicaid provider.

(9) Medicaid Provider means a provider who has been issued a provider number by the Division and is not currently subject to sanction by the Division.

(10) Prior Payment Amount means the total of all payments received by the claimant from all other sources, including the LEMLA patient, prior to submitting a LEMLA claim.

(11) LEMLA Claim Amount means the total cost of such services provided to a LEMLA patient that are directly connected to injuries related to law enforcement activity. It shall not include any charges for services provided to a LEMLA patient for a preexisting disease or condition, or services that are unrelated to the "injuries related to law enforcement activities."

Stat. Auth.: ORS 413-042, ORS 414.065
Stats. Implemented: ORS 414.805 — ORS 414.815
Hist.: AFS 1-1992, f. 1-14-92, cert. ef. 2-1-92; AFS 6-1992, f. & cert. ef. 3-9-92; AFS 24-1993, f. 10-27-93, cert. ef. 11-1-93; AFS 10-2002, f. & cert. ef. 7-1-02; Renumbered from 461-012-0100, DMAP 9-2011, f. 6-6-11, cert. ef. 7-1-11

410-160-0100
Process and Procedure

(1) The purpose of the Law Enforcement Medical Liability Account (LEMLA) is to provide a fund to reimburse a claimant for emergency medical services provided to a LEMLA patient.

(2) The time limit for submitting claims to LEMLA is one year after the date of injury. If a claimant has been paid by a LEMLA patient's insurer or health care contractor and the LEMLA patient's insurer or health care contractor subsequently demands return of the payment, a claimant must bill LEMLA not later than 180 days from the date of the demand letter or one year from the date of injury, whichever is later.

(3) The Division shall process all claims received in accordance with the following procedures:

(a) The claim shall be date stamped on the date received by LEMLA;

(b) The Division shall review each claim submitted to verify that the claim contains all of the following required information:

(A) The LEMLA claim form, with the following information:

(i) Certification by an authorized representative of the law enforcement agency involved with an injury that the injury is related to law enforcement activity;

(ii) The release date, if any, as determined by the law enforcement agency. If the LEMLA patient has not yet been released, state that on the LEMLA claim form;

(iii) LEMLA patient's name;

(iv) Prior payment amount;

(v) Date of injury;

(vi) Claimant's Medicaid provider number;

(vii) Claimant's name;

(viii) LEMLA claim amount;

(ix) Cause or nature of injury.

(B) Attached to the LEMLA form, the following information:

(i) Documentation that demonstrates the claimant has billed the LEMLA patient or the LEMLA patient's insurer or health care contractor for the charges or expenses owed to the claimant and that the claimant has made a reasonable effort to collect from the LEMLA patient or the LEMLA patient's insurer or health care contractor;

(ii) A copy of the hospital or provider billing document that shows the usual charge and date of service.

(c) The Division shall reject claims that do not contain all of the information required in subsection (3)(b) of this rule;

(d) The Division shall review the documentation of reasonable collection effort. If 45 days have not elapsed since the claimant billed the LEMLA patient or the LEMLA patient's insurer or health care contractor, the claim may be rejected;

(e) The Division shall review the date of injury. If the date stamped on the claim under subsection (3)(a) of this rule is more than one year after the date of injury, the claim shall be rejected. The one-year time limit may not apply if the provisions of section (2) of this rule apply with regards to an insurer or health care contractor demanding repayment of a previously paid claim.

(4) Using the LEMLA claim amount, the Division shall pay claimants, subject to any adjustment made under section (5) of this rule, according to the following:

(a) For hospitals, by the current "Hospital Fee Schedule-Adjusted Cost/Charge Ratios for Oregon Hospitals," established by the Director of the Department of Consumer and Business Services;

(b) For all Medicaid providers except hospitals, the Division shall pay 75 percent of the LEMLA claim amount.

(5) After determining the amount under section (4) of this rule, the Division shall add the amount received in section (6) of this rule. If the total is more than the usual charge, the Division shall reduce the amount of its payment by the amount in excess of the usual charge.

(6) The claimant is responsible for making reasonable effort to collect from the LEMLA patient or the LEMLA patient's insurer or health care contractor. Claimants are required to report all collections made when a claimant submits a claim to the Division for payment.

(7) If the Division has paid a claimant and the claimant subsequently receives payment from any other source, the claimant is required to repay the Division the amount received, minus the difference between the usual amount billed and the amount the Division paid. This means claimants are entitled to reimburse themselves for the amount the Division did not pay, with the excess due to the Division as repayment of an overpayment. The repayment is due and payable by check to the Division within 30 days after the claimant has received the funds from the other source.

(8) The Division shall continue to pay for medical services for injuries related to law enforcement activities while the LEMLA patient is incarcerated. Upon release of the LEMLA patient from physical custody, the Division shall no longer pay for further medical expenses incurred. If the LEMLA patient is cited in lieu of arrest or released instead of booked, the Division shall no longer pay for further medical expenses upon discharge or release from the hospital or other medical facility.

(9) The Division shall pay all accepted claims to the extent that the Division has sufficient funds available, subject to the maximum limit for payment of expenses authorized by law. The Division shall monitor the expenses and if the Division determines that the authorized limit may be exceeded, or that insufficient funds are available, the Division shall take the following actions:

(a) The Division shall continue to accept claims and date stamp them in the order the claims are received. The Division shall then suspend further processing of the claim;

(b) The Division shall notify each claimant that the claim has been suspended and the reason for the action;

(c) The Division shall maintain a file of suspended claims and await further legislative direction regarding the disposition of the claims.

Stat. Auth.: ORS 413.042, ORS 414.065

Stats. Implemented: ORS 414.805 — ORS 414.815

Hist.: AFS 1-1992, f. 1-14-92, cert. ef. 2-1-92; AFS 6-1992, f. & cert. ef. 3-9-92; AFS 24-1993, f. 10-27-93, cert. ef. 11-1-93; AFS 18-1995, f. & cert. ef. 8-1-95; AFS 10-2002, f. & cert. ef. 7-1-02; Renumbered from 461-012-0150, DMAP 9-2011, f. 6-6-11, cert. ef. 7-1-11

DIVISION 165

OREGON MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

410-165-0000
Basis and Purpose

(1) These rules (OAR chapter 410, division 165) govern the Oregon Health Authority (Authority), Health Systems Division, Medical Assistance Programs (Division), Medicaid Electronic Health Record (EHR) Incentive Program. The Medicaid EHR Incentive Program provides incentive payments consistent with federal law concerning such payments to eligible providers participating in the Medicaid program who adopt, implement, upgrade, or successfully demonstrate meaningful use of certified EHR technology and who are qualified by the program.

(2) The Medicaid EHR Incentive Program is implemented pursuant to:

(a) The American Reinvestment and Recovery Act of 2009, Pub. L. No. 111-5, section 4201;

(b) The Centers for Medicare and Medicaid Services (CMS) federal regulation 42 CFR Part 495 (2010, 2012, 2014, and 2015) pursuant to the Social Security Act sections 1903(a)(3)(F) and 1903(t);

(c) The Division's General Rules program, OAR chapter 410, division 120;

(d) The Authority's Provider Rules, OAR chapter 943, division 120.

(3) The following retroactive effective dates apply to these rules:

(a) For all sections in these rules that refer to CMS federal regulation 42 CFR Part 495 (2015), the effective date is December 15, 2015;

(b) For all sections and references in these rules that refer to CMS federal regulation 42 CFR Part 495 (2014), the effective date is October 1, 2014;

(c) For eligible hospitals, except for sections and references in these rules applicable under section (3)(a) or (b) above, the effective date is October 1, 2013, which is also the start date for program year 2014;

(d) For eligible professionals, except for sections and references in these rules applicable under section (3)(a) or (b) above, the effective date is January 1, 2014, which is also the start date for program year 2014.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042 & 414.033
Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 2-2015(Temp), f. 1-30-15, cert. ef. 2-3-15 thru 8-1-15; DMAP 20-2015, f. & cert. ef. 4-8-15; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0020
Definitions

The following definitions apply to OAR 410-165-0010 through 410-165-0140:

(1) "Acceptance documents" means written evidence supplied by a provider demonstrating that the provider met Medicaid EHR Incentive Program eligibility criteria or participation requirements according to standards specified by the Division.

(2) "Acute care hospital" means a healthcare facility including, but not limited to, a critical access hospital with a Centers for Medicare and Medicaid Services' (CMS) certification number (CCN) that ends in 0001-0879 or 1300-1399 and where the average length of patient stay is 25 days or fewer.

(3) "Adopt, implement, or upgrade" means:

(a) Acquire, purchase, or secure access to certified EHR technology capable of meeting meaningful use requirements;

(b) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or

(c) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training or upgrade from existing EHR technology to certified EHR technology.

(4) "Attestation" means a statement that:

(a) Is made by an eligible provider or preparer during the application process;

(b) Represents that the eligible provider met the thresholds and requirements of the Medicaid EHR Incentive Program; and

(c) Is made under penalty of prosecution for falsification or concealment of a material fact.

(5) "Certified EHR technology" has the meaning given that term in 42 CFR 495.302 (2010, 2012, and 2014), 42 CFR 495.4 (2010, 2012, and 2015), 42 CFR 495.6 (2014), 42 CFR 495.20 (2015), and 45 CFR 170.102 (2010, 2011, 2012, 2014, and 2015).

(6) "Children's hospital" means a separately certified hospital, either freestanding or a hospital within a hospital that predominantly treats individuals under 21 years of age and that:

(a) Has a CCN that ends in 3300–3399; or

(b) Does not have a CCN but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program as a children's hospital.

(7) "Dentist" has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.100.

(8) "Eligible hospital" means an acute care hospital with at least 10 percent Medicaid patient volume or a children's hospital.

(9) "Eligible professional" means a professional who:

(a) Is a physician, dentist, nurse practitioner, nurse-midwife nurse practitioner, or physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is so led by a physician assistant;

(b) Meets patient volume requirements described in OAR 410-165-0060; and

(c) Is not a hospital-based professional.

(10) "Eligible provider" means an eligible hospital or eligible professional.

(11) "Encounter" means:

(a) For an eligible hospital:

(A) Services rendered to an individual for inpatient discharge; or

(B) Services rendered to an individual in an emergency department on any one day.

(b) For an eligible professional, services rendered to an individual on any one day.

(12) "Enrolled provider" means a hospital or health care practitioner who is actively registered with the Authority pursuant to OAR 943-120-0320.

(13) "Entity promoting the adoption of certified EHR technology" means an entity designated by the Authority that promotes the adoption of certified EHR technology by enabling:

(a) Oversight of the business and operational and legal issues involved in the adoption and implementation of certified EHR technology; or

(b) The exchange and use of electronic clinical and administrative data between participating providers in a secure manner including, but not limited to, maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible providers.

(14) "Federal fiscal year (FFY)" means October 1 to September 30.

(15) "Federally Qualified Health Center (FQHC)" has the meaning given that term in OAR 410-120-0000.

(16) "Grace period" means a period of time or specified date following the end of a program year when an eligible provider may submit an application to the Medicaid EHR Incentive Program for that program year.

(17) "Hospital-based professional" means a professional who furnishes 90 percent or more of Medicaid-covered services in a hospital emergency room (place of service code 23) or inpatient hospital (place of service code 21) in the calendar year (CY) preceding the program year, but does not include a professional practicing predominantly at a FQHC or RHC.

(18) "Individuals receiving Medicaid" means individuals served by an eligible provider where the services rendered would qualify under the Medicaid encounter definition.

(19) "Meaningful EHR user" means an eligible provider that meets the criteria set forth in OAR 410-165-0080.

(20) "Medicaid encounter" means:

(a) For an eligible hospital applying for program year 2011 or 2012:

(A) Services rendered to an individual per inpatient discharge where Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid for part or all of the service; or Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid all or part of the individual's premiums, copayments, or cost-sharing; or

(B) Services rendered in an emergency department on any one day where Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid for part or all of the service; or Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid all or part of the individual's premiums, copayments, and cost-sharing.

(b) For an eligible hospital applying for program year 2013 or later, either:

(A) Services rendered to an individual per inpatient discharge where the individual was enrolled in Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children's Health Insurance Program (CHIP) if part of a state's Medicaid expansion (does not apply to Oregon's as it is designated as a separate CHIP state) at the time the billable service was provided; or

(B) Services rendered in an emergency department on any one day where the individual was enrolled in Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children's Health Insurance Program (CHIP) if part of a state's Medicaid expansion (does not apply to Oregon's as it is designated as a separate CHIP state) at the time the billable service was provided.

(c) For an eligible professional applying for program year 2011 or 2012, either:

(A) Services rendered to an individual on any one day where Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid for part or all of the service; or

(B) Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid all or part of the individual's premiums, copayments, and cost-sharing.

(d) For an eligible professional applying for program year 2013 or later, services rendered to an individual on any one day where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children's Health Insurance Program (CHIP) if part of a state's Medicaid expansion (does not apply to Oregon's as it is designated as a separate CHIP state) at the time the billable service was provided.

(21) "National Provider Identifier" has the meaning given that term in 45 CFR Part 160 and OAR 410-120-0000.

(22) "Needy individual" means individuals served by an eligible professional where the services rendered qualify under the needy individual encounter definition.

(23) "Needy individual encounter" means:

(a) For an eligible professional applying for program year 2011 or 2012, services rendered to an individual on any one day where:

(A) Medicaid or CHIP or a Medicaid or CHIP demonstration project approved under the Social Security Act section 1115 paid for part or all of the service;

(B) Medicaid or CHIP or a Medicaid or CHIP demonstration project approved under the Social Security Act section 1115 paid all or part of the individual's premiums, copayments, or cost-sharing;

(C) The services were furnished at no cost and calculated consistent with 42 CFR 495.310(h) (2010); or

(D) The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

(b) For an eligible professional applying for program year 2013 or later, services rendered to an individual on any one day where:

(A) The services were rendered to an individual enrolled in a Medicaid program or a Medicaid demonstration project approved under the Social Security Act section 1115 or CHIP at the time the billable service was provided;

(B) The services were furnished at no cost and calculated consistently with 42 CFR 495.310(h) (2010); or

(C) The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

(24) "Nurse practitioner" has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.166.

(25) "Panel" means a managed care panel, medical or health home program panel, or similar provider structure with capitation or case assignment that assigns patients to providers.

(26) "Patient volume" means:

(a) For eligible hospitals, the proportion of Medicaid encounters to total encounters expressed as a percentage;

(b) For eligible professionals who do not meet the definition of "practices predominantly," the proportion of Medicaid encounters to total encounters expressed as a percentage;

(c) For eligible professionals who meet the definition of "practices predominantly," the proportion of needy individual encounters to total encounters expressed as a percentage.

(27) "Pediatrician" means a physician who predominantly treats individuals under the age of 21.

(28) "Physician" has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.50.

(29) "Physician assistant" has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.60.

(30) "Practices predominantly" means an eligibility criterion to permit use of needy individual patient volume. An eligible professional practices predominantly if:

(a) For program year 2011 or 2012, more than 50 percent of an eligible professional's total patient encounters over a period of six months in the calendar year preceding the program year occur at an FQHC or RHC;

(b) For program year 2013 and later, more than 50 percent of an eligible professional's total patient encounters occur at an FQHC or RHC:

(A) During a six-month period in the calendar year preceding the program year; or

(B) During a six-month period in the most recent 12 months prior to attestation.

(31) "Preparer" means an individual authorized by an eligible provider to act on behalf of the provider to complete an application for a Medicaid EHR incentive via an electronic media connection with the Authority.

(32) "Program" means the Medicaid EHR Incentive Program.

(33) "Program year" means:

(a) The CY for an eligible professional;

(b) For an eligible hospital:

(A) The federal fiscal year for program years 2011 through 2014 and for program 2015 if the attestation date is before December 15, 2015;

(B) The CY for program year 2015 and later if the attestation date is on or after December 15, 2015.

(34) "Provider Web Portal" means the Authority's website that provides a secure gateway for eligible providers or preparers to apply for the Program.

(35) "Qualify" means to meet the eligibility criteria and participation requirements to receive a payment for the program year. The Program makes the determination as to whether an eligible provider qualifies.

(36) "Rural Health Clinic (RHC)" means a clinic located in a rural and medically underserved community designated as an RHC by CMS. Payment by Medicare and Medicaid to an RHC is on a cost-related basis for outpatient physician and certain non-physician services.

(37) "So led" means when an FQHC or RHC has a physician assistant who is:

(a) The primary provider in the clinic;

(b) A clinical or medical director at the clinical site of practice; or

(c) An owner of the RHC.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.033

Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 2-2015(Temp), f. 1-30-15, cert. ef. 2-3-15 thru 8-1-15; DMAP 20-2015, f. & cert. ef. 4-8-15; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0040
Application

(1) An eligible provider shall apply to the Program each program year that the eligible provider seeks an incentive payment. To apply, an eligible provider or preparer shall:

(a) Register with CMS;

(b) After registering with CMS, apply to the Program within the grace period for each program year:

(A) For program years 2011 and 2012, the following applies:

(i) For a first year application, the grace period is 60 days;

(ii) For all subsequent years, the grace period is 90 days.

(B) For program year 2013, the grace period is 90 days;

(C) For program year 2014, the following applies:

(i) For eligible hospitals, the grace period ends on January 31, 2015;

(ii) For eligible professionals, the grace period ends on May 31, 2015.

(D) For program year 2015 and later, the following applies:

(i) For eligible providers who are attesting for adopt, implement, or upgrade defined in section (3), the grace period ends on March 31, 2016;

(ii) For eligible hospitals that are attesting for meaningful use through CMS for the Medicare EHR Incentive Program and for the

Medicaid EHR Incentive Program, the grace period ends on March 31, 2016;

(iii) For eligible professionals who are attesting for meaningful use described in OAR 410-165-0080, the grace period ends on August 31, 2016;

(iv) For eligible hospitals that are children's hospitals defined in OAR 410-165-0020 that are attesting for meaningful use described in OAR 410-165-0080 through the Medicaid EHR Program, the grace period ends on December 31, 2016.

(E) For program year 2016 and later, the grace period is 90 days.

(c) Attest that:

(A) The information submitted is true, accurate, and complete; and

(B) They understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(d) Maintain for a minimum of seven years from the date of completed application complete, accurate, and unaltered copies of all acceptance documents associated with all data transmissions and attestations. The information maintained shall include at a minimum documentation to support:

(A) The financial or legal obligation for the adoption, implementation, or upgrade of certified EHR technology including, but not limited to, the purchase agreement or contract;

(B) Demonstration of meaningful use for the year corresponding to the program year;

(C) Patient volume for the year corresponding to the program year; and

(D) The eligible hospital's payment calculation data including, but not limited to, Medicare cost reports.

(2) An eligible provider shall submit the acceptance documents referred to in section (1)(d)(A) when the eligible provider is attesting for a payment for the adoption, implementation, or upgrade to certified EHR technology or when new certified EHR technology is acquired. If the eligible provider is an eligible hospital seeking its first year payment, it shall submit the acceptance documents referred to in section (1)(d)(D).

(3) The Program reviews the completed application and the acceptance documents to determine if the eligible provider qualifies for an incentive payment:

(a) The Program shall verify the information in the application;

(b) The Program shall determine if the eligible provider's information complies with the eligibility criteria and participation requirements;

(c) The Program shall notify the eligible provider about the incentive payment determination;

(d) The Authority may reduce the incentive payment to pay off debt if an eligible provider or incentive payment recipient owes a debt under a collection mandate to the State of Oregon. The incentive payment is considered paid to the eligible provider even when part or all of the incentive may offset the debt. The Authority may not reduce the incentive payment amount for any other purpose unless permitted or required by federal or state law; and

(e) The Authority shall distribute 1099 forms to the tax identification number designated to receive the Medicaid EHR incentive payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS, 413.042 & 414.033

Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; Administrative correction, 11-22-13; DMAP 2-2015(Temp), f. 1-30-15, cert. ef. 2-3-15 thru 8-1-15; DMAP 20-2015, f. & cert. ef. 4-8-15; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0060
Eligibility

(1) There are three categories of eligibility criteria:

(a) Eligible professionals;

(b) Eligible professionals practicing predominately in a FQHC or RHC; and

(c) Eligible hospitals.

(2) To be eligible for a Medicaid EHR incentive payment for the program year, an eligible professional as listed in Table 165-0060-1 shall meet the Program criteria each year:

(a) To be eligible for an incentive payment, an eligible professional shall at a minimum:

(A) Meet and follow the scope of practice regulations as applicable for each profession as defined in 42 CFR Part 440;

(B) Meet the following certified EHR technology and meaningful use requirements for the corresponding year of participation:

(i) First year of participation:

(I) Adopt, implement, or upgrade certified EHR technology; or

(II) Meet the definition of a Meaningful EHR user described in OAR 410-165-0020.

(ii) Subsequent years of participation, meet the definition of a Meaningful EHR user described in OAR 410-165-0020.

(C) Either not be a hospital-based professional or for program year 2013 or later meet the requirements that allow a reversal of a hospital-based determination. To be considered non-hospital-based in future program years after an initial reversal determination, the professional shall attest in each subsequent program year that the professional continues to meet the requirements. To meet the requirements, the professional shall do all of the following:

(i) Fund the acquisition, implementation, and maintenance of certified EHR technology, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital and use such certified EHR technology in the inpatient or emergency department of a hospital;

(ii) Provide documentation to the Program for review and approval for the program year and in accordance with OAR 410-165-0040;

(iii) Meet all applicable requirements to receive an incentive payment; and

(iv) If attesting to meaningful use, demonstrate using all encounters at all locations equipped with certified EHR technology, including those in the inpatient and emergency departments of the hospital.

(D) Meet one of the following criteria:

(i) Have a minimum of 30 percent patient volume attributable to individuals receiving Medicaid; or

(ii) Be a pediatrician who has a minimum of 20 percent patient volume attributable to individuals receiving Medicaid.

(b) An eligible professional shall calculate patient volume as listed in Table 165-0060-2 by using the patient volume calculation method either of patient encounter or of patient panel. The patient panel volume calculation method may be used only when all of the following apply:

(A) The patient panel is appropriate as a patient volume calculation method for the eligible professional; and

(B) There is an auditable data source to support the patient panel data.

(c) An eligible professional shall calculate patient volume as listed in Table 165-0060-2 by using either the patient volume of the eligible professional or the patient volume of the group. The patient volume of the group may be used only when all of the following apply:

(A) The group's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

(B) There is an auditable data source to support the group's patient volume determination;

(C) All eligible professionals in the group must use the same patient volume calculation method for the program year;

(D) The group uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and

(E) If an eligible professional works inside and outside of the group, then the patient volume calculation includes only those encounters associated with the group and not the eligible professional's outside encounters.

(d) An eligible professional's patient volume must be calculated using one of the following methods:

(A) The patient encounter calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional shall divide the total Medicaid encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period in the preceding calendar year; or

(ii) For program year 2013 and later, the eligible professional shall divide the total Medicaid encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period either in the preceding calendar year or in the twelve-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(B) The patient encounter calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall divide the group's total Medicaid encounters by the group's total patient encounters in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, the eligible professional shall divide the group's total Medicaid encounters by the group's total patient encounters in any representative, continuous 90-day period either in the preceding calendar year or in the twelve-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(C) The patient panel calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the eligible professional's panel in any representative, 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the eligible professional's unduplicated Medicaid encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in section (1)(d)(C)(i)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the eligible professional's panel in any representative, 90-day period in either the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the eligible professional's unduplicated Medicaid encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in section (2)(d)(C)(ii)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(D) The patient panel calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the group's panel in any representative, 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the group's unduplicated Medicaid encounters in the same 90-day period; and

(II) Divide the result calculated above in section (1)(d)(D)(i)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the group's panel in any representative, 90-day period in either the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the group's unduplicated Medicaid encounters that same 90-day period;

(II) Divide the result calculated above in section (1)(d)(D)(ii)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(3) To be eligible for a Medicaid EHR incentive payment for the program year, an eligible professional practicing predominantly in an FQHC or an RHC, as listed in Table 165-0060-1, must meet the Program eligibility criteria each year by meeting either section (2) of this rule or by meeting the following FQHC and RHC specific criteria:

(a) At a minimum, the eligible professional shall:

(A) Meet and follow the scope of practice regulations as applicable for each professional as prescribed by 42 CFR Part 440;

(B) Meet the following certified EHR technology and meaningful use requirements for the corresponding year of participation:

(i) First year of participation:

(I) Adopt, implement, or upgrade certified EHR technology; or

(II) Meet the definition of a meaningful EHR user described in OAR 410-165-0020.

(ii) Subsequent years of participation, meet the definition of a meaningful EHR user described in OAR 410-165-0020.

(C) Have a minimum of 30 percent patient volume attributable to needy individuals.

(b) An eligible professional shall calculate patient volume as listed in Table 165-0060-3 by using the patient volume calculation method either of patient encounter or of patient panel. The patient panel volume calculation method may be used only when all of the following apply:

(A) The patient panel is appropriate as a patient volume calculation method for the eligible professional; and

(B) There is an auditable data source to support the patient panel data.

(c) An eligible professional must calculate patient volume as listed in Table 165-0060-3 by using either the patient volume of the eligible professional or the patient volume of the group. The group's patient volume may be used only when all of the following apply:

(A) The group's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

(B) There is an auditable data source to support the group's patient volume determination;

(C) All eligible professionals in the group shall use the same patient volume calculation method for the program year;

(D) The group uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and

(E) If an eligible professional works inside and outside of the group, the patient volume calculation includes only those encounters associated with the group and not the outside encounters.

(d) An eligible professional's needy individual patient volume shall be calculated using one of the following methods:

(A) The patient encounter calculation method based on the eligible professional's patient volume:

(i) For program year 2011 or 2012, the eligible professional shall divide the total needy individual encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, the eligible professional shall divide the total needy individual encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period either in the preceding calendar year or in the12-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(B) The patient encounter calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall divide the group's total needy individual encounters by the group's total patient encounters in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, divide the group's total needy individual encounters by the group's total patient encounters in any representative, continuous 90-day period either in the preceding calendar year or in the 12-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(C) The patient panel calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total needy individual patients assigned to the eligible professional's panel in any representative, 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the eligible professional's unduplicated needy individual encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in section (2)(d)(C)(i)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total needy individual patients assigned to the eligible professional's panel in any representative, 90-day period either in the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the eligible professional's unduplicated needy individual encounters rendered the same 90-day period;

(II) Divide the result calculated above in section (2)(d)(C)(ii)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(D) The patient panel calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total needy individual patients assigned to the group's panel in any representative, 90-day period in the prior calendar year, provided at least one needy individual encounter took place with the patient in the preceding calendar year, to the group's unduplicated Medicaid encounters in the same 90-day period; and

(II) Divide the result calculated above in section (2)(d)(D)(i)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total needy individual patients assigned to the group's panel in any representative, 90-day period either in the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one needy individual encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the group's unduplicated Medicaid encounters that same 90-day period;

(II) Divide the result calculated above in section (2)(d)(D)(ii)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(4) To be eligible for a Medicaid EHR incentive payment for the program year, an eligible hospital shall meet the Program criteria each year:

(a) To be eligible for an incentive payment, an eligible hospital shall meet the certified EHR technology and meaningful use requirements for the corresponding year of participation:

(A) First year of participation:

(i) Adopt, implement, or upgrade certified EHR technology;

(ii) Eligible hospitals that are children's hospitals shall meet the definition of a meaningful EHR user; or

(iii) Eligible hospitals that participate in both the Medicare and Medicaid EHR Incentive Programs shall demonstrate meaningful use under the Medicare EHR Incentive Program to CMS and be deemed a meaningful EHR user for the program year.

(B) Subsequent years of participation:

(i) Eligible hospitals that participate in both the Medicare and Medicaid EHR Incentive Programs shall demonstrate meaningful use under the Medicare EHR Incentive Program to CMS and be deemed a meaningful EHR user for the program year; or

(ii) Eligible hospitals that are children's hospitals shall meet the definition of a meaningful EHR user;

(b) If an eligible hospital is an acute care hospital, it shall calculate patient volume by dividing the total eligible hospital Medicaid encounters by the total encounters in any representative, continuous 90-day period:

(A) For program year 2011 and 2012, in the preceding federal fiscal year;

(B) For program year 2013 and later, either in the preceding federal fiscal year or in the 12-month timeframe preceding the attestation date. The eligible hospital may not use the same 90-day timeframe to calculate patient volume in different program years.

(5) Table 165-0060-1. [Table not included. See ED. NOTE.]

(6) Table 165-0060-2. [Table not included. See ED. NOTE.]

(7) Table 165-0060-3. [Table not included. See ED. NOTE.]

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.033

Hist.: DMAP 20-2011, f. 7-21-11, cert. ef. 7-22-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 2-2015(Temp), f. 1-30-15, cert. ef. 2-3-15 thru 8-1-15; DMAP 20-2015, f. & cert. ef. 4-8-15; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0080
Meaningful Use

(1) An eligible provider shall demonstrate being a meaningful EHR user as prescribed by 42 CFR 495.4 (2010, 2012, and 2015), 42 CFR 495.6 (2010, 2012, and 2014), 42 CFR 495.8 (2010, 2012, and 2014), 42 CFR 495.20 (2015), 42 CFR 495.22 (2015), 42 CFR 495.24 (2015), and 42 CFR 495.40 (2015):

(a) For eligible providers demonstrating meaningful use under the Program in Stage 1 prior to December 15, 2015 to comply with 42 CFR 495.8, the State of Oregon requires the eligible provider to

satisfy the objective "Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice;"

(b) For eligible hospitals:

(A) If CMS deems an eligible hospital to be a meaningful EHR user for the Medicare EHR Incentive Program for a program year, the eligible hospital is automatically deemed to be a meaningful EHR user for the Program for the same program year;

(B) An eligible hospital deemed to be a meaningful EHR user by CMS for a program year does not have to meet the requirements specified in section (1)(a) for the Program for the same program year.

(2) As prescribed by 42 CFR 495.4 (2010, 2012, and 2015), the following meaningful use EHR reporting periods shall be used by eligible providers that are demonstrating meaningful use to the Program:

(a) Program years 2011, 2012, and 2013:

(A) Eligible professionals:

(i) For the first time, either:

(I) Any continuous 90-day period in the calendar year; or

(II) The calendar year.

(ii) For a subsequent time: the calendar year.

(B) Eligible hospitals:

(i) For the first time, either:

(I) Any continuous 90-day period in the federal fiscal year; or

(II) The federal fiscal year.

(ii) For a subsequent time, the federal fiscal year.

(b) Program year 2014:

(A) Eligible professionals, either:

(i) Any continuous 90-day period in calendar year 2014; or

(ii) Any of the following 3-month periods:

(I) January 1, 2014 through March 31, 2014;

(II) April 1, 2014 through June 30, 2014;

(III) July 1, 2014 through September 30, 2014; or

(IV) October 1, 2014 through December 31, 2014.

(B) Eligible hospitals, either:

(i) Any continuous 90-day period in federal fiscal year 2014; or

(ii) Any of the following 3-month periods:

(I) October 1, 2013 through December 31, 2013;

(II) January 1, 2014 through March 31, 2014;

(III) April 1, 2014 through June 30, 2014; or

(IV) July 1, 2014 through September 30, 2014.

(c) Program year 2015, prior to December 15, 2015:

(A) Eligible professionals attesting for the first year, either:

(i) Any continuous 90-day period in the calendar year; or

(ii) The calendar year.

(B) Eligible professionals attesting for a subsequent year, the calendar year;

(C) Eligible hospitals attesting for the first year, either:

(i) Any continuous 90-day period in the federal fiscal year; or

(ii) The federal fiscal year.

(D) Eligible hospitals attesting for a subsequent year, the federal fiscal year.

(d) On or after December 15, 2015, for program year 2015, any continuous 90-day period in the calendar year;

(e) For program year 2016 and subsequent years, the following applies to eligible providers attesting for:

(A) The first year, either:

(i) Any continuous 90-day period in the calendar year; or

(ii) The calendar year.

(B) A subsequent year, the calendar year.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.033

Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 2-2015(Temp), f. 1-30-15, cert. ef. 2-3-15 thru 8-1-15; DMAP 20-2015, f. & cert. ef. 4-8-15; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0100

Participation and Incentive Payments

(1) To qualify for an incentive payment, an eligible provider shall meet the Program eligibility criteria and participation requirements for each year the eligible provider applies:

(a) An eligible provider shall meet the eligibility criteria for each program year of:

(A) Type of eligible provider;

(B) Patient volume minimum; and

(C) Certified EHR technology adoption, implementation, or upgrade requirements in the first year of participation and meaningful use requirements in subsequent years, or meaningful use requirements in all years of participation.

(b) An eligible provider must meet the participation requirements for each program year including:

(A) Be an enrolled Medicaid provider with the Division;

(B) Maintain current provider information with the Division;

(C) Possess an active professional license and comply with all licensing statutes and regulations within the state where the eligible provider practices;

(D) Have an active Provider Web Portal account;

(E) Ensure the designated payee is able to receive electronic funds transfer from the Authority; and

(F) Comply with all applicable Oregon Administrative Rules, including chapter 410, division 120, and chapter 943, division 120.

(c) An eligible professional may reassign the entire amount of the incentive payment to:

(A) The eligible professional's employer with whom the eligible professional has a contractual arrangement allowing the employer to bill and receive payments for the eligible professional's covered professional services;

(B) An entity with which the eligible professional has a contractual arrangement allowing the entity to bill and receive payments for the eligible professional's covered professional services; or

(C) An entity promoting the adoption of certified EHR technology.

(2) An eligible professional shall follow the Program participation conditions and requirements. The eligible professional shall:

(a) Receive an incentive payment from only one state for a program year;

(b) Only receive an incentive payment from either Medicare or Medicaid for a program year, but not both;

(c) Not receive more than the maximum incentive amount of $63,750 over a six-year period or the maximum incentive of $42,500 over a six-year period if the eligible professional qualifies as a pediatrician who meets the 20 percent patient volume minimum and less than the 30 percent patient volume;

(d) Participate in the Program:

(A) Starting as early as calendar year (CY) 2011, but no later than CY 2016;

(B) Ending no later than CY 2021;

(C) For a maximum of six years; and

(D) On a consecutive or non-consecutive annual basis.

(e) Be allowed to switch between the Medicare and Medicaid Programs only one time after receiving at least one incentive payment and only for a program year before 2015.

(3) The Authority shall disburse payments to the eligible professional following verification of eligibility for the program year:

(a) An eligible professional is paid an incentive amount for the corresponding program year for each year of qualified participation in the Program;

(b) The payment structure is as follows for:

(A) An eligible professional qualifying with 30 percent minimum patient volume:

(i) The first payment incentive amount is $21,250; and

(ii) The second, third, fourth, fifth, or sixth payment incentive amount is $8,500; or

(B) An eligible pediatrician qualifying with 20 percent but less than 30 percent minimum patient volume:

(i) The first payment incentive amount is $14,167; and

(ii) The second, third, fourth, fifth, or sixth payment incentive amount is $5,667.

(4) An eligible hospital shall follow the Medicaid EHR Incentive Program participation conditions including requirements that the eligible hospital:

(a) Receives a Medicaid EHR incentive payment from only one state for a program year;

(b) May participate in both the Medicare and Medicaid EHR Incentive Programs only if the eligible hospital meets all eligibility criteria for the program year for both programs;

(c) Participates in the Program:

(A) Starting as early as program year 2011 but no later than program year 2016;

(B) Ending no later than program year 2021;

(C) For a maximum of three years;

(D) On a consecutive or non-consecutive annual basis for program years prior to program year 2016; and

(E) On a consecutive annual basis for program years starting in program year 2016.

(d) A multi-site hospital with one CMS CCN is considered one hospital for purposes of calculating payment.

(5) The Authority shall disburse payments to the eligible hospital following verification of eligibility for the program year. An eligible hospital is paid the aggregate incentive amount over three years of qualified participation in the Program:

(a) The payment structure as listed in Table 165-0100-1 is as follows:

(A) The first payment incentive amount is equal to 50 percent of the aggregate EHR amount;

(B) The second payment incentive amount is equal to 40 percent of the aggregate EHR amount; and

(C) The third payment incentive amount is equal to 10 percent of the aggregate EHR amount.

(b) The aggregate EHR amount is calculated as the product of the "overall EHR amount" times the "Medicaid Share" as listed in Table 165-0100-2. The aggregate EHR amount is calculated once for the first year participation and then paid over three years according to the payment schedule:

(A) The overall EHR amount for an eligible hospital is based upon a theoretical four years of payment the hospital would receive and is the sum of the following calculation performed for each of such four years. For each year, the overall EHR amount is the product of the initial amount, the Medicare share, and the transition factor:

(i) The initial amount as listed in Table 165-0100-3 is equal to the sum of the base amount, which is set at $2,000,000 for each of the theoretical four years plus the discharge-related amount that is calculated for each of the theoretical four years:

(I) For initial amounts calculated in program years 2011 or 2012, the discharge-related amount is $200 per discharge for the 1,150th through the 23,000th discharge, based upon the total discharges for the eligible hospital (regardless of source of payment) from the hospital fiscal year that ends during the federal fiscal year (FFY) prior to the FFY year that serves as the first payment year. No discharge-related amount is added for discharges prior to the 1,150th or any discharges after the 23,000th;

(II) For initial amounts calculated in program year 2013 or later, the discharge-related amount is $200 per discharge for the 1,150th through the 23,000th discharge, based upon the total discharges for the eligible hospital (regardless of source of payment) from the hospital fiscal year that ends before the FFY that serves as the first payment year. No discharge-related amount is added for discharges prior to the 1,150th or any discharges after the 23,000th;

(III) For purposes of calculating the discharge-related amount for the last three of the theoretical four years of payment, discharges are assumed to increase each year by the hospital's average annual rate of growth; negative rates of growth shall also be applied. Average annual rate of growth is calculated as the average of the annual rate of growth in total discharges for the most recent three years for which data are available per year.

(ii) The Medicare share that equals 1;

(iii) The transition factor that equals:

(I) 1 for the first of the theoretical four years;

(II) 0.75 for the second of the theoretical four years;

(III) 0.5 for the third of the theoretical four years; and

(IV) 0.25 for the fourth of the theoretical four years.

(B) The Medicaid share for an eligible hospital is equal to a fraction:

(i) The numerator for the FFY and with respect to the eligible hospital is the sum of:

(I) The estimated number of inpatient-bed-days that are attributable to Medicaid individuals; and

(II) The estimated number of inpatient-bed-days that are attributable to individuals who are enrolled in a managed or coordinated care organization, a pre-paid inpatient health plan, or a pre-paid ambulatory health plan administered under 42 CFR Part 438.

(ii) The denominator is the product of:

(I) The estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

(II) The estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during such period.

(iii) In computing inpatient-bed-days for the Medicaid share, an eligible hospital may not include either of the following:

(I) Estimated inpatient-bed-days attributable to individuals that may be made under Medicare Part A; or

(II) Inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C.

(iv) If an eligible hospital's charity care data necessary to calculate the portion of the formula for the Medicaid share are not available, the eligible hospital's data on uncompensated care may be used to determine an appropriate proxy for charity care, but shall include a downward adjustment to eliminate bad debt from uncompensated care data if bad debt is not otherwise differentiated from uncompensated care. Auditable data sources shall be used; and

(v) If an eligible hospital's data necessary to determine the inpatient bed-days attributable to Medicaid managed care patients are not available, that amount is deemed to equal 0. In the absence of an eligible hospital's data necessary to compute the percentage of inpatient bed days that are not charity care as described under subparagraph (B)(ii)(II) in this section, that amount is deemed to be 1.

(6) The aggregate EHR amount is determined by the state from which the eligible hospital receives its first incentive payment. If a hospital receives incentive payments from other states in subsequent years, total incentive payments received over all payment years of the program can be no greater than the aggregate EHR amount calculated by the state from which the eligible hospital received its first incentive payment.

(7) Table 165-0100-1. [Table not included. See ED. NOTE.]

(8) Table 165-0100-2. [Table not included. See ED. NOTE.]

(9) Table 165-0100-3. [Table not included. See ED. NOTE.]

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.033

Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 2-2015(Temp), f. 1-30-15, cert. ef. 2-3-15 thru 8-1-15; DMAP 20-2015, f. & cert. ef. 4-8-15; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0120
Appeals

(1) The appeals process for the Program is governed by 42 CFR 495.370 and the Authority's Provider Appeals Rules in chapter 410, division 120.

(2) Pursuant to 42 CFR 495.312 and 42 CFR 495.370, the Authority may have CMS conduct the audits and handle any subsequent appeals of whether eligible hospitals are meaningful EHR users.

(3) A provider who applies for a Medicaid EHR incentive payment may appeal the Program's decision. Appeals are governed by the Division's Provider Appeal Rules OAR chapter 410, division 120. The provider's appeal shall note the specific reason for the appeal, due to one or more of the following issues:

(a) An incentive payment;

(b) An incentive payment amount;

(c) A provider eligibility determination;

(d) The demonstration of adopting, implementing, or upgrading; or

(e) Meaningful use eligibility other than a meaningful use eligibility issue where CMS handles the appeal, as provided in section (2) of this rule.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.033

Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

410-165-0140
Oversight and Audits

(1) A provider who qualifies for a Medicaid Electronic Health Record (EHR) incentive payment under the Program is subject to audit or other post-payment review procedures pursuant to OAR 943-120-1505.

(2) The Authority and the Department of Human Services may recover overpayments from the person or entity who received an incentive payment from the Program.

(3) As authorized in 42 CFR 495.312, the Authority and the Department of Human Services may designate CMS to conduct audits on hospitals' meaningful use attestations.

(4) The person or entity who received a Medicaid EHR incentive overpayment must repay the amount specified within 30 calendar days from the mailing date of written notification of the overpayment as prescribed by OAR 943-120-1505.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.033

Hist.: DMAP 13-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 20-2013(Temp), f. & cert. ef. 4-26-13 thru 10-23-13; DMAP 56-2013, f. & cert. ef. 10-22-13; DMAP 21-2016(Temp), f. 5-11-16, cert. ef. 5-13-16 thru 11-8-16; DMAP 47-2016, f. 7-18-16, cert. ef. 8-1-16

DIVISION 170

BEHAVIOR REHABILITATION SERVICES PROGRAM GENERAL RULES

410-170-0000
Effective Date and Administration of the BRS Program

(1) OAR 410-170-0000 through 410-170-0120 are effective on January 1, 2014.

(2) All BRS contractor's and BRS provider's programs must meet the requirements in the BRS program general rules (OAR 410-170-0000 through 410-170-0120). Additional agency-specific BRS program rules for the Department of Human Services are contained in 413-090-0055 through 413-090-0090, and for the Oregon Youth Authority are contained in 416-335-0000 through 416-335-0100.

(3) All references to federal and state laws and regulations referenced in these rules are those in place on November 13, 2013, and the agency-specific BRS program rules that are effective on January 1, 2014.

(4) Delegation of Authority: The Oregon Health Authority may delegate authority to another agency or a unit of government to carry out some of its obligations under these rules.

Stat. Auth.: ORS 183.355, 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0010
Purpose

The purpose of the Behavior Rehabilitation Services (BRS) Program is to remediate the BRS client's debilitating psychosocial, emotional and behavioral disorders by providing such services as behavioral intervention, counseling, and skills-training. These rules describe the general program requirements for the BRS program, prior authorization process, services and placement related activities, BRS contractor and BRS provider requirements, reimbursement rates, and compliance and oversight activities.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0020
Definitions

The following definitions apply to terms used in OAR 410-170-0000 through 410-170-0120.

(1) Agency means the state agency that has a contract with the BRS contractor to provide services and placement related activities to the BRS client, and provides prior authorization for the BRS client to receive services and placement related activities pursuant to the BRS program general rules and, as applicable, agency-specific BRS program rules. The agency will be one of the following state agencies: the Department of Human Services, the Oregon Health Authority, or the Oregon Youth Authority.

(2) Approved provider parent means an individual who a BRS contractor, a BRS provider, or OYA has approved to provide services or placement related activities to the BRS client in the home of that individual. Approved provider parents who provide services are considered direct care staff, and must meet those qualifications in OAR 410-170-0030(4).

(3) Behavior Rehabilitation Services (BRS) program is a program that provides services and placement related activities to the BRS client to address their debilitating psychosocial, emotional and behavioral disorders in a community placement utilizing either a residential care model or therapeutic foster care model.

(4) Billable care day means each calendar day the BRS client is in the direct care of the BRS provider at 11:59 p.m. or meets the requirements in OAR 410-170-0110.

(5) BRS client means the person who has prior authorization from an agency to receive services or placement related activities through the BRS program in accordance with the BRS program general rules, and as applicable agency-specific BRS program rules.

(6) BRS contractor means the entity contracted with an agency to be responsible for providing services and placement related activities to the BRS client. The BRS contractor may also be the BRS provider if it provides direct services and placement related activities to the BRS client.

(7) BRS provider means a facility, institution, corporate entity, or other organization that provides direct services and placement related activities to the BRS client.

(8) BRS type of care means the type of program model, services, placement related activities, staffing requirements and qualifications which are necessary to meet the medical and other needs of the BRS client.

(9) Caseworker means the individual who coordinates the services and placement related activities for the BRS client with the BRS contractor and BRS provider.

(10) Child or children means a person or persons under 18 years of age.

(11) Children's health insurance program (CHIP) means the 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.

(12) Designated LPHA means a licensed practitioner of the healing arts, who has a contract with, is approved by, or is employed by the agency to make a determination on the medical appropriateness of the BRS program for the BRS client.

(13) DHS or Department means the Department of Human Services, Child Welfare.

(14) Direct care staff means an individual who is employed by or who has a contract or an agreement with the BRS provider, and is responsible for assisting social service staff in providing individual and group counseling, skills-training and therapeutic

interventions, and monitoring and managing the BRS client's behavior to provide a safe, structured living environment that is conducive to treatment.

(15) Initial service plan (ISP) means the initial written individualized services plan, developed by the BRS contractor or BRS provider, identifying the services that must be provided to the BRS client during the first 45 days in its BRS program or until the master service plan is written. Additional requirements are described in OAR 410-170-0070.

(16) Licensed practitioner of the healing arts (LPHA) means a physician or other practitioner licensed in the State of Oregon who is authorized within the scope of his or her practice, as defined under state law, to diagnose and treat individuals with physical or mental disabilities, or psychosocial, emotional and behavioral disorders.

(17) Master service plan (MSP) means the written individualized services plan, developed by the BRS contractor or BRS provider, identifying the services that must be provided to the BRS client in its BRS program. Additional requirements are described in OAR 410-170-0070.

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

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

(20) OYA means the Oregon Youth Authority.

(21) Physical restraint means the act of restricting the BRS client's voluntary movement as an emergency measure to manage and protect the BRS client or others from injury when no alternate actions are sufficient to manage the BRS client's behavior. Physical restraint does not include temporarily holding a BRS client to assist him or her or assure his or her safety, such as preventing a child from running onto a busy street.

(22) Placement related activities means the BRS contractor's or BRS provider's activities related to the operation of the program and the care of the BRS client as set forth in the BRS program general rules, applicable agency-specific BRS program rules, the contract or agreement with the agency or the BRS contractor, and applicable federal and state licensing and regulatory requirements. Placement related activities may include but are not limited to providing the BRS client with: food, clothing, shelter, daily supervision, access to educational, cultural and recreational activities; and case management. Room and board is not funded by Medicaid or CHIP.

(23) Private child-caring agency is defined by the definitions in ORS 418.205, and means a "child-caring agency" that is not owned, operated, or administered by any governmental agency or unit:

(a) A child-caring agency means an agency or organization providing:

(A) Day treatment for disturbed children;

(B) Adoption placement services;

(C) Residential care, including but not limited to foster care or residential treatment for children;

(D) Outdoor youth programs (defined at OAR 413-215-0911); or

(E) Other similar services for children;

(b) A child-caring agency does not include residential facilities or foster care homes certified or licensed by the Department under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental disability services.

(24) Proctor parent means an approved provider parent who is certified by OYA and a private child-caring agency in accordance with the applicable provisions in OAR 416-530-0000 through 416-530-0200 and 416-550-0000 through 416-550-0080, and who is employed by or who has a contract or agreement with the private child-caring agency to provide some services and placement related activities to the BRS client in the individual's home.

(25) Program coordinator or program director means an individual employed by or contracted with the BRS provider, and is responsible for supervising staff, providing overall direction to the BRS provider, planning and coordinating program activities and delivery of services and placement related activities, and ensuring the safety and protection of the BRS client and the BRS provider's staff.

(26) Public child-caring agency means, for purposes of this rule, an agency or institution operated by a governmental agency or unit other than DHS, OYA, or OHA, which provides care to the BRS client in a residential community setting.

(27) Residential care model means that services and placement related activities are provided to the BRS client in a residential community setting and not in the home of an approved provider parent.

(28) Respite care means a formal planned arrangement to relieve an approved provider parent's responsibilities by an individual temporarily assuming responsibility for the care and supervision of the BRS client in the home of the respite provider or approved provider parent. Respite care must be less than 14 consecutive days.

(29) Seclusion means the involuntary confinement of a BRS client to an area or room from which the BRS client is physically prevented from leaving.

(30) Services means the treatment provided to the BRS client in a BRS provider's program, including but not limited to treatment planning, individual and group counseling, skills-training, and parent training.

(31) Social service staff means an individual employed by or contracted with the BRS provider, and is responsible for case management and the development of the ISP or MSP for the BRS client; individual, group and family counseling; individual and group skills-training; assisting the direct care staff in providing appropriate treatment to the BRS client; coordinating services with other agencies; and documenting the BRS client's treatment progress.

(32) Therapeutic foster care model means services and placement related activities are provided to the BRS client who resides in the home of an approved provider parent.

(33) Total daily rate means the total amount of the service payment and placement related activities payment for a billable care day.

(34) Young adult means a person aged 18 through 20 years.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0030
BRS Contractor and BRS Provider Requirements

(1) Conditions of BRS contractor and BRS provider participation. The BRS contractor must ensure that itself and its BRS providers meet the following minimum requirements:

(a) Have the necessary current and valid licenses, approvals or certifications required by federal or state law or regulations for the entity and its staff to operate a BRS program;

(b) Have a license to operate a private child-caring agency or be approved by the Department of Human Services' Office of Licensing and Regulatory Oversight to operate a public child-caring agency;

(c) Comply with all federal and state laws and regulations required to be a licensed or an approved foster care agency under OAR 413-215-0301 to 413-215-0396 or residential care agency under OAR 413-215-0501 to 413-215-0586 and, if the BRS client is a person age 18 or older, comply with the licensing or approval requirements that would apply if the BRS client was a child;

(d) Comply with the provider enrollment requirements in OAR 410-120-1260;

(e) Comply with the requirements in OAR 410-120-1380(1)(c)(J) for excluding individuals and entities from being subcontractors if they are found on the listed exclusion list(s); and

(f) Have a contract or agreement with an agency, or as applicable a BRS contractor, to provide services and placement related activities to the BRS client.

(2) Compliance with Federal and State Law. The BRS contractor must, and must ensure its BRS providers, comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid services under the Medicaid Act, Title XIX, 42 USC 1396 et seq. and the BRS program, including but not limited to all applicable provisions in OAR 410-120-0000 through 410-120-1980.

(3) Confidentiality of BRS client information:

(a) Confidentiality Generally: The BRS contractor must not, and ensure its BRS providers do not, use or disclose any information concerning a BRS client for any purpose not directly connected with the administration of the BRS contractor's or BRS provider's program or as otherwise permitted by law, except with the written consent of the agency, or if the agency is not the BRS client's guardian, on the written consent of the person or persons authorized by law to consent to such use or disclosure. The BRS contractor must, and must require its employees and BRS providers to, comply with all appropriate federal and state laws, rules and regulations regarding the confidentiality of records related to the BRS client;

(b) HIPAA Compliance and Medical Privacy. The BRS contractor must, and ensure its BRS providers, comply with all applicable confidentiality requirements in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191, August 21, 1996) and its implementing regulations in 45 CFR 160 and 164 et. seq., and all applicable confidentiality requirements in state statutes and administrative rules, including but not limited to ORS 179.505 and OAR chapter 410, division 120;

(c) Maintenance of Written Records: The BRS contractor must, and ensure its BRS providers, appropriately secure all records and files related to BRS clients to prevent access by unauthorized persons or entities;

(d) Disclosure to the agency, Authority or other governmental oversight or licensing entities:

(A) The BRS contractor must, and ensure its BRS providers, promptly provide access to any information or written documentation in its possession related to the BRS client or its BRS program upon the request of the agency for any reason; and

(B) The BRS contractor must, and ensure its BRS providers, promptly provide access to any information or written documentation in its possession related to the BRS client or its BRS program that is necessary for the purpose of evaluating, overseeing or auditing the BRS contractor's program upon the request of the Authority or other governmental oversight or licensing entities.

(4) Staff Qualifications. The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, has a program coordinator, social service staff, and direct care staff who meet and maintain the following minimum qualifications:

(a) No less than 50% of the direct care staff for a BRS provider must have a Bachelor's degree from an accredited college or university. A combination of formal education and experience with children or young adults may be substituted for a Bachelor's degree. Direct care staff must be under the direction of a qualified social service staff member or a program coordinator;

(b) Direct care staff, social service staff, and the program coordinator, who directly work with BRS clients, must:

(A) Receive a minimum of 28 hours of initial training prior to or within 30 days of employment or certification on the following topics: BRS services documentation, mandatory reporting of child abuse, program policies and expectations, gender- and cultural-specific services, behavior and crisis management, medication administration, discipline and restraint policies, and suicide prevention. Any direct care staff, social service staff, or program coordinator who has not yet completed this initial training prior to employment or certification, must be supervised by a person who has completed this training when having direct contact with BRS clients; and

(B) Receive a minimum of 16 hours of training annually on the following topics: skills-training that supports evidence-based or promising practices, and other subjects relevant to the responsibilities of providing services and placement related activities to the BRS client; and

(C) Have and maintain cardiopulmonary resuscitation (CPR) and first aid certification;

(c) The program coordinator or program director must have a Bachelor's degree from an accredited college or university, preferably with major study in psychology, sociology, social work, social sciences, or a closely allied field, and two years of experience in the supervision and management of a residential facility for the care and treatment of children or young adults;

(d) Social service staff must have a Master's degree from an accredited college or university with major study in social work or a closely allied field and one year of experience in the care and treatment of children or young adults; or have a Bachelor's degree with major study in social work, psychology, sociology or a closely allied field and two years of experience in the care and rehabilitation of children or young adults.

(5) Fitness Determination:

(a) The BRS contractor and BRS provider must ensure that its employees, volunteers, contractors, vendors, approved provider parents, or other persons providing services or placement related activities to BRS clients, comply with all applicable criminal record and child abuse background checks and any fitness determination process required by federal or state law or regulation;

(b) The BRS contractor and the BRS provider must ensure that its employees, volunteers, contractors, vendors, approved provider parents, or other persons providing services or placement related activities to BRS clients, who have not yet successfully completed the requirements in section (5)(a) of this rule, are supervised by a person who has successfully met these requirements when having direct contact with BRS clients;

(c) Except in cases where more stringent legal requirements apply, the BRS contractor and BRS provider must ensure that its employees, volunteers, contractors, vendors, approved provider parents, or other persons providing services or placement related activities to BRS clients, report to it any arrests or court convictions, any known allegation of child abuse or neglect, and any other circumstance that could reasonably affect a fitness determination within one business day. The BRS contractor and BRS provider must report this information to the agency on the same day it receives the information.

(6) Mandatory Reporting:

(a) The BRS contractor and BRS provider must comply with the child abuse reporting laws in ORS 419B.010 through 419B.050;

(b) The BRS contractor and BRS provider must require any staff member, including employees, volunteers, subcontractors, approved provider parents, or other persons providing services or placement related activities to BRS clients, to immediately make a report or cause a report to be made under ORS 419B.015 anytime the staff member has reasonable cause to believe that any child with whom the staff member comes in contact has suffered abuse, as defined by 419B.005(1), or that any person with whom the staff member comes in contact has abused a child;

(c) The BRS contractor and BRS provider must train their staff regarding child abuse reporting requirements;

(d) The BRS contractor must ensure that its BRS provider complies with the requirements of this section.

(7) Communication:

(a) The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, maintains a system for immediate and on-going communication amongst program staff regarding the whereabouts, status and condition of the BRS clients in its program;

(b) The BRS contractor must ensure that direct care staff and social service staff have access to a BRS client's information to the

extent it is relevant to providing the BRS client with services and placement related activities;

(c) The BRS contractor must provide, or ensure that its BRS provider provides, immediate verbal notification to the caseworker and the agency (if an additional contact person is designated) when there is a communication outage at the program, and must provide an alternative means by which the program may be contacted, if possible.

(8) Staffing Requirements:

(a) Supervision of BRS clients: The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, meets and maintains appropriate staffing levels to ensure supervision of the BRS clients in its program at all times (24 hours a day, 7 days a week), including taking steps to ensure that a BRS client is supervised while temporarily outside of the program. The BRS provider must not leave a BRS client unsupervised, except in cases where there is a service plan for the BRS client to be out of the BRS provider's direct supervision;

(b) Therapeutic Foster Care Model:

(A) The Authority's or the Department's BRS contractors. The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, meets and maintains the following adult to child ratios in its therapeutic foster care homes:

(i) Shelter Evaluation and Assessment and Independent Living Services:

(I) A maximum of 3 BRS clients shall be placed in the home of an approved provider parent;

(II) A maximum of 5 children (including both BRS clients and non-BRS clients) and young adults (BRS clients only) shall live in an approved provider parent home with two parents;

(III) A maximum of 4 children (including both BRS clients and non-BRS clients) and young adults (BRS clients only) shall live in an approved provider parent home with one parent; and

(IV) No more than two children (including both BRS clients and non-BRS clients) under the age of three shall live in an approved provider parent home;

(ii) Intensive Community Care, Therapeutic Foster Care, and Enhanced Therapeutic Foster Care:

(I) A maximum of 2 BRS clients shall be placed in the home of an approved provider parent;

(II) A maximum of 5 children (including both BRS clients and non-BRS clients) and young adults (BRS clients only) shall live in an approved provider parent home with two parents;

(III) A maximum of 4 children (including both BRS clients and non-BRS clients) and young adults (BRS clients only) shall live in an approved provider parent home with one parent; and

(IV) No more than two children (including both BRS clients and non-BRS clients) under the age of three shall live in an approved provider parent home;

(iii) Notwithstanding section (8)(b)(A)(i) and (ii) of this rule, the BRS contractor or BRS provider may exceed these limits on the maximum number of children and young adults who shall live in a home when the approved provider parent is providing respite care;

(B) OYA's BRS contractors. The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, meets and maintains the adult to child or young adult ratios described in OYA-specific BRS program rules for therapeutic foster care homes;

(c) Residential Care Model: The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, meets and maintains the following direct care staff to BRS client ratios for the BRS type of care it provides in its residential care BRS program:

(A) Shelter Assessment and Evaluation, Intensive Community Care, and Independent Living Service: During scheduled school days, weekends and non-scheduled school days, the program must:

(i) Have 1 direct care staff member for every 7 BRS clients onsite between 7 a.m. and 3 p.m.;

(ii) Have 1 direct care staff member for every 4.7 BRS clients onsite between 3 p.m. and 11 p.m.; and

(iii) Have 1 direct care staff member for every 9.3 BRS clients onsite between 11 p.m. and 7 a.m.;

(B) Community Step-Down, Independent Living Program, and BRS Basic Residential and Rehabilitation Services:

(i) During scheduled school days, the program must:

(I) Have 1 direct care staff member for every 7 BRS clients onsite between 7 a.m. and 3 p.m.;

(II) Have 1 direct care staff member for every 4.7 BRS clients onsite between 3 p.m. and 11 p.m.;

(III) Have 1 direct care staff member for every 9.3 BRS clients onsite between 11 p.m. and 7 a.m.; and

(ii) During weekends and non-scheduled school days, the program must:

(I) Have 1 direct care staff member for every 4.7 BRS clients onsite between 7 a.m. and 3 p.m.;

(II) Have 1 direct care staff member for every 4.7 BRS clients onsite between 3p.m. and 11 p.m.;

(III) Have 1 direct care staff member for every 9.3 BRS clients onsite between 11 p.m. and 7 a.m.;

(C) Intensive Rehabilitation Residential Services, BRS Residential, BRS Enhanced, and Short-Term Stabilization Program:

(i) During scheduled school days, the program must:

(I) Have 1 direct care staff member for every 7 BRS clients onsite between 7 a.m. and 3 p.m.;

(II) Have 1 direct care staff member for every 2.8 BRS clients onsite between 3 p.m. and 11 p.m.;

(III) Have 1 direct care staff member for every 9.3 BRS clients onsite between 11 p.m. and 7 a.m.; and

(ii) During weekends and non-scheduled school days, the program must:

(I) Have 1 direct care staff member for every 4.7 BRS clients onsite between 7 a.m. and 3 p.m.;

(II) Have 1 direct care staff member for every 2.8 BRS clients onsite between 3 p.m. and 11 p.m.;

(III) Have 1 direct care staff member for every 9.3 BRS clients onsite between 11 p.m. and 7 a.m.;

(d) For purposes of calculating the number of direct care staff under section (8)(c) of this rule only, a social service staff member or program coordinator may be included if that staff member is specifically scheduled to and actually provides direct supervision to BRS clients onsite during the relevant time period;

(e) Under section (8)(c) of this rule only, in the event that no BRS clients are onsite at the program due to home visits or other planned absences, the BRS contractor and BRS provider must ensure that its program has the resources and procedures in place to serve the BRS client who may need to return to the program prior to the scheduled return date;

(f) In the event a BRS client is temporarily admitted to a hospital (other than to a psychiatric hospital) but is still enrolled in the BRS provider's program, the BRS contractor and BRS provider must ensure that its program works with the caseworker, and the family when appropriate, to develop a plan approved by the agency for supervision during the BRS client's hospitalization;

(g) The BRS contractor may, or allow its BRS provider to, request prior written agency approval for its BRS program to deviate from the ratios described in section (8)(b) and (c) of this rule or agency-specific BRS program rules. If the agency grants a waiver, this shall only apply to BRS program ratio requirements specified in these rules and agency-specific BRS program rules. The BRS contractor and BRS provider must comply with any ratio requirements applicable under federal or state licensing requirements or approvals;

(9) Physical Facility. The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, do the following:

(a) Provide an environment suitable for the treatment of a BRS client, which meets all applicable safety, health and general environment standards required for a residential community setting, if services are provided to the BRS client in a residential care model, or in the home of an approved provider parent certified by

the BRS provider, if services are provided to the BRS client in a therapeutic foster care model;

(b) Provide separate bedrooms for children and persons 18 years or older, except in cases where the child shares a bedroom with a young adult who is the child's parent and caregiver or where there is written approval from the Department of Human Services' Office of Licensing and Regulatory Oversight Coordinator and the agency;

(c) Provide separate bedrooms for BRS clients who have inappropriate sexual behaviors identified in their service plan and BRS clients who do not have those behaviors identified in their service plan, unless there is written approval from the agency;

(d) Provide that BRS clients, who have inappropriate sexual behaviors identified in their service plan, occupy a bedroom either individually or in a group of three or more BRS clients who have inappropriate sexual behaviors identified in their service plan, unless there is written approval from the agency;

(e) Provide separate bedrooms for BRS clients and other members of the household unless there is written approval from the agency;

(f) Provide separate bedrooms or dormitories for females and males;

(g) Provide physical separation of BRS clients served in its BRS program from persons housed in a detention facility or youth correction facility;

(h) Provide that at least one door in each bedroom is unlocked at all times;

(i) Provide that at least one door in each dormitory is unlocked at all times, unless the BRS contractor or BRS provider receives prior written agency approval to lock all dormitory doors for eight hours at night; and

(j) Provide a means of egress for BRS clients to leave the facility.

(10) BRS providers and BRS contractors are not required to comply with (9)(b) and (c) of this rule if they provide services or placement related activities in a dormitory setting.

(11) BRS Program Policies and Procedures:

(a) The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, has the following written policies and procedures, which have been reviewed and approved by the agency:

(A) Admission criteria and standards to accept a BRS client into its program;

(B) Staff training policies and procedures, including child abuse reporting expectations under ORS 419B.005, 419B.010 and 419B.015;

(C) Policies and procedures related to reviewing referrals to its program and notification of admission decisions;

(D) A behavior management system policy designed to consistently encourage appropriate behaviors by the BRS client in a non-punitive manner;

(E) A behavioral rehabilitation program model that uses evidence-based or promising practices whenever possible and the curriculum, policies, and procedures which implement that model;

(F) Policies regarding the BRS client's and family's rights, including but not limited to the search and seizure of the BRS client's person, property, and mail; visitation and communication; and discharges initiated by the BRS client;

(G) A grievance policy describing the process through which the BRS client, and, if applicable, the BRS client's parent, guardian or legal custodian may present grievances to the BRS provider about its operation and a process to resolve issues;

(H) A suicide prevention policy and procedure that describes how the BRS provider must respond in the event a BRS client exhibits self-injurious, self-harm or suicidal behavior. This policy must describe warning signs of suicide; emergency protocol and contacts; training requirements for staff, including suicide prevention training and suicide risk assessment tool training; procedures for determining implementation of additional supervision precautions and for determining removal of additional supervision precautions; suicide risk assessment procedures on the day of intake; documentation requirements for suicide ideation, self-harm, and special observation precautions to ensure immediate communication to all staff; a process for tracking suicide behavioral patterns; and a "post-intervention" plan with identified resources;

(I) A seclusion and physical restraint policy that describes when such interventions may be used in compliance with applicable federal and state laws and regulations, including but not limited to requirements for licensed or approved public or private child-caring agencies and agency-specific BRS program rules. Physical restraint or seclusion shall only be used as a last resort, and shall not be used for discipline, punishment, convenience of personnel, or as a substitute for activities, treatment or training. The policy must describe how staff are trained and monitored and who may perform such interventions;

(J) A medication management policy which complies with applicable licensing requirements and agency-specific BRS program rules. At minimum, the policy must describe:

(i) How and where medications are stored and dispensed; and

(ii) How the BRS provider must notify the caseworker if the BRS client refuses prescribed medications for more than 7 days or refuses a medication that has been identified by any LPHA as requiring an immediate report for health care reasons;

(K) A quality improvement policy and procedures that monitor the operation of the BRS program to ensure compliance with all applicable laws and regulations, including but not limited to tracking service hours, monitoring the timeliness of reporting requirements, and monitoring the quality of service delivery;

(b) The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, reviews and updates its policies and procedures as listed in section (11)(a) of this rule biannually, and has any updated policies and procedures reviewed and approved by the agency;

(c) The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, complies with, and maintains documentation of its compliance, with all policies and procedures described in section (11)(a) of this rule, and with any modifications to their policies and procedures that are required by the agency.

(12) Documentation Requirements:

(a) The BRS contractor and BRS provider must:

(A) Comply with all documentation requirements in OAR 410-120-1360, BRS program general rules and agency-specific BRS program rules;

(B) Use forms reviewed and approved by the agency to document the following if required: the ISP, the assessment and evaluation report, the MSP, the MSP 90 day updates, the daily and weekly log for service hours, and the invoice form;

(C) Maintain current documentation of its staff's compliance with applicable training, qualifications, and licensing requirements, which must be readily available for on-site review by the caseworker, agency, and other appropriate licensing or oversight entity;

(D) Create, maintain and update an individualized case file for each BRS client either in hard copy or electronically, including but not limited to service documentation (service plans, weekly service type and hour records, and discreet service notes), which must be readily available for on-site review by the BRS provider's direct care staff and social service staff, the caseworker, the agency, and the appropriate licensing or oversight entity;

(E) Ensure that all documentation about the BRS client is written in terms that are easily understood by all persons involved in service planning and delivery, including but not limited to the service plans, progress notes and reports, assessments, and incident reports; and

(F) Ensure that all documentation (paper or electronic) identifies any corrections made, including the original information, what was corrected or changed, the date of the correction, and who made the correction. White out, eraser tape, electronic deletions or other means of eradicating information to make corrections on documentation may not be used;

(b) Incident Reports: The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, creates and maintains a record of all incidents and crisis interventions on a form approved by the agency, including but not limited to use of seclusion and physical restraint, a risk to the status or custody of the BRS client, or other incidents likely to cause complaints, generate safety, programmatic or other serious concerns, or come to the attention of the media or law enforcement.

(A) Incident reports must contain the following information:

(i) Name of the BRS client;

(ii) The date, location, and type of incident or crisis intervention;

(iii) The duration of any seclusions or physical restraints employed in the context of the incident;

(iv) Name of staff involved in the incident or crisis intervention, including the names of any witnesses;

(v) Description of the incident or crisis intervention, including precipitating factors, preventative efforts employed, and description of circumstances during the incident;

(vi) Physical injuries to the BRS client or others resulting from the incident or crisis intervention, including information regarding any follow-up medical care or treatment;

(vii) Documentation showing that any necessary reports were made to the appropriate agency, any other entity required by law to be notified, and, as applicable the BRS client's parent, guardian or legal custodian;

(viii) Documentation indicating the date that a copy of the incident report was sent to the caseworker;

(ix) Actions or interventions taken by program staff;

(x) Any follow-up recommendations for the BRS client or staff;

(xi) Any follow-up or investigation conducted by the BRS contractor or BRS provider's supervisory staff and administrative personnel, DHS, OHA, OYA or other entities; and

(xii) The BRS contractors or BRS provider's review of the incident or crisis intervention.

(B) The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, provides immediate verbal notification to the caseworker, the agency's designated contact, and as applicable the appropriate licensing entity of the following types of incidents: incidents posing a risk to the status or custody of the BRS client, and any other incidents that are of a nature serious enough to raise safety, programmatic, or other serious concerns. Verbal notification must be followed up by the submission of a written incident report to the individuals or entities described in this section within 1 business day. Compliance with this notification requirement does not satisfy child abuse reporting requirements under ORS 419B.005 to 419B.045;

(C) The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, provides a written incident report within 5 business days to the caseworker regarding any use of seclusion or physical restraint on a BRS client;

(D) At the end of each month, the BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, sends copies of all incident reports for that month, not previously submitted under section (12)(b)(B) of this rule, to the designated agency contact;

(c) The BRS contractor and BRS provider must promptly provide documentation to the agency upon request or by the deadline specified in a written request, whichever is sooner. The BRS contractor's or BRS provider's failure to provide the agency with the requested documentation by the agency's deadline may result in the agency pursuing any one or a combination of the sanctions or remedies against the BRS contractor described in OAR 410-170-0120 or agency-specific BRS rules.

(13) Overnight Absences: The BRS contractor must ensure that its program, either operated by itself or by its BRS provider, receives prior written approval from the caseworker whenever the BRS client will be sleeping outside of its program for any reason (such as home visits, camping trips, court appearances, hospital admissions, or detention) excluding cases of emergency:

(a) Initial approval shall be completed at intake and will include information from the caseworker documenting any special instructions such as:

(A) Conditions under which an overnight absence from the program would be approved;

(B) Home visit resources that are acceptable;

(C) Any required notifications to the community: victim, court, special interest group, or law enforcement;

(D) Approved and non-approved contacts during absences, as applicable; and

(E) Approved and non-approved activities, as applicable;

(b) After initial approval by the caseworker, the BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, notifies the caseworker of each upcoming overnight visit at least 2 business days prior to the visit, and provides the following information:

(A) Dates of visit;

(B) Type of visit or activity;

(C) Location of visit or activity; and

(D) Explanation of how any special conditions or requirements will be addressed;

(c) The BRS contractor and BRS provider shall not permit the BRS client to leave the state or country without prior written approval by the agency.

(14) Publicly-Operated Community Residences. The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, that provides services and placement related activities in a publicly-operated community residence does not serve more than 16 residents, unless it receives prior written approval from the Authority with a determination that it is not an institution for mental diseases (see definitions in 42 CFR 435.1010).

(15) The BRS contractor's Supervision of the BRS Provider:

(a) The BRS contractor is responsible for monitoring and ensuring that its BRS providers comply with all applicable laws and regulations related to the BRS program. The Authority and agency may pursue any sanctions, remedies, or recovery of an overpayment as described in OAR 410-170-0120 or agency-specific BRS rules against the BRS contractor for failing to monitor and ensure its BRS providers are in compliance with all applicable laws and regulations related to the BRS program;

(b) The BRS contractor is solely responsible for any and all obligations owed to its BRS provider under its subcontract or agreement;

(16) The BRS Contractor's Supervision of the Approved Provider Parent:

(a) The BRS contractor must, or must ensure that its BRS provider, monitors and ensures that its approved provider parents comply with all applicable laws and regulations related to the BRS program. The Authority and agency may pursue any sanctions, remedies, or recovery of an overpayment described in OAR 410-170-0120 or agency-specific BRS rules against the BRS contractor for failing to monitor and ensure its approved provider parents are in compliance with all applicable laws and regulations related to the BRS program;

(b) The BRS contractor must, or ensure that its BRS provider:

(A) Recruits, trains, reimburses, and supports the approved provider parent in providing services or placement related activities to the BRS client;

(B) Visits the approved provider parent's home a minimum of one time each month for the purposes of supervision, monitoring, training and support;

(C) Provides at minimum the following support services to the approved provider parent:

(i) Twenty-four hour back-up services: The BRS contractor must, or ensure that its BRS provider, have staff available to provide the approved provider parent with back-up services at all times (24 hours per day, 7 days a week), which includes on-call services, consultation, and direct crisis counseling. Approved provider parents must be given the contact details (names and phone numbers) of the program staff that are available to provide these back-up services;

(ii) Forty eight hours of respite care: The BRS contractor must provide, or ensure that its BRS provider provides, the approved provider parent with the opportunity to receive 48 hours per month of time away from approved provider parent responsibilities. Daytime supervision and night-time monitoring equivalent to that provided by the approved provider parent must be arranged and provided to the BRS client during that time;

(c) The BRS contractor, or as applicable the BRS provider, is solely responsible for any and all obligations owed to the approved provider parent under its subcontract or agreement.

(17) Conflict of Interest: The BRS contractor must, or ensure that its BRS provider, notifies the agency in writing when a current employee or newly hired employee is also an employee of the agency. The BRS contractor must, or ensure that its BRS provider, submits the notification to the contract administrator and the agency's contracts unit and shall include the name of the employee and their job description. The agency must review the employment situation for any actual or potential conflicts of interest as identified under ORS chapter 244.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0040
Prior Authorization for the BRS Program; Appeal Rights

(1) The BRS program requires prior authorization from the agency in accordance with the Authority's rules, the general BRS program rules and applicable agency-specific BRS program rules. A referral by a LPHA or agency to the Authority for prior authorization of the BRS program is not a prior authorization.

(2) Prior Authorization Criteria for the BRS program:

(a) The Authority shall provide prior authorization for the BRS program to a person who:

(A) Is enrolled in the Oregon Health Plan (OHP), is eligible for Oregon's Medicaid or CHIP program, and is eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, according to the procedures established by the Authority;

(B) Has a determination by a designated LPHA that the BRS program is medically appropriate to meet his or her medical needs;

(C) Is not receiving residential mental health or residential developmental disability services from another governmental unit or entity;

(D) Is a child or young adult; and

(E) Does not have a current prior authorization for the BRS program for the requested time period from OYA or the Department;

(b) OYA or the Department may provide prior authorization for the BRS program for a person that meets the requirements in its agency-specific BRS program rules.

(3) In order to meet the requirement in section (2)(a)(B) of this rule, the designated LPHA must determine that the BRS program is medically appropriate because the person:

(a) Has a primary mental, emotional or behavioral disorder, or developmental disability that prevents the person from functioning at a developmentally appropriate level in the person's home, school or community;

(b) Demonstrates severe emotional, social and behavioral problems, including but not limited to: drug and alcohol abuse; anti-social behaviors requiring close supervision, intervention and structure; sexual behavioral problems; or behavioral disturbances;

(c) Requires out-of-home behavioral rehabilitation treatment in order to restore or develop the person's appropriate functioning at a developmentally appropriate level in the person's home, school or community;

(d) Is able to benefit from the BRS program at a developmentally-appropriate level;

(e) Does not have active suicidal, homicidal, or serious aggressive behaviors; and

(f) Does not have active psychosis or psychiatric instability.

(4) The Authority may also request that the designated LPHA determine the BRS type of care that is medically appropriate for the person. The designated LPHA must make that determination based on the following factors, including but not limited to the:

(a) Severity of the person's psychosocial, emotional and behavior disorders;

(b) Intensity and type of services that would be appropriate to treat the person;

(c) Type of setting or treatment model that would be most beneficial to the person;

(d) Least restrictive and intensive setting based on the person's treatment history, degree of impairment, current symptoms and the extent of family and other supports; and

(e) Behavior management needs of the person.

(5) The agency is not required to provide prior authorization or to make payment for services or placement related activities under the following circumstances:

(a) The person was not eligible for the BRS program at the time services or placement related activities were provided;

(b) The documentation is not adequate to determine the type, medical appropriateness, or frequency and duration of services;

(c) The services or placement related activities billed or provided are not consistent with the information submitted when the prior authorization was requested;

(d) The services or placement related activities billed are not consistent with those provided;

(e) The services or placement related activities were not provided within the timeframe specified on the notice of prior authorization;

(f) The BRS program is not covered under the person's medical assistance package;

(g) The services or placement related activities were not authorized or provided in compliance with the BRS program general rules, agency-specific BRS program rules, or applicable DMAP General Rules (OAR 410-120-0000 to 410-120-1920);

(h) The person does not meet the prior authorization requirements as stated above;

(i) The BRS contractor or BRS provider was not eligible to receive reimbursement through the BRS program at the time the services or placement related activities were provided; or

(j) The person's needs could be better met through another system of care, the individual is eligible for services under that system of care; the individual has been given notice of that eligibility; and the services necessary to support a successful transition to the alternate system of care have been provided.

(6) Retroactive Eligibility and Authorization:

(a) In those instances when the BRS client is made retroactively eligible for the BRS program, the agency may grant prior authorization if:

(A) The BRS contractor or BRS provider received preliminary approval from the agency prior to admitting the BRS client into its program while the prior authorization process was pending;

(B) The BRS client met all prior authorization criteria and eligibility requirements on the date that the services and placement related activities were provided;

(C) The BRS provider delivered the services and placement related activities in accordance with all applicable BRS program general rules and agency-specific BRS program rules; and

(D) Prior authorization was retroactively approved by the agency within 5 business days from the date that the BRS client was admitted into the BRS provider's program;

(b) Prior authorization after 5 business days from the date the BRS client was admitted into the BRS contractor's or BRS provider's program requires documentation that prior authorization could not have been obtained within those 5 business days.

(7) Prior authorization is valid for the time period specified on the agency's prior authorization notice, but is not to exceed 12 months from the date on the notice, unless the BRS client is no longer eligible for a medical assistance program that covers the BRS program, in which case the authorization shall terminate on the date coverage ends.

(8) The BRS contractor is responsible for ensuring that there is a prior authorization from the agency for the BRS client in

advance of providing the services or placement related activities for the applicable time period unless section (6) of this rule applies.

(9) If a person is denied prior authorization for the BRS program under section (2)(a) of this rule, OAR 413-090-0075(1)(a), or OAR 416-335-0040(1)(a), the person is entitled to notice and contested hearing rights under OAR 410-120-1860 and 410-120-1865. The contested case hearing shall be held by the Authority.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0050
Program Referrals and Admission to BRS Provider

(1) After the BRS client has received prior authorization for the BRS program, the agency shall refer the BRS client for admission to one or more BRS contractors or BRS providers that provide the appropriate BRS type of care.

(2) The agency shall provide the BRS contractor, or as applicable the BRS provider, with the following documents in the BRS client's referral packet:

(a) Information identifying the person or entity with legal authority over the BRS client, which may be the BRS client's parent, guardian or legal custodian;

(b) Any prior evaluations, assessments, or other documents that provide background information about the BRS client or that support the need for the BRS client's current level of services; and

(c) The caseworker's case plan describing necessary services or similar planning form for the BRS client.

(3) The BRS contractor, or as applicable the BRS provider, must make admission decisions for the BRS client based on its agency-approved written admission criteria unless provided with written authorization from the agency to accept a BRS client who does not meet its admission criteria.

(4) The BRS contractor, or as applicable the BRS provider, shall not deny an eligible BRS client admission to its program if a vacancy exists within the program at the time of referral and the BRS client meets its agency-approved admission criteria, unless it receives written approval from the referring agency.

(5) The BRS contractor must not, and ensure its BRS providers do not, deny an eligible BRS client admission to its program for any of the following reasons:

(a) The presence or absence of family members to support the placement;

(b) The race, religion, sexual orientation, color, or national origin of the BRS client involved;

(c) The BRS client's place of residence; or

(d) The absence of an identified after-care resource.

(6) The BRS contractor must, or must ensure its BRS provider, notifies the caseworker of its admission decision within 5 business days of receiving the BRS client's referral packet, unless an earlier timeframe is required in agency-specific BRS rules. If the BRS provider denies admission to the BRS client, then it must provide the caseworker with a written explanation.

(7) The BRS contractor must, or must ensure its BRS provider, maintains documentation (either electronically or in hard copy) of all its admission decisions for BRS clients referred by an agency or BRS contractor, which includes the following:

(a) The name of the BRS client referred;

(b) The date the referral was received;

(c) The reason the referral was accepted or denied; and

(d) The date the referral was responded to in writing.

(8) Intake Procedures:

(a) On the day that the BRS client is physically admitted to the BRS contractor's or BRS provider's program, its staff must provide the BRS client and, as applicable, the BRS client's parent, guardian or legal custodian, with copies of the following policies:

(A) Behavior management system policy;

(B) Grievance policy;

(C) BRS client's and family's rights policies, including but not limited to visitation and communication policies and the policies regarding the search and seizure of the BRS client's person, property, and mail;

(D) Discharge polices, including but not limited to a discharge initiated by the BRS client;

(E) Seclusion and physical restraint policies;

(F) Suicide prevention policy and procedures; and

(G) Medication management policy;

(b) The BRS contractor must ensure its program, either operated by itself or by its BRS provider, maintains signed documentation indicating that the BRS client and, as applicable, the BRS client's parent, guardian or legal custodian received and understood the information described in section (8)(a) of this rule;

(c) If any of the policies described in section (8)(a) of this rule are individualized for a particular BRS client and differ from the program's standard documented practices, these variations shall be explained and documented, and included in or attached to the BRS client's service plan;

(d) If the BRS client's parent, guardian or legal custodian is unavailable at the time of admission, the BRS contractor must ensure its program, either operated by itself or by its BRS provider, documents in the BRS client's case file that it has forwarded this information to the BRS client's parent, guardian or legal custodian by facsimile, mail or electronic mail within 48 hours of the BRS client's admission to the program;

(e) The agency is responsible for notifying the BRS contractor or BRS provider of any changes to the information described in section (2) of this rule. In addition, the agency must provide the BRS contractor or BRS provider with the following information;

(A) Applicable written authorizations by the BRS client or the BRS client's parent, guardian or legal custodian consenting to the BRS client's participation in the BRS program;

(B) If applicable, the prepaid health plan or coordinated care organization in which the BRS client is enrolled;

(C) The BRS client's current medical information, medication regime, and other medical needs; and

(D) If applicable, the BRS client's school information, parental contact information, or similar types of information.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0060
Discharge from the BRS Contractor or BRS Provider

(1) Discharge initiated by the BRS client:

(a) The BRS client's participation in the BRS program is voluntary. The BRS contractor must, or ensure its BRS provider, develops and follows a process that allows the BRS client to provide no more than 3 business days advance notice of his or her decision to leave the BRS contractor's or BRS provider's program. If the BRS client wants to be discharged from the program, the BRS client is only required to provide the BRS contractor or BRS provider with 3 business days advance notice;

(b) If the BRS client wants to be discharged from the program, the BRS client must give the BRS contractor or BRS provider notice that complies with the policy described above. After receiving that notice, the BRS contractor or BRS provider must provide immediate verbal notification within 1 business day to the caseworker and the agency's designated contact and, if applicable, the BRS client's parent, guardian or legal custodian to allow for alternate placement arrangements. The BRS contractor or BRS provider must provide written notification to the caseworker and the agency's designated contact within 1 business day of its verbal notification.

(2) Planned discharge initiated by the BRS contractor, BRS provider, or the agency:

(a) Initiated by the BRS contractor or BRS provider:

(A) The BRS contractor or BRS provider must notify the caseworker in writing as soon as reasonably practicable regarding its intent to initiate the planned discharge of the BRS client from its program;

(B) Following notification, the BRS contractor or BRS provider and caseworker shall meet to discuss the case. If a discharge date can be agreed upon, the BRS client shall be discharged on that date. If they cannot agree, the caseworker shall

remove the BRS client from the program within 30 days from the original written notice to the caseworker, resulting in the BRS client's planned discharge;

(b) Initiated by the agency:

(A) The BRS client's caseworker must notify the BRS contractor or BRS provider in writing as soon as reasonably practicable regarding the agency's intent to initiate the planned discharge of the BRS client from its program;

(B) Following notification, the caseworker and the BRS contractor or BRS provider must meet to discuss the case. If a discharge date can be agreed upon, the BRS client must be discharged on that date. If they cannot agree, the caseworker may remove the BRS client from the program resulting in the BRS client's planned discharge.

(3) Emergency Discharge:

(a) Initiated by the BRS contractor or BRS provider:

(A) The BRS contractor or BRS provider may request the immediate discharge of a BRS client from its program if, after contact with the agency staff, there is mutual agreement that the BRS client is a clear and immediate danger to self or others. In such situations, the caseworker must consider the notification a priority and respond to the BRS contractor or BRS provider as soon as practicable but no later than one business day;

(B) The BRS contractor or BRS provider and caseworker must discuss the BRS client's continuation in, temporary removal or discharge from the program;

(b) Initiated by the agency: The agency may immediately remove the BRS client from the BRS contractor's or BRS provider's program for any reason, resulting in the BRS client's emergency discharge;

(c) Initiated by the parent or guardian: A parent or guardian with appropriate legal authority, as determined by the agency, may immediately remove the BRS client from the BRS contractor's or BRS provider's program, resulting in the BRS client's emergency discharge.

(4) Discharge from a particular program does not impact a BRS client's prior authorization for the BRS program generally. A BRS client may be referred to another BRS contractor or BRS provider or request re-referral to the same program, as long as the prior authorization remains valid and the BRS client remains eligible for the BRS program.

(5) Temporary Removal: The agency may temporarily remove the BRS client for any reason without resulting in a discharge from the BRS contractor's or BRS provider's program.

(6) Storage of the BRS client's personal property:

(a) The BRS contractor or BRS provider must store property belonging to the BRS client in its program for up to 30 days in a secure location following discharge, when the BRS client exits the program without his or her property;

(b) The BRS contractor or BRS provider must contact the BRS client's caseworker as soon as possible to make arrangements for the property to be retrieved. If the property has not been retrieved by the 15th day following discharge, the BRS contractor or BRS provider must contact the caseworker once more in order to remind them of the need to retrieve the property by the 30th day.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0070
BRS Service Planning

(1) Initial Service Plan (ISP):

(a) The BRS contractor or BRS provider must:

(A) Ensure that a social service staff member completes a written ISP within two business days of the BRS client's admission to its program;

(B) Provide an opportunity for the following individuals to participate in developing the BRS client's ISP, including but not limited to: the BRS client, the BRS client's family, social service staff, the BRS client's caseworker and any other significant persons involved with the BRS client;

(C) Obtain and maintain the signatures of all participants or documentation that the individuals listed in section (1)(a)(B) of this rule were provided with the opportunity to participate in developing the ISP;

(D) Obtain written approval of the ISP prior to its implementation from the caseworker and, as applicable and appropriate, the BRS client and the BRS client's parent, guardian or legal custodian; and

(E) Provide the services identified in the ISP during the first 45 days in the BRS provider's program or until the MSP is written;

(b) The BRS contractor or BRS provider must ensure that the ISP is individualized, developmentally appropriate, and based on a thorough assessment of the BRS client's referral information, and include at minimum the following:

(A) A plan to address specific behaviors identified in the referral information including the intervention to be used;

(B) A plan for any overnight home visits;

(C) The anticipated discharge date;

(D) The anticipated type of placement at discharge;

(E) A plan to address any needs identified in the referral information;

(F) Existing orders for medication and any prescribed treatments for medical conditions, mental health conditions, or substance abuse;

(G) Any type of behavior management system that will be used as an intervention; and

(H) Specific behavior management needs.

(2) Assessment and Evaluation Report (AER):

(a) The BRS contractor or BRS provider must:

(A) Ensure that a social service staff member conducts a comprehensive assessment of the BRS client and completes a written AER; and

(B) Submit the written AER to the caseworker within 30 days of the BRS client's admission to its program;

(b) The BRS contractor or BRS provider must ensure that the AER includes information about the BRS client with regard to the following domains:

(A) Legal custody and basis for custody;

(B) Medical information including prescribed medications and dosages;

(C) Family information including specific cultural factors;

(D) Mental health information;

(E) Alcohol and drug use both current and historical;

(F) Educational needs;

(G) Vocational needs;

(H) Social living skills; and

(I) Placement plans including home visits, anticipated discharge date, and placement resources;

(c) The BRS contractor or BRS provider must ensure that the AER describes the following:

(A) Identified problems, reason for referral or placement, and pertinent historical information;

(B) The BRS client's behaviors, response to current services, and strengths and assets;

(C) Significant incidents or interventions or both;

(D) The behavior management level needed for the BRS client, specifically any behavior management needs greater than usual for its program;

(E) Identification of any service goals; and

(F) Identified needs by assessment and history.

(d) Abbreviated AERs:

(A) Upon the request of the caseworker, the BRS contractor or BRS provider must submit an abbreviated AER regarding the BRS client's current status by the deadline stated in the written request;

(B) If a BRS client is transferred to the current BRS program from another BRS program and the BRS client's most recent AER is less than 90 days old, the current BRS contractor or BRS provider may submit an abbreviated AER to the caseworker within 30 days of the BRS client's transfer to its program;

(C) The BRS contractor or BRS provider must ensure an abbreviated AER includes at minimum the information in section

(2)(b)(A) of this rule and any other specific information requested by the caseworker. If the information is available, the BRS contractor or BRS provider must also include the information in section (2)(b)(B) through (D) of this rule;

(3) Master Service Plan (MSP):

(a) The BRS contractor or BRS provider must:

(A) Ensure that a social service staff member completes a written individualized MSP within 45 days of the BRS client's admission to its program;

(B) Provide the opportunity for the individuals listed in section (1)(a)(B) of this rule to participate in developing the BRS client's MSP;

(C) Obtain and maintain the signatures of all participants or documentation that the individuals listed in section (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP;

(D) Obtain written approval of the MSP prior to its implementation from the caseworker and, as applicable and appropriate, the BRS client and the BRS client's parent, guardian or legal custodian; and

(E) Provide the services identified in the MSP;

(b) The BRS contractor or BRS provider must ensure that the MSP includes goals that are measurable and attainable within a specified time frame, and address at minimum the following domains where need is indicated by the BRS client's assessment and history:

(A) Legal custody and basis for custody;

(B) Medical information including medications and dosages;

(C) Family information including specific cultural factors;

(D) Mental health information;

(E) Alcohol and drug use both current and historical;

(F) Educational needs;

(G) Vocational needs;

(H) Social living skills;

(I) Placement plans including home visits, anticipated discharge date, and placement resources;

(J) Other needs identified in the BRS client's AER that do not fall in one of the other identified domains above; and

(K) Completion criteria individualized for each BRS client. Completion is defined by progress in acquiring pro-social behaviors, attitudes, and beliefs while in the program, and not engaging in behavior that seriously jeopardizes the safety of staff and other program participants;

(c) The BRS contractor or BRS provider must ensure that the MSP is individualized and developmentally appropriate, and includes:

(A) Specifically stated and prioritized service goals for the BRS client that include the caseworker's recommendations and goals that the BRS client wants to achieve;

(B) Specific interventions and services its program shall provide to address each goal, including the use of a behavior management system as an intervention and any behavior management needs that are greater than usual for the program;

(C) Staff responsible for providing the identified services;

(D) Specifically stated behavioral criteria for evaluating the achievement of goals;

(E) A timeframe for the completion of goals;

(F) The method used to monitor the BRS client's progress towards completing goals and the person responsible for monitoring progress; and

(G) Aftercare and transition goals and planning;

(d) The BRS contractor or BRS provider must identify in the MSP those needs identified in a BRS client's AER that will be addressed by an outside provider and identify that provider. The BRS contractor or BRS provider must also facilitate the BRS client's access to other providers whenever needs identified in the AER cannot be met within the scope of the services offered by its program;

(e) The BRS contractor or BRS provider must also describe in the MSP any plan for the BRS client to participate in overnight home visits, including but not limited to documenting when the home visits are to occur, identifying the frequency of the visits (up to a maximum of 8 days per month), and describing how the visits relate to the BRS client's goals identified in the MSP. The BRS contractor or BRS provider must make every attempt to schedule home visits so that they do not conflict with services. Any deviation from the approved home visit plan requires prior written approval from the agency.

(4) Master Service Plan 90 Day Updates:

(a) The BRS contractor or BRS provider must:

(A) Ensure that a social service staff member reviews and updates in writing the BRS client's MSP no later than 90 days from the date the MSP was first finalized or the last time it was updated, and every 90 days thereafter. Social service staff must review the MSP, and update it in writing if necessary, earlier whenever additional information becomes available that suggests that other services should be provided;

(B) Provide the opportunity for the individuals listed in section (1)(a)(B) of this rule to participate in developing the BRS client's MSP updates;

(C) Obtain and maintain the signatures of all participants or documentation that the individuals listed in section (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP updates;

(D) Obtain written approval of an updated MSP prior to its implementation from the caseworker and, as applicable and appropriate, the BRS client and the BRS client's parent, guardian or legal custodian; and

(E) Provide the services identified in the most recent MSP update;

(b) The BRS contractor or BRS provider must ensure that the written update to the MSP is individualized and developmentally appropriate, and includes at minimum the following:

(A) The BRS client's progress towards achieving service goals;

(B) The BRS client's performance on the behavior management system;

(C) The BRS client's performance on any individualized plans developed to address specific behaviors;

(D) Any modifications to services based on the BRS client's new behaviors or identified needs;

(E) Any changes regarding recommendations, the discharge date, or aftercare and transition plans; and

(F) A summary of incidents involving the BRS client that have occurred since the last time the MSP was updated.

(5) Aftercare and Transition Plan (ATP):

(a) The BRS contractor or BRS provider must:

(A) Ensure that a social service staff member develops and completes a written ATP at least 30 days prior to or as close as possible to the BRS client's planned discharge;

(B) Provide the opportunity for the individuals listed in section (1)(a)(B) of this rule and members of the service planning team to participate in developing the BRS client's written ATP;

(C) Obtain and maintain the signatures of all participants or documentation that the individuals listed in section (1)(a)(B) of this rule and members of the service planning team were provided with the opportunity to participate in developing the written ATP;

(D) Provide a copy of the written ATP to the individuals described in section (1)(a)(B) of this rule and members of the service planning team; and

(E) Obtain written approval of the written ATP from the caseworker and, as applicable and appropriate, the BRS client and the BRS client's parent, guardian or legal custodian;

(b) The BRS contractor or BRS provider must ensure that the written ATP describe how the BRS client will successfully transition from its program to the community, specifically addressing the period of 90 days after discharge from its program. The BRS contractor or BRS provider must ensure that the written ATP includes, at minimum, the following:

(A) Identification of the BRS client's individual needs and unmet goals;

(B) Identification of the aftercare services and supports outside of its program that will be available for the 90-day time period;

(C) Identification of the person or entity responsible for providing the aftercare services; and

(D) Schedule for regular telephone contact by BRS provider staff with the BRS client and, as applicable, the BRS client's family, caseworker or other identified significant persons;

(c) The BRS contractor or BRS provider shall not be required to provide an initial and final written ATP under the following circumstances:

(A) The agency, legal guardian, or custodian removes the BRS client from the program with little or no advance notice and in a manner not in accordance with the existing ATP;

(B) The BRS client is discharged from the program on an emergency basis due to the BRS client's behavior, runaway status without a plan to return to the program, or transfer to another program or higher level of care; or

(C) The BRS client initiates an immediate voluntary discharge from the program.

(6) Discharge Summary: The BRS contractor or BRS provider must ensure that a social service staff member completes and provides a written discharge summary to the caseworker within 15 days following the BRS client's planned or actual discharge from its program. The discharge summary must include the BRS client's progress towards service goals.

(7) Aftercare Summary: The BRS contractor or BRS provider must ensure that a social service staff member completes and provides a written aftercare summary to the caseworker within 120 days following the BRS client's discharge from its program. An aftercare summary is not required if the BRS provider was not required to complete an ATP. The aftercare summary must summarize the BRS client's status and progress on the ATP for the 90 days following the BRS client's discharge from the BRS provider, including but not limited to the BRS client's adjustment to the community and any further recommendations.

(8) Notwithstanding sections (5) through (7) of this rule, the BRS contractor or BRS provider is not required to complete an ATP, discharge summary and aftercare summary for the BRS clients receiving services and placement related activities in the following BRS types of care:

(a) Shelter, Assessment and Evaluation;

(b) Intensive Community Care; and

(c) Independent Living Service.

(9) Independent Living Program: A BRS contractor or BRS provider that provides services and placement related activities in an Independent Living Program:

(a) Is not required to complete an ISP, AER, ATP, and aftercare summary for the BRS clients in its program, notwithstanding sections (1), (2) and (5) through (7) of this rule; and

(b) Must complete an MSP, the MSP updates and a discharge summary for the BRS clients in its program consistent with the requirements in sections (3) and (4) of this rule, and the additional requirements for a master service plan — transition and the master service plan — transition updates as described in OAR 416-335-0060.

(10) Short-Term Stabilization Program: A BRS contractor or BRS provider that provides services and placement related activities in a Short-Term Stabilization Program:

(a) Is not required to complete an ISP and aftercare summary for the BRS clients in its program, notwithstanding sections (1) and (7) of this rule;

(b) Must complete an AER for the BRS clients in its program consistent with the requirements in section (2) of this rule, except in cases where the BRS client is not expected to remain in its program for more than 30 days;

(c) Must complete an ATP for the BRS clients in its program consistent with the requirements in section (5) of this rule except for those in section (5)(b)(D), and must complete the additional requirements for an aftercare and transition plan — stabilization in OAR 416-335-0070 for BRS clients who are being discharged home or into a non-BRS foster care placement; and

(d) Must complete a MSP and the MSP updates for the BRS clients in its program consistent with the requirements in sections (3) and (4) of this rule, and the additional requirements for a master service plan — stabilization and the master service plan — stabilization updates as described in OAR 416-335-0070.

(11) Documentation: The BRS contractor or BRS provider must ensure that all BRS service plans described in this rule are developed and maintained in the BRS client's case file in accordance with the timeframes and criteria in this rule, unless otherwise exempted.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0080
Services

(1) The BRS contractor or BRS provider must provide services to the BRS client in accordance with the BRS client's ISP or MSP.

(2) All services must be structured and directly supervised by the BRS contractor or BRS provider's staff.

(3) Types of Services:

(a) Crisis counseling: The BRS contractor or BRS provider provides the BRS client with counseling on a 24-hour basis in order to stabilize the BRS client's behavior until the problem can be resolved or assessed and treated by a qualified mental health professional or licensed medical practitioner;

(b) Individual and group counseling: The BRS contractor or BRS provider provides face-to-face individual or group counseling sessions to the BRS client which are designed to remediate the problem behaviors identified in the BRS client's ISP or MSP;

(c) Milieu therapy: The BRS contractor or BRS provider provides the BRS client with structured activities and planned interventions designed to normalize psycho-social development, promote safety, stabilize environment, and assist in responding in developmentally appropriate ways. The program's staff must monitor the BRS client in these activities, which include developmental, recreational, academic, rehabilitative, or other productive work. Milieu therapy occurs in concert with one of the other types of services;

(d) Parent training: Direct care staff or social service staff provide planned activities or interventions (face-to-face or by telephone) to the BRS client's family or identified aftercare resource family. Parent training is designed to assist the family in identifying the specific needs of the BRS client, to support the BRS client's efforts to change, and to improve and strengthen parenting knowledge or skills indicated in the ISP or MSP as being necessary for the BRS client to return home or to another community living resource;

(e) Skills-training: The BRS contractor or BRS provider provides the BRS client with planned, curriculum-based individual or group sessions designed to improve specific areas of functioning in the BRS client's daily living as identified in the ISP or MSP. Skills-training may be designed to develop appropriate social and emotional behaviors, improve peer and family relationships, improve self-care, encourage conflict resolution, reduce aggression, improve anger control, and reduce or eliminate impulse and conduct disorders;

(4) The BRS contractor or BRS provider must:

(a) Provide a combination of services necessary to comply with the BRS client's ISP or MSP and the requirements in OAR 410-170-0090 for the appropriate BRS type of care;

(b) Create and maintain written documentation describing the services provided to each BRS client which includes at a minimum the following information:

(A) Name of the BRS client;

(B) Date of service;

(C) Name and position of the staff member providing the service to the BRS client;

(D) Length of time staff spent providing the service to the BRS client;

(E) Description of the service provided; and

(F) Description of the BRS client's participation in the service;

(c) Create and maintain a written weekly record in each BRS client's case file with the total number of service hours provided each day to the BRS client and a breakdown of the number of hours spent providing each particular type of service described in section (3) of this rule; and

(d) Ensure that that social service staff review the documentation described in this section each week for quality, content, and appropriateness with the BRS client's ISP or MSP.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0090
BRS Types of Care

The BRS types of care are as follows:

(1) Shelter Assessment and Evaluation, Intensive Community Care, Independent Living Service, Community Step-Down, and Independent Living Program:

(a) The BRS contractor or BRS provider may use either a residential care model or therapeutic foster care model for these BRS types of care;

(b) The BRS client is placed in these BRS types of care to identify deficiencies and develop necessary skills;

(c) The BRS contractor or BRS provider providing one of these BRS types of care must ensure that a minimum of six hours of services are available per week to each BRS client as follows;

(A) One hour of individual counseling or individual skills-training provided by social service staff; and

(B) Five hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.

(2) Therapeutic Foster Care, BRS Proctor and Multidimensional Treatment Foster Care:

(a) The BRS contractor or BRS provider must use a therapeutic foster care model for these BRS types of care;

(b) The BRS client placed in these BRS types of care requires structure, behavior management, and support services to develop the skills necessary to be successful in a less restrictive environment;

(c) The BRS contractor or BRS provider providing one of these BRS types of care must ensure that a minimum of 11 hours of services are available per week to each BRS client as follows:

(A) Two hours of individual counseling or individual skills-training, one of which is provided by social service staff; and

(B) Nine hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.

(3) BRS Proctor Day Treatment:

(a) The BRS contractor or BRS provider must use a therapeutic foster care model for this BRS type of care and provide skills-training in a day treatment setting;

(b) The BRS client placed in this BRS type of care requires enhanced structure during the day time hours. This level of care provides the structure of day treatment for necessary skill development and a less restrictive home setting with an approved provider parent;

(c) The BRS contractor or BRS provider providing this BRS type of care must ensure that a minimum of eleven hours of services are available per week to each BRS client as follows:

(A) Two hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and

(B) Nine hours of individual or group counseling, crisis counseling, skills- training, or parent training;

(4) BRS Basic Residential, BRS Rehabilitation Services:

(a) The BRS contractor or BRS provider must use a residential care model for these BRS types of care. The BRS contractor or BRS provider must provide 24 hour supervision of the BRS client by ensuring that at least one direct care staff is on duty and awake whenever a BRS client is present in its program;

(b) The BRS client placed in these BRS types of care requires the structure, behavior management, and support services of a residential care model for necessary skill development;

(c) The BRS contractor or BRS provider providing these BRS types of care must ensure that a minimum of eleven hours of services are available per week to each BRS client as follows:

(A) Two hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and

(B) Nine hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.

(5) Intensive Rehabilitation Services, BRS Residential, BRS Enhanced, Short-Term Stabilization Program:

(a) The BRS contractor or BRS provider must use a residential care model for these BRS types of care. The BRS contractor or BRS provider must provide 24-hour supervision of the BRS client by ensuring that at least one direct care staff is on duty and awake whenever a BRS client is present in its program;

(b) The BRS client placed in these BRS types of care requires more intensive structure, behavior management and support services than a BRS client in the BRS types of care described in section (4) of this rule;

(c) The BRS contractor or BRS provider providing one of these BRS types of care must ensure that a minimum of 11 hours of services are available per week to each BRS client as follows:

(A) Two hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and

(B) Nine hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.

(6) Enhanced Therapeutic Foster Care:

(a) The BRS contractor or BRS provider must use a therapeutic foster care model for this BRS type of care;

(b) The BRS client placed in this BRS type of care can be maintained in a home of an approved provider parent with structure, behavior management and enhanced supports. The BRS client placed in this BRS type of care has difficulty in a group setting and requires a placement utilizing a therapeutic foster care model;

(c) The BRS contractor or BRS provider providing this BRS type of care must ensure that a minimum of 13 hours of services are available per week to each BRS client as follows:

(A) Two hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and

(B) Eleven hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0100
Placement Related Activities for the Authority's BRS Contractors and BRS Providers

(1) In cases where the Authority is the agency, the BRS contractor or BRS provider must provide the following placement related activities, and all facilities, personnel, materials, equipment, supplies and services, and transportation necessary to provide those activities including but not limited to:

(a) Transportation: The BRS contractor or BRS provider is responsible for the transportation of the BRS client to: attend school, to the extent not provided by the school district; medical, dental, and therapeutic appointments, to the extent not provided through the Oregon Health Plan; recreational and community activities; places of employment; and shopping for incidental items;

(b) Educational and vocational activities: The BRS contractor or BRS provider must have a system in place to meet the educational and vocational needs of the BRS client in its program either on-site or at an off-site location or a combination of the two;

(c) Recreational, social, and cultural activities:

(A) The BRS contractor or BRS provider shall provide recreation time for the BRS client on a daily basis, and offer activities that are varied in type to allow BRS clients to obtain new experiences. The BRS contractor or BRS provider shall document recreation as having been provided, by recording the type of activity the BRS client participated in, and the date it occurred;

(B) The BRS contractor or BRS provider shall provide each BRS client 2 to 3 opportunities per week to participate in recreational activities in the community, unless the BRS client is clearly unable to participate in offsite activities due to safety issues. If a BRS client is restricted from participation in community recreation, the BRS contractor or BRS provider shall document the reason in the BRS client's case file, and the reason must be reviewed regularly to ensure that the BRS client is not unnecessarily restricted from offsite activities. The BRS contractor or BRS provider shall offer any BRS client who is restricted from community activities alternative opportunities for recreation on-site;

(C) The BRS contractor or BRS provider shall provide access to or make available social and cultural activities for the BRS clients as part of the therapeutic milieu of the program. These activities are to promote the BRS client's normal development and help broaden the BRS client's understanding and appreciation of the community, arts, environment and other cultural groups;

(D) The BRS contractor or BRS provider may not permit BRS clients to participate in recreational activities that present a higher level of risk to BRS clients without pre-approval by the caseworker. This applies to activities that require a moderate to high level of technical expertise to perform safely, present environmental hazards, or where special certification or training is recommended or required such as: whitewater rafting, rock climbing, ropes courses, activities on or in any body of water where a certified lifeguard is not present and on duty, camping, backpacking, mountain climbing, using motorized yard equipment, and horseback riding;

(d) Academic Assistance: The BRS contractor or BRS provider shall provide adequate opportunities for the BRS clients to complete homework assignments with assistance from staff if needed.

(2) Non BRS-Related Medical Care:

(a) If there is no record that the BRS client has received a physical examination within the six months immediately prior to the BRS client's placement with its program, the BRS contractor or BRS provider shall ensure or make every effort to ensure that the BRS client receives a general medical check, consistent with health insurance allowances, within 30 days of placement. The BRS contractor or BRS provider shall keep documentation of this procedure in the BRS client's file and send a copy to the BRS client's caseworker;

(b) The BRS contractor or BRS provider shall ensure that each BRS client's mental health, physical health, (including alcohol and drug treatment services), dental and vision needs are arranged for. This does not include paying the cost of services or medications which are covered by the Oregon Health Plan (OHP) or by the BRS client's third party private insurance coverage. For services or medications not covered by OHP or third party private insurance, the BRS contractor or BRS provider must notify and work with the caseworker to resolve payment issues;

(c) The BRS contractor or BRS provider shall administer and monitor medications consistent with all applicable licensing rules and the program's own medication management policy;

(d) The BRS contractor or BRS provider shall facilitate the BRS client's access to other providers whenever identified needs cannot be met within the scope of services offered by the program. If health care services are needed but the program is unable to access the needed services for the BRS client, the BRS contractor or BRS provider shall immediately notify the caseworker about this in writing and document its unsuccessful efforts to access healthcare for the BRS client in the BRS client's case file.

(3) The Authority's BRS contractor, if not also the BRS provider, is responsible for ensuring its BRS provider provides the placement related activities to the BRS client as described in this rule.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

410-170-0110
Billing and Payment for Services and Placement Related Activities

(1) The BRS contractor is compensated for a billable care day (service and placement related activities rates) on a fee-for-service basis, except as otherwise provided for in these rules. The Authority does not make payments for any calendar day that does not meet the definition of a billable care day under this rule.

(2) Billable care day rates are provided in the "BRS Rates Table," dated May 1, 2016, which is adopted as Exhibit 1 and incorporated by reference into this rule. The BRS Rates Table is available at http://www.oregon.gov/OHA/healthplan/pages/brs.aspx. A printed copy may be obtained from the agency.

(3) Billable Care Day:

(a) For purposes of computing a billable care day, the BRS client must be in the direct care of the BRS provider at 11:59 p.m. of that day or be on an authorized home visit in accordance with section (4) of this rule;

(b) A billable care day does not include any day where the BRS client is on runaway status, in detention, an inpatient in a hospital, or has not yet entered or has been discharged from the BRS contractor's or BRS provider's program.

(4) Home Visits:

(a) The BRS contractor shall only include a maximum of eight calendar days of home visits in a month as billable care days;

(b) In order to qualify as an authorized home visit day, the BRS contractor must:

(A) Ensure that the home visit is tied to the BRS client's ISP or MSP;

(B) Work with the BRS client and the BRS client's family or substitute family on goals for the home visit and receive regular reports from the family on the BRS client's progress while on the home visit;

(C) Have staff available to answer calls from the BRS client and BRS client's family or substitute family and to provide services to the BRS client during the time planned for the home visit if the need arises;

(D) Document communications with the BRS client's family or substitute family; and

(E) Document the BRS client's progress on goals set for the home visits.

(5) Invoice form:

(a) The BRS contractor must submit a monthly billing form to the agency in a format acceptable to the agency on or after the first day of the month following the month in which it provided services and placement related activities to the BRS client. The billing form must specify the number of billable care days provided to each BRS client in that month;

(b) The BRS contractor must provide, upon request in a format that meets the agency's approval, written documentation of each BRS client's location for each day claimed as a billable care day;

(c) The BRS contractor may only submit a claim for a billable care day consistent with the agency's prior authorization.

(6) Payment for a Billable Care Day:

(a) The agency shall pay the service and placement related activities rates to the BRS contractor for each billable care day in accordance with the BRS Rates Table described in section (2) of this rule;

(b) Notwithstanding section (6)(a) of this rule, the Authority shall only pay the service rate for each billable care day to a public child-caring agency, who by rule or contract provides the local match share for Medicaid claims under OAR 410-120-0035 and 42 CFR 433 Subpart B. The Authority may not pay the placement related activities rate for each billable care day to these types of public child-caring agencies;

(c) To the extent the payment for services is funded by Medicaid and CHIP funds, the BRS contractor and the BRS provider are subject to Medicaid billing and payment requirements in these rules and the Authority's general rules (OAR 410-120-0000 to 410-120-1980).

(7) Third Party Resources:

(a) The Authority's BRS contractors must make reasonable efforts to obtain payment first from other resources consistent with OAR 410-120-1280(16);

(b) The Department's and OYA's BRS contractors are not required to review or pursue third party resources. The Department and OYA must make reasonable efforts to obtain payment first from other resources consistent with OAR 410-120-1280(16) for Medicaid-eligible BRS clients.

(8) Public child-caring agencies who are responsible by rule or contract for the local match share portion of eligible Medicaid claims must comply with OAR 410-120-0035 and 42 CFR 433 Subpart B.

(9) In cases where the BRS contractor is not also the BRS provider, the BRS contractor is responsible for compensating the BRS provider for billable care days pursuant to the agency-approved subcontract between the BRS contractor and the BRS provider.

(10) The Authority may not be financially responsible for the payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid or CHIP program. If the Authority has previously paid the agency or BRS contractor for any claim that CMS disallows, the payment shall be recouped pursuant to OAR 410-120-1397. The Authority shall recoup or recover any other overpayments as described in OAR 410-120-1397 and OAR 943-120-0350 and 943-120-0360.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14; DMAP 42-2015(Temp), f. & cert. ef. 8-11-15 thru 2-6-16; DMAP 4-2016(Temp), f. 2-5-16, cert. ef. 2-7-16 thru 8-4-16; DMAP 8-2016, f. & cert. ef. 2-23-16; DMAP 25-2016(Temp), f. & cert. ef. 6-3-16 thru 11-29-16

410-170-0120
Compliance Reviews & Sanctions

(1) The BRS contractor must cooperate, and ensure its BRS providers cooperate, with program compliance reviews or audits conducted by any federal or state or local governmental agency or entity related to the BRS program.

(2) The Authority or agency, or both, must conduct compliance reviews periodically, including but not limited to review of documentation and onsite inspections.

(3) If the agency determines that the BRS contractor is not in compliance with its contract to provide BRS services or placement related activities, including but not limited to non-compliance with state or federal law or regulation, then the agency may:

(a) Provide technical assistance;

(b) Require the BRS contractor or BRS provider to develop and implement a corrective action plan;

(c) Pursue any or all remedies authorized under the contract;

(d) Pursue any other remedy authorized by state or federal law; or

(e) Pursue any combination of the above.

(4) If the agency determines that the BRS contractor or the BRS provider is not in compliance with state or federal law or regulation then, in addition to pursuing any contract remedy, the agency may:

(a) Provide technical assistance;

(b) Require the BRS contractor or BRS provider to develop and implement a corrective action plan;

(c) Refer the case to an appropriate licensing or other oversight federal or state or local governmental agency or entity;

(d) Pursue any other remedy authorized by state or federal law; or

(e) Pursue any combination of the above.

(5) In addition to the remedies provided in section (3) and (4) above, if the Authority determines that the BRS contractor or the BRS provider is not in compliance with state or federal law or regulation, then the Authority may:

(a) Impose sanctions pursuant to OAR 410-120-1400 and 410-120-1460;

(b) Recover an overpayment pursuant to OAR 410-120-1397; or

(c) Any combination of the above.

(6) Overpayment:

(a) The Authority Identified: When an overpayment is identified, the Authority must notify the BRS contractor or BRS provider in writing. The overpayment amount will be determined at the Authority's discretion through direct examination of claims, through statistical sampling and extrapolation techniques or other means. Procedures for recovery of funds are as described in OAR 410-120-1397 or by applicable contract language;

(b) BRS contractor or Provider Identified: When a BRS contractor or BRS provider discovers that they requested and may have received reimbursement not in compliance with all applicable rules they must contact the Division's Medicaid Policy Unit and Office of Payment Accuracy and Recovery (OPAR) promptly to report the possible inappropriate payment and discuss the manner by which the appropriateness will be determined as well as programmatic changes and other notifications to be made.

(7) The BRS contractor or the BRS provider may appeal an Authority's notice of action for sanctions or overpayments under the appeal processes specified in the notice and applicable administrative rules for the Authority.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14

DIVISION 172

MEDICAID PAYMENT FOR BEHAVIORAL HEALTH SERVICES

410-172-0600
Acronyms and Definitions

(1) "ASAM PPC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care.

(2) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

(3) "Behavioral Health Services" means medically appropriate services rendered or made available to a recipient for treatment of a behavioral health or substance use disorders diagnosis.

(4) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division as defined in OAR 309-019-0105.

(5) "Letter" means the document awarded to providers by AMH indicating the provider has complied with specific program requirements or administrative rule.

(6) "Level of Care" means the type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.

(7) "Level of Care Determination" means the standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.

(8) "Recovery Assistant" means a provider who provides a flexible range of services. Recovery assistants provide face-to-face services in accordance with a service plan that enables a participant to maintain a home or apartment, encourages the use of existing natural supports, and fosters involvement in treatment, social, and community activities. A recovery assistant shall:

(a) Be at least 18 years old;

(b) Meet the background check requirements described in OAR 410-180-0326;

(c) Conform to the standards of conduct as described in OAR 410-180-0340.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0610
Provider Enrollment

(1) Providers shall be enrolled with the Division as a behavioral health provider. Paid providers of behavioral health services shall possess a current and valid license, letter, or certificate.

(2) Providers shall provide services within the scope of professional standards and practice defined by the providers licensing board or certifying organization.

(3) Providers shall meet all requirements in OAR 410-120-1260 (Medical Assistance Programs Provider Enrollment), OAR 943-120-0310 (Provider Requirements), and OAR 943-120-0320 (Provider Enrollment).

(4) Providers shall not be included on any US Office of Inspector General Exclusion lists.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0620
Documentation Standards

(1) OHP providers shall maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request.

(2) All records shall document the specific service provided, the number of services comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service.

(3) Clinical records shall document the recipient's diagnosis and the medical need for the service.

(4) The record shall be annotated each time a service is provided and be signed or initialed by the individual providing the service.

(5) Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in these rules, other Division rules, and pertinent contracts.

(6) For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services shall also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services shall comply with OAR 309-018-0140 through OAR 309-018-0150.

Stat. Auth.: ORS 413.042, 430.640, 430.705, & 430.715
Stats. Implemented: ORS 414.025, 414.065, & 430.640
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0630
Medically Appropriate

(1) In addition to the definition of medically appropriate in OAR 410-120-0000 for behavioral health services, "medically appropriate" means the services and supports required to diagnose, stabilize, care for, and treat a behavioral health condition.

(2) The Division shall make payment for medically appropriate behavioral health services when the services or supports are:

(a) Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;

(b) Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;

(c) Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;

(d) Not provided solely for the convenience of the recipient, the recipient's family, or the provider of the services or supplies;

(e) Not provided solely for recreational purposes;

(f) Not provided solely for research and data collection;

(g) Not provided solely for the purpose of fulfilling a legal requirement placed on the recipient.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0640
Behavioral Health Services Fee Schedule

(1) The Division shall pay providers based on the Behavioral Health Services Fee Schedule (fee-for-service (FFS) payment rates for behavioral health services) posted on the Authority web site.

(2) Payment shall be made at each provider's usual and customary charge or the Division's published reimbursement upper payment limit, whichever is less, minus payments received or due from other payers. Payments to other specified providers shall be made according to other approved schedules.

(3) The Division's maximum allowable rate-setting process uses a methodology that is based on the existing Medicaid fee schedule with adjustments for legislative changes and payment levels.

(4) Limitations contained in the Behavioral Health Services Fee Schedule, such as the maximum rate and the amount, duration, and scope of services provided, are subject to change at the discretion of the Division. Updates and changes are posted on the Behavioral Health Services Fee Schedule website at www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(5) Payment shall be made for services listed in the Medicaid Behavioral Health Procedure Fee Schedule that are rendered to Medicaid-eligible individuals by a qualified provider during the period in which the provider is enrolled with the Division.

(6) For cost-reimbursed services, the 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. Providers whose rates are paid based on a collective bargaining agreement are not exempt from this requirement.

(7) In accordance with 42 CFR § 405.506, a charge that exceeds the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or an applicable lowest charge level may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort, or expense that support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. The mere fact that the physician's or other person's customary charge is higher than prevailing would not justify a determination that it is reasonable.

(8) Payment by the Division does not limit the Authority or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines that payment for the service was not provided in accordance with applicable Oregon Administrative Rules or the service does not meet the criteria for quality or medical appropriateness of the care.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0650
Prior Authorization

(1) Some services or items covered by the Division require authorization before the service may be provided. Services requiring prior authorization are published on the Medicaid Behavioral Health Services Fee Schedule.

(2) The Division shall authorize payment for the type of service or level of care that meets the recipient's medical need and that has been adequately documented.

(3) The Division shall only authorize services that are medically appropriate and for which the required documentation has been supplied. The Division may request additional information from the provider to determine medical appropriateness.

(4) Documentation submitted when requesting authorization shall support the medical justification for the service. The authorization request shall contain:

(a) A cover sheet detailing relevant provider and recipient Medicaid numbers;

(b) Requested dates of service;

(c) HCPCS or CPT Procedure code requested; and

(d) Amount of service or units requested;

(e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 309-019-0140; or

(f) Any additional supporting clinical information supporting medical justification for the services requested;

(g) For substance use disorder services, the Division uses the American Society of Addition Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. Providers shall use the ASAM;

(h) For Applied Behavioral Analysis (ABA) services, the Division requires submission of:

(A) An evaluation as described in OAR 410-172-0770(1) from a physician or psychologist experienced in the diagnosis and treatment of autism;

(B) A referral for treatment as described in OAR 410-172-0770(1)(e) from a physician and/or psychologist experienced in the diagnosis and treatment of autism;

(C) A functional analysis and a behavior treatment plan from a licensed health care professional as defined in section 1 of 2015 Oregon Laws Chapter 674; or by a behavior analyst or assistant behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board; or by an individual actively pursuing or holding a declaration of practice through the Oregon Behavior Analysis Regulatory Board as described in OAR 824-035-0005.

(i) Residential treatment services for children may require a letter of approval by a designated quality improvement organization (QIO) as defined in this rule;

(j) Some services require additional approval or authorization by a physician, the Authority, or designee. Services requiring additional approval are listed on the Behavioral Health Fee Schedule or described in this rule.

(5) The Division may not authorize services under the following circumstances:

(a) The request received by the Division was not complete;

(b) The provider did not hold the appropriate license, certificate, or credential at the time services were requested;

(c) The recipient was not eligible for Medicaid at the time services were requested;

(d) The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the Division;

(e) The services requested are not in compliance with OAR 410-120-1260 through 410-120-1860;

(f) Authorization for payment may be given for a past date of service if:

(A) On the date of service, the recipient was made retroactively eligible or was retroactively dis-enrolled from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP);

(B) The services provided meet all other criteria and Division or Authority administrative rules and;

(C) The request for authorization is received within 30 days of the date of service.

(6) Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.

(7) Payment authorization is valid for the time-period specified on the authorization notice but may not exceed 12 months unless the recipient's benefit package no longer covers the service, in which case the authorization shall terminate on the date coverage ends.

(8) Prior authorization of services shall be subject to periodic utilization review and retrospective review to ensure services meet the definition of medical appropriateness.

(9) Payments shall be made for the provision of active treatment services. If active treatment is not documented during any period in which the Division has prior authorized services, the Division may limit or cancel prior authorization or recoup such payments.

(10) If providers fail to comply with requests for documents for purposes of verifying medical appropriateness within the specified time-frames, the Authority may deem the records non-existent and cancel prior authorization.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 60-2016(Temp), f. & cert. ef. 10-7-16 thru 4-4-17

410-172-0660
Rehabilitative Behavioral Health Services

(1) Rehabilitative behavioral health services means medical or remedial services recommended by a licensed medical practitioner or other licensed practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or substance use disorder and are intended to restore functioning to the highest degree possible.

(2) Remedial rehabilitative behavioral health services shall be recommended by a licensed practitioner of the healing arts as described in parts 4(c–h) and 5(a–d) within the scope of their practice under state law.

(3) Rehabilitative behavioral health services that include medical services shall be recommended by and provided under ongoing oversight of a licensed medical practitioner as described in part 4(a–b) of this rule within the scope of their practice under state law.

(4) Rendering providers of rehabilitative behavioral health services shall meet one of the following qualifications:

(a) Physician or Physician Assistant licensed in the State of Oregon;

(b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(c) Psychologist licensed by the Oregon Board of Psychology;

(d) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(e) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(f) Licensed Master Social Worker licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(g) Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;

(h) Licensed Occupational Therapist licensed by the Oregon Occupational Therapy Licensing Board;

(i) Organizational certificate of approval issued by the Health Systems Division (Division) as described in OAR 309-012-0130 through 309-012-0220.

(5) Board registered intern providers shall be supervised by a provider as described in section (4)(c–e) of this rule under an active board approved plan of practice and supervision and meet one of the following qualifications:

(a) Psychologist Associate Residents as described in OAR 858-010-0037;

(b) Licensed Psychologist Associate under continued supervision as described in OAR 858-010-0038;

(c) Licensed Professional Counselor intern or Marriage and Family Therapist intern registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011;

(d) Certificate of Clinical Social Work Associate issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009;

(e) Registered bachelor of social work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105.

(6) Providers exempt from licensure or registration per ORS 675.090(f), 675.523(3), or 675.825(c) shall be employed by or contracted with a provider organization certified by the Authority under ORS 430.610 to 430.695 as described in (4)(i) of this rule and meet one of the following qualifications:

(a) Qualified mental health professional as defined in OAR 309-019-0125(8);

(b) Qualified mental health associate as defined in OAR 309-019-0125(7);

(c) Mental health intern as defined in OAR 309-019-0105; or

(d) Peer-Support Specialist as defined in OAR 410-180-0305.

(7) In addition to meeting the provider requirements described in this rule, providers of Assertive Community Treatment (ACT) services shall be certified as a fidelity ACT team by the Division or its designee as described in OAR 309-019-0100.

(8) In addition to meeting the provider requirements described in this rule, providers of Supported Employment or Supported Education services shall be certified by the division or its designee as described in OAR 309-019-0100.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 16-2016(Temp), f. & cert. ef. 4-15-16 thru 10-11-16; DMAP 50-2016(Temp), f. 8-1-16, cert. ef. 8-3-16 thru 10-11-16; DMAP 59-2016, f. 10-4-16, cert. ef. 10-11-16

410-172-0670
Substance Use Disorder Treatment Services

(1) Substance Use Disorder (SUD) treatment services include, but are not limited to, screening; assessment; individual counseling; group counseling; individual family, group or couple counseling; care coordination; medication-assisted treatment; medication management; collection and handling of specimens for substance analysis; interpretation services; detoxification for substance use disorders; synthetic opioid treatment; and acupuncture.

(2) Providers seeking reimbursement for the provision of substance use disorder services within the scope of their practice under state law shall meet one of the following qualifications:

(a) Certificate issued by the Division as described in OAR chapter 415 division 012;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent individuals under ORS 443.400 or a detoxification center as defined in ORS 430.306 shall have a certificate issued by the Division as described in OAR chapter 415, division 012;

(c) Synthetic opioid treatment programs shall meet the requirements described in OAR chapter 415, division 020;

(d) Substance use detoxification programs shall meet the standards described in OAR 415, chapter 050;

(e) Physician or Physician Assistant licensed by the State of Oregon;

(f) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(g) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(h) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(i) Psychologist licensed by the Oregon Board of Psychology;

(j) Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;

(k) Licensed Master Social Worker licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(L) Acupuncturist licensed by the Oregon Medical Board.

(3) Board registered intern providers shall be supervised by a paid provider described in section (2)(g-i) of this rule under an active board approved plan of practice and supervision and meet one of the following qualifications:

(a) Psychologist Associate Residents as described in OAR 858-010-0037;

(b) Licensed Psychologist Associate under continued supervision as described in OAR 858-010-0038;

(c) Licensed Professional Counselor intern or Marriage and Family Therapist intern registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011;

(d) Certificate of Clinical Social Work Associate issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009;

(e) Registered bachelor of social work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105.

(4) Providers exempt from licensure or registration per ORS 675.090(f), 675.523(3) or 675.825(c) shall be employed by or contracted with a provider organization certified by the Authority under ORS 430.610 to 430.695 as described in (2)(a–d) of this rule and meet one of the following qualifications:

(a) Qualified mental health professional as defined in OAR 309-019-0125(8);

(b) Qualified mental health associate as defined in OAR 309-019-0125(7);

(c) Mental health intern as defined in OAR 309-019-0105(68); or

(d) Peer-Support Specialist or Recovery Mentor as defined in OAR 410-180-0305(13);

(e) Substance Use Disorder counselor certified by a national or state accrediting body.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 50-2016(Temp), f. 8-1-16, cert. ef. 8-3-16 thru 10-11-16; DMAP 59-2016, f. 10-4-16, cert. ef. 10-11-16

410-172-0680
Residential Treatment Services for Children

(1) Paid providers of children's psychiatric residential treatment services shall:

(a) Hold a Certificate of Approval Pursuant to OAR 309-012-0130 through 309-012-0220 from AMH; and

(b) Be accredited as a psychiatric residential treatment facility for children under age 18 by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the State of Oregon;

(c) Be licensed by the Office of Licensing and Regulatory Oversight (OLRO);

(2) Residential Treatment Services for Children shall provide a program consistent with standards set by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the state.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0690
Admission Procedure for Residential Treatment Services for Children

(1) Admission procedures for children eligible for Medicaid shall be reviewed through an independent psychiatric review process established by the Division to certify the need for services.

(2) The referring source or the facility shall make available for the Certificate of Need (CONS) process the following information about the referred child:

(a) A written psychological or psychiatric evaluation completed within the previous 60 days;

(b) A written psychosocial history following the format required by the admission procedure of the facility to which the child has been referred;

(c) Results of any direct recipient observation and assessment subsequent to the referral;

(d) Other information from the referral source, other involved community agencies, and the family that are pertinent and appropriate to the admission procedure;

(e) Level of Need Determination Process outcome and Child and Adolescent Service intensity instrument (CASII) score;

(f) Identified care coordinator;

(g) Identified Intensive Community Based Treatment Services (ICTS) provider;

(h) Identified child and family team members;

(i) Service Coordination Plan or expected date of completion;

(j) Documentation regarding attempt or failure at lower level of care placement;

(k) Letter from Community Mental Health Program (CMHP) approving the referral to this level of care;

(L) Documentation that private insurance benefit will not fund stay.

(3) Certification for emergency admissions shall be made by the team responsible for a plan of care as described in CFR 441.156 within 14 days from the date of admission.

(4) The Division shall authorize payment for psychiatric residential treatment services for children upon the approval of a certificate of need by the Division or designee.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0700
1915(i) Home and Community Based Services

(1) Habilitation services are designed to help an individual attain or maintain their maximal level of independence, including the individual's acceptance of a current residence and the prevention of unnecessary changes in residence. Services are provided in order to assist an individual to acquire, retain, or improve skills in one or more of the following areas: Assistance with activities of daily living, cooking, home maintenance, community inclusion and mobility, money management, shopping, community survival skills, communication, self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

(2) Psychosocial rehabilitation services are medical or remedial services recommended by a licensed physician or other licensed practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible.

(3) Providers seeking reimbursement for the provision of rehabilitative behavioral health services shall meet one of the following qualifications:

(a) Physician or Physician Assistant licensed in the State of Oregon;

(b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(c) Psychologist licensed by the Oregon Board of Psychology;

(d) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(e) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(f) Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;

(g) Licensed Master Social Worker licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(h) Licensed Occupational Therapist licensed by the Oregon Occupational Therapy Licensing Board;

(i) Organizational certificate of approval issued by the Division as described in OAR 309-012-0130 through 309-012-0220.

(4) Board registered intern providers shall be supervised by a paid provider as described in section (3)(c–f) of this rule under an active board approved plan of practice and supervision and meet one of the following qualifications:

(a) Psychologist Associate Residents as described in OAR 858-010-0037;

(b) Licensed Psychologist Associate under continued supervision as described in OAR 858-010-0038;

(c) Licensed Professional Counselor intern or Marriage and Family Therapist intern registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011;

(d) Certificate of Clinical Social Work Associate issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009;

(e) Registered bachelor of social work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105.

(5) Providers exempt from licensure or registration per ORS 675.090(f), 675.523(3), or 675.825(c) shall be employed by or contracted with a provider organization certified by the Authority under ORS 430.610 to 430.695 as described in (3)(i) of this rule and meet one of the following qualifications:

(a) Qualified mental health professional as defined in OAR 309-019-0105;

(b) Qualified mental health associate as defined in OAR 309-019-0105;

(c) Mental health intern as defined in OAR 309-019-0105; or

(d) Peer-Support Specialist as defined in OAR 410-180-0305;

(e) Recovery Assistant.

(6) Providers of 1915(i) services may be required to meet Community Mental Health Program (CMHP) liability insurance requirements.

(7) Due to federal requirements for the Authority to ensure the impartiality of paid providers rendering services to 1915(i) eligible members, providers may be restricted from conducting eligibility reviews or developing the behavioral health assessment or service plan.

(8) To be eligible for services under the 1915(i) State Plan HCBS, the individual shall meet the following requirements:

(a) Been diagnosed with a chronic mental illness as defined in ORS 426.495;

(b) Been assessed as needing assistance to perform at least two personal care services as identified in these rules due to a chronic mental illness.

(9) Eligibility for 1915(i) services is determined by an external Independent and Qualified Agent (IQA) as identified by the Division.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 50-2016(Temp), f. 8-1-16, cert. ef. 8-3-16 thru 10-11-16; DMAP 59-2016, f. 10-4-16, cert. ef. 10-11-16

410-172-0710
Residential Personal Care

(1) Personal care services provided to a resident of a Division licensed residential treatment program include a range of assistance, as developmentally appropriate, and are provided to individuals with behavioral health conditions that enable them to accomplish tasks that they would normally do for themselves if they did not have a behavioral health condition. Assistance may be in the form of hands-on assistance (actually performing a personal care task) or cueing (redirecting) so that the individual performs the task by him

or herself. Behavioral health personal care attendant services are provided in accordance with an individual's authorized plan for services recommended by a provider meeting the qualifications of a QMHP or QMHA as defined in OAR 309-019-0105.

(2) Personal care assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(3) Personal care services may be provided on a continuing basis or on episodic occasions.

(4) Paid providers of facility-based personal care services shall meet one of the following:

(a) Licensed residential facility pursuant to OAR chapter 309, divisions 035 and 040;

(b) Secure Residential Treatment Facility (SRTF);

(c) Residential Treatment Facility (RTF);

(d) Residential Treatment Home (RTH);

(e) Adult Foster Home (AFH).

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 50-2016(Temp), f. 8-1-16, cert. ef. 8-3-16 thru 10-11-16; DMAP 59-2016, f. 10-4-16, cert. ef. 10-11-16

410-172-0720
Prior Authorization and Re-Authorization for Residential Treatment

(1) The Authority does not consider a request for a fixed episode of care or standardized length of stay to be medically appropriate. Requested length of stay shall be based on an assessment of individual need and the medical appropriateness of the proposed time for treatment.

(2) Residential treatment is intended as an outcome-based, transitional, and episodic period of care to provide service and supports in a structured environment that will allow the individual to successfully reintegrate into an independent community-based living arrangement.

(3) Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environment in the community.

(4) Authority licensed residential treatment programs are reimbursed for the provision of rehabilitation, substance use disorder, habilitation, or personal care services as defined in these rules.

(5) The Division shall authorize admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation.

(6) Prior authorization requests for admission and continued stay may be reviewed to determine:

(a) The medical appropriateness of the admission for residential services provided;

(b) The appropriateness of the recommended length of stay;

(c) The appropriateness of the recommended plan of care;

(d) The appropriateness of the licensed setting selected for service delivery;

(e) A level of care determination was appropriately documented.

(7) If the Division determines that a residential service prior authorization request is not within coverage parameters, the provider shall be notified in writing and shall have ten business days to provide additional written documentation to support the medical appropriateness of the admission and procedures.

(8) If the reconsidered decision is to uphold the denial, prior authorization shall be denied.

(9) The provider may appeal any final decision through the Division administrative appeals process as described in OAR 410 120-1560 through1875.

(10) Upon denial of a prior authorization request for continued stay, the Division shall authorize payment for up to 60 days of continued stay for the purposes of supporting transition management and planning for the recipient.

(11) The Division shall determine re-authorization and authorization of continued stays based upon one of the following:

(a) The recipient continues to meet all basic elements of medical appropriateness and;

(b) One of the following criteria shall be met:

(A) Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;

(B) The recipient has developed new or worsening symptoms or behaviors that require continued stay in the current level of care;

(12) Requests for continued stay based on these criteria shall include documentation of ongoing re-assessment and necessary modification to the current treatment plan or residential plan of care.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0730
Payment Limitations for Behavioral Health Services

(1) Services shall be subject to periodic utilization review to determine medical appropriateness.

(2) If a review reveals that a recipient received less than active treatment, payment shall not be allowed under these rules and prior authorization may be cancelled.

(3) The Division shall make no payment for services if the Division or designee has determined the service is not medically appropriate.

(4) Residential treatment services are provided to Medicaid Title XIX eligible individuals in facilities with 16 or fewer beds. Payment is excluded for individuals in "institutions of mental diseases" (IMD) who are over age 18 and under age 65. IMDs are defined in 42 CFR 435.1010.

(5) For residential facilities, the Division may not pay for planned or unplanned absences unless the provider can document clinical services were rendered during the temporary absence.

(6) For residential facilities, the Division shall pay for the day of admission but may not pay for the day of transfer or discharge.

(7) Medicaid may not reimburse costs associated with room and board for recipients residing in Authority licensed residential treatment programs.

(8) Consistent with 42 CFR 447.40, payment for a reserved bed is not covered under Medicaid.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0760
Applied Behavior Analysis

(1) Applied Behavior Analysis (ABA) services shall be recommended by a licensed physician or licensed psychologist who has experience or training in the diagnosis of autism spectrum disorder and holds at least one of the following educational degrees and valid licensure:

(a) Physician licensed to practice in the State of Oregon;

(b) Psychologist licensed to practice in the State of Oregon;

(2) Paid providers of ABA services shall hold the following license, registration, or declaration of practice:

(a) Licensed Behavior Analyst as described in OAR 824-030-0010;

(b) Licensed health care professional who is registered with the Oregon Behavior Analyst Certification Board as described in OAR 824-030-0030;

(c) Individual actively pursuing or holding a declaration of practice through the Oregon Behavior Analysis Regulatory Board as described in OAR 824-035-0005.

(3) Non-paid providers of ABA services shall hold the following license or registration:

(a) Assistant Behavior Analyst licensed by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0020;

(b) Behavior Analysis Interventionists registered by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0040.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 60-2016(Temp), f. & cert. ef. 10-7-16 thru 4-4-17

410-172-0770
Individual Eligibility for Applied Behavioral Analysis Treatment

(1) Prior to receiving services, individuals receiving ABA shall have an evaluation by a physician or psychologist experienced in the diagnosis and treatment of autism using the current DSM criteria that includes:

(a) A Diagnosis of an Autism spectrum disorder or stereotypy with self-abusive behavior due to neurological dysfunction;

(b) Documentation of and results from a standardized tool that has been used to substantiate the autism disorder or questionnaires or observation that have been used to substantiate a diagnosis of stereotypy with self-abusive behavior due to neurological dysfunction;

(c) Documentation of behaviors that are considered to have an adverse impact on the individual's development or communication;

(d) Documentation of behavior that is injurious to themselves or others or that interferes with everyday functions or activities;

(e) Documentation that less intensive treatment or other therapy has been considered or found insufficient;

(f) Any other documentation that would substantiate the diagnosis of autism or stereotypy with self-abusive behavior due to a neurological dysfunction including but not limited to:

(A) Notes from well-child visits or other medical professionals;

(B) Results from any additional assessments such as IQ tests, speech and language tests, or tests of auditory function.

(g) A referral for ABA treatment shall include:

(A) A diagnosis of autism or stereotypy with self-abusive behavior due to a neurological dysfunction;

(B) A copy of the evaluation described above;

(C) A referral for ABA treatment without specifying hours or intensity.

(2) Refer to the Health Evidence Review Commission's Prioritized List for guideline notes related to ABA therapy.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15; DMAP 60-2016(Temp), f. & cert. ef. 10-7-16 thru 4-4-17

410-172-0780
Behavioral Health Personal Care Attendant Program

(1) Behavioral health personal care attendant services are essential services that enable an individual to move into or remain in his or her own home. Behavioral health personal care attendant services are provided in accordance with an individual's authorized plan for services by a QMHA or QMHP as defined in OAR 309-019-0105:

(a) Behavioral health personal care attendant services are provided directly to an eligible individual and are not meant to provide respite or other services to an individual's natural support system. Behavioral health personal care attendant services may not be implemented for the purpose of benefiting an individual's family members or the individual's household in general;

(b) Behavioral health personal care attendant services are limited to 20 hours per month per eligible individual;

(c) To meet an extraordinary personal care need, an individual, representative, or legal representative may request an exception to the 20-hour per month limitation. An exception shall be requested through the local community mental health program or agency contracted with the Authority serving the individual. The Division has up to 45 days upon receipt of an exception request to determine whether an individual's assessed personal care needs warrant exceeding the 20-hour per month limitation.

(2) Personal care services include:

(a) Basic personal hygiene, providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(b) Toileting, bowel, or bladder care, assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, and bowel care;

(c) Mobility, transfers, or repositioning, assisting an individual with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, and encouraging or assisting with range-of-motion exercises;

(d) Nutrition, preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(e) Medication or oxygen management, assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(f) Delegated nursing tasks, as defined in OAR 411-034-0010.

(3) When any of the services listed in section (2) of this rule are essential to the health, safety, and welfare of an individual and the individual is receiving personal care paid by the Division, the following support services may also be provided:

(a) Housekeeping tasks necessary to maintain the individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the individual's needs may be considered in housekeeping;

(b) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services (described in OAR chapter 410, division 136) and assistance with mobility and transfers or cognition in getting to and from appointments or to an office within a medical clinic or center;

(c) Observing the individual's health status and reporting any significant changes to physicians, health care professionals, or other appropriate persons;

(d) First aid and handling of emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another individual and responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(e) Cognitive assistance or emotional support provided to an individual by another person due to confusion, dementia, behavioral symptoms, or mental or emotional disorders. Cognitive assistance or emotional support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(4) Payment may not be made for any of the following excluded services:

(a) Shopping;

(b) Community transportation;
(c) Money management;
(d) Mileage reimbursement;
(e) Social companionship;
(f) Day care, adult day services (described in OAR chapter 411, division 066), respite, or baby-sitting services;
(g) Medicaid home delivered meals (described in OAR chapter 411, division 040);
(h) Care, grooming, or feeding of pets or other animals; or
(i) Yard work, gardening, or home repair.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0790
Eligibility for Behavioral Health Personal Care Attendant Services

(1) To be eligible for Behavioral Health personal care attendant services, an individual shall:
(a) Demonstrate the need for assistance from a qualified provider due to a disabling behavioral health condition with personal care services and meet the eligibility criteria described in this rule;
(b) Be a current recipient of a Medicaid OHP full benefit package.
(2) An individual is not eligible to receive Behavioral Health personal care attendant services if:
(a) The individual is receiving personal care services from a licensed 24-hour residential services program (such as an adult foster home, residential treatment home, or residential treatment facility);
(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution;
(c) The individual's assessed service needs are being met under other Medicaid-funded home and community-based service options of the individual's choosing.
(3) Behavioral health personal care attendant services are not intended to replace routine care commonly needed by an infant or child typically provided by the infant's or child's parent.
(4) Behavioral health personal care attendant services may not be used to replace other non-Medicaid governmental services.
(5) The Authority may close the eligibility and authorization for Behavioral Health personal care attendant services if an individual fails to:
(a) Employ a provider that meets the requirements in this rule;
(b) Receive personal care from a qualified provider paid by the Authority for 30 continuous calendar days or longer.
(6) Behavioral health personal care attendant services may not duplicate other Medicaid services.
(7) Individuals eligible for Behavioral Health personal care attendant services as described shall apply through the local community mental health program or agency contracted with AMH.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, & 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0800
Personal Care Attendant Employer-Employee Relationship

(1) The relationship between a provider and an eligible individual or the individual's representative is that of employee and employer.
(2) As an employer, the individual shall create and maintain a job description for a potential provider that is in coordination with the individual's plan for services.
(3) The only benefits available to homecare and personal support attendants are those negotiated in a collective bargaining agreement and as provided in statute. The collective bargaining agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Homecare and personal support workers are not state or Division employees.
(4) To be eligible for Behavioral Health personal care attendant services, the individual or the individual's representative shall demonstrate the ability to:
(a) Locate, screen, and hire a provider meeting the requirements described in this rule;
(b) Supervise and train a provider;
(c) Schedule work, leave, and coverage;
(d) Track the hours worked and verify the authorized hours completed by a provider;
(e) Recognize, discuss, and attempt to correct any performance deficiencies with the provider and provide appropriate, progressive, disciplinary action as needed; and
(f) Discharge an unsatisfactory provider.
(5) The Authority shall pay for Behavioral Health personal care attendant services to the provider on an individual's behalf. Payment for services is not guaranteed until the Authority has verified that an individual's provider meets the qualifications set forth in this rule.
(6) In order to receive Behavioral Health personal care attendant services from a personal support worker or homecare worker, an individual shall be able to meet or designate a representative to meet the employer responsibilities in section (4) of this rule.
(7) Termination and the grounds for termination of employment are determined by an individual or the individual's representative. An individual may terminate an employment relationship with a provider at any time and for any reason. An individual shall establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal, notice of resignation, work scheduling, and absence reporting.
(8) After appropriate intervention, an individual unable to meet the employer responsibilities in section (4) of this rule may be determined ineligible for Behavioral Health personal care attendant services.
(9) An individual determined ineligible for Behavioral Health personal care attendant services may request these services at the individual's next annual re-assessment. Improvements in health and cognitive functioning may be factors in demonstrating the individual's ability to meet the employer responsibilities described in section (4) of this rule. The waiting period may be shortened if an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the individual's next annual re-assessment.
(10) An individual may designate a representative to act on the individual's behalf to meet the employer responsibilities in section (4) of this rule. An individual's legal representative may be designated as the individual's representative:
(a) The Authority may deny an individual's designation of a representative if the representative has:
(A) A history of a substantiated abuse of an adult as described in OAR chapter 411, division 20, OAR chapter 407, division 45, or OAR chapter 943, division 45;
(B) A history of founded abuse of a child as described in ORS 419 B.005;
(C) Participated in billing excessive or fraudulent charges; or
(D) Failed to meet the employer responsibilities, including previous termination for failure to meet the employer responsibilities in section (4) of this rule.
(b) An individual may select another representative if the Authority suspends, terminates, or denies an individual's designation of a representative.
(11) An individual with a guardian shall have a representative for service planning purposes. A guardian may designate themselves the individual's representative.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0810
Personal Care Attendant Qualifications

(1) A qualified provider is an individual who, in the Authority's judgment, demonstrates by background, skills, and abilities knowledge and ability to perform or to learn to perform the required work. A qualified provider shall:

(a) Maintain a drug-free work place;

(b) Complete the background check process described in OAR 943, division 007 with an outcome of approved or approved with restrictions;

(c) May not be an individual's legal representative;

(d) Be authorized to work in the United States in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules;

(e) Be 18 years of age or older.

(2) A qualified provider may be employed through a contracted in-home care agency or enrolled as a homecare worker or personal support worker under a provider number. The Authority shall establish the rates for services.

(3) Providers that provide Behavioral Health personal care attendant services shall:

(a) Be enrolled in the Consumer-Employed Provider Program and meet all of the standards in OAR chapter 411, division 31;

(b) Meet the provider enrollment and termination criteria described in OAR 411-031-0040 for personal support workers.

(4) The Authority shall conduct background rechecks at least every other year from the date a provider is enrolled. The Authority may conduct a recheck more frequently based on additional information discovered about a provider, such as possible criminal activity or other allegations.

(5) Prior background check approval for another Authority provider type is inadequate to meet background check requirements for homecare or personal support workers.

(6) Provider enrollment may be inactivated when a provider fails to comply with the background recheck process. Once a provider's enrollment is inactivated, the provider shall reapply and meet the requirements described in these rules to reactivate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0820
Provider Termination

(1) The Authority may deny or terminate a personal care attendant's provider enrollment and provider number as described in OAR 411-031-0050. The termination, administrative review, and hearings rights for homecare workers are set forth in OAR 411-031-0050.

(2) The Authority may deny or terminate a personal support worker's provider enrollment and provider number when the personal support worker:

(a) Has been appointed the legal guardian of an individual;

(b) Has a background check that results in a closed case pursuant to OAR chapter 943, division 007;

(c) Lacks the skills, knowledge, or ability to perform or learn to perform the required work;

(d) Violates the protective service and abuse rules in OAR chapter 411, division 20, OAR chapter 407, division 45, and OAR chapter 943, division 45;

(e) Commits fiscal improprieties;

(f) Fails to provide the authorized services required by an eligible individual;

(g) Has been repeatedly late in arriving to work or has absences from work not authorized in advance by an individual;

(h) Has been intoxicated by alcohol or drugs while providing authorized services to an individual or while in the individual's home;

(i) Has manufactured or distributed drugs while providing authorized services to an individual or while in the individual's home; or

(j) Has been excluded as a provider by the U.S. Department of Health and Human Services, Office of Inspector General from participation in Medicaid, Medicare, or any other federal health care programs.

(3) A personal support worker may contest the Authority's decision to terminate the personal support worker's provider enrollment and provider number:

(a) A designated employee from the Authority shall review the termination and notify the personal support worker of the decision;

(b) A personal support worker may file a request for a hearing with the Authority's local office if all levels of administrative review have been exhausted and the provider continues to dispute the Authority's decision. The local office shall file the request for a hearing with the Office of Administrative Hearings as described in OAR chapter 137, division 3. The request for a hearing shall be filed within 30 calendar days of the date of the written notice from the Authority;

(c) When a contested case is referred to the Office of Administrative Hearings, the referral shall indicate whether the Authority is authorizing a proposed order, a proposed and final order, or a final order;

(d) No additional hearing rights have been granted to a personal support worker by this rule other than the right to a hearing on the Authority's decision to terminate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0830
Personal Care Attendant Service Assessment, Authorization, and Monitoring

(1) A behavioral health case manager shall meet in person with an individual to assess the individual's ability to perform the personal care tasks listed in this rule:

(a) An individual's natural supports may participate in the assessment if requested by the individual;

(b) A behavioral health case manager shall assess an individual's service needs, identify the resources meeting any, some, or all of the individual's needs and determine if the individual is eligible for behavioral health personal care attendant services or other services;

(c) A behavioral health case manager shall meet with an individual in person at least once every 365 days to review the individual's service needs.

(2) A behavioral health case manager shall prepare a service plan identifying the tasks for which an individual requires assistance and the number of monthly authorized service hours. The case manager shall document an individual's natural supports that currently meet some or all of the individual's assistance needs:

(a) The service plan shall describe the tasks to be performed by a qualified provider and shall authorize the maximum monthly hours that may be reimbursed for those services;

(b) A case manager shall consider the cost effectiveness of services that adequately meet the individual's service needs when developing service plans;

(c) Payment for behavioral health personal care attendant services shall be prior authorized by a behavioral health case manager and based on the service needs of an individual as documented in the individual's written service plan.

(3) When there is an indication that an individual's personal care needs have changed, a case manager shall conduct an in-person reassessment with the individual and any of the individual's natural supports if requested by the individual:

(a) Following annual reassessments and those conducted after a change in an individual's personal care needs, a case manager shall review service eligibility, the cost effectiveness of the individual's service plan, and whether the services provided are meeting the individual's identified service needs;

(b) The case manager may adjust the hours or services in the individual's service plan and shall authorize a new service plan, if appropriate, based on the individual's current service needs.

(4) A behavioral health case manager shall provide ongoing coordination of behavioral health personal care attendant services, including authorizing changes in providers and service hours, addressing risks, and monitoring and providing information and referral to an individual when indicated.

(5) The Authority may not authorize services within an eligible individual's home when:

(a) The individual's home has dangerous conditions that jeopardize the health or safety of the individual or the provider and necessary safeguards cannot be taken to improve the setting;

(b) The services cannot be provided safely or adequately by a provider;

(c) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and necessary safeguards cannot be provided to protect the individual's safety, health, and welfare.

(6) A behavioral health case manager shall present an individual or the individual's representative with information on service alternatives and provide assistance to assess other choices when a provider or service setting selected by the individual or the individual's representative is not authorized.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0840
Personal Care Attendant Payment Limitations

(1) The number of behavioral health personal care attendant service hours authorized for an individual per calendar month is based on projected amounts of time to perform specific personal care and supportive services to the eligible individual. The total of these hours are limited to 20 hours per individual per month. Individuals whose assessed service needs exceed the 20 hour limit may receive approval for additional hours.

(2) The Authority shall pay for behavioral health personal care attendant services when all acceptable provider enrollment standards have been verified and both the employer and provider have been formally notified in writing that payment by the Authority is authorized.

(3) In accordance with OAR 410-120-1300, all provider claims for payment shall be submitted within 12 months of the date of service.

(4) Payment may not be claimed by a provider until the hours authorized for the payment period have been completed, as directed by an eligible individual or the individual's representative.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0850
Telemedicine for Behavioral Health

(1) Telemedicine encompasses different types of programs, services, and delivery mechanisms for medically appropriate covered services within the recipient's benefit package:

(a) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Evidence Review Commission and the applicable HERC-approved code requirements, delivered consistent with the HERC Evidence-Based Guidelines;

(b) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a provider located in a distant site and the recipient being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated below.

(2) Behavioral health services specifically identified as allowable for telephonic delivery are listed on the Behavioral Health Fee schedule published by the Authority.

(3) Unless expressly authorized in OAR 410-120-1200 (Exclusions), other types of telecommunications are not covered such as images transmitted via facsimile machines and electronic mail when:

(a) Those methods are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or

(b) Those methods and specific services are not specifically allowed pursuant to the Oregon Health Evidence Review Commission's Prioritized List of Health Services and Evidence Based Guidelines.

(4) Providers billing for covered telemedicine services shall:

(a) Comply with HIPAA and the Authority's Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records;

(b) Obtain and maintain technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules set forth in OAR 943 division 14;

(c) Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;

(d) Comply with the relevant HERC evidence-based guidelines for telephone and e-mail consultation. Refer to the current prioritized list and evidence based guidelines at http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(e) Maintain clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(5) For purposes of behavioral health services, the Authority shall provide coverage for telemedicine services to the same extent that the services would be covered if they were provided in person.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715

Hist.: DMAP 85-2014(Temp), f. 12-24-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

410-172-0860
Billing for Dual Eligible Individuals

(1) As described in OAR 410-120-1280 (8), when an individual has both Medicare and coverage through Medicaid, providers shall make reasonable efforts to obtain payment from other resources including Medicare or other Third Party Liability (TPL).

(2) In accordance with OAR 410-120-1280 (f), OAR 410-141-0420, and OAR 410-141-3420, behavioral health providers may bill the Division directly and may not be required to bill Medicare under the following circumstances:

(a) For behavioral health services that are never covered by Medicare or another insurer;

(b) For behavioral health services that are not covered when rendered by the following provider types:

(A) Qualified Mental Health Professional (non-licensed) as defined in OAR 309-019-0105;

(B) Qualified Mental Health Associate as defined in OAR 309-019-0105;

(C) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(D) Certified Peer Support Specialist as defined in OAR 410-180-0305;

(E) Recovery Assistant;

(F) Certified Alcohol and Drug Counselor.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Hist.: DMAP 32-2015, f. 6-24-15, cert. ef. 6-26-15

DIVISION 180

TRADITIONAL HEALTH WORKERS

410-180-0300
Purpose

These rules establish the criteria for training, certification and enrollment of traditional health workers (THW) in a registry maintained by the Oregon Health Authority (Authority). THWs include community health workers, personal health navigators, peer wellness specialists, peer support specialists and birth doulas not otherwise regulated or certified by the state of Oregon. These rules also establish curriculum requirements and procedures for Authority approval of programs seeking to train Oregon's traditional health workers.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0305
Definitions

The following definitions apply to OAR 410-180-0300 through 410-180-0380:

(1) "Authority" means the Oregon Health Authority.

(2) "Authority approved training program" means an organization that provides and education in the core curriculum that meets Authority standards for one or more types of traditional health workers and has been approved by the Authority to train those types of traditional health workers.

(3) "Birth doula" means a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.

(4) "Birth doula certification organization" means an entity nationally or internationally recognized for training and certifying birth doulas whose educational requirements includes the core curriculum topics described in these rules.

(5) "Community based organization" (CBO) means a public or private nonprofit organization that is representative of a community or significant segments of a community and engaged in meeting that community's needs in the areas of social, human, or health services.

(6) "Community health worker" has the meaning given that term in ORS 414.025.

(7) "Contact hour" means an hour of classroom, group or distance learning training. Contact hour does not include homework time, preparatory reading, or practicum.

(8) "Competencies" mean key skills and applied knowledge necessary for THWs to be effective in the work field and carry out their roles.

(9) "Equivalent credit" means an individual has fulfilled the requirements of a course or combination of courses, by completing a relatively comparable course or combination of courses.

(10) "Grandfathered traditional health worker" means an individual certified before June 30, 2019 by the Authority as a result of their prior work experience and fulfillment of all additional requirements for grandfathering as set forth in these rules.

(11) "Peer support specialist" means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition, young adult to young adult). A peer support specialist shall be:

(a) A self-identified individual currently or formerly receiving addictions or mental health services;

(b) A self-identified individual in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;

(c) A self-identified individual in recovery from problem gambling; or

(d) The family member of an individual currently or formerly receiving addictions or mental health services.

(12) "Peer wellness specialist" has the meaning given that term in ORS 414.025.

(13) "Personal health navigator" has the meaning given that term in ORS 414.025.

(14) "Registry" means a list maintained by the Authority of traditional health workers certified under these rules.

(15) "THW applicant" means an individual who has applied to the Authority for traditional health worker certification.

(16) "Traditional health worker" (THW) means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the state of Oregon.

(17) "Training program applicant" means an organization or entity that has applied for Authority approval of its training program and curricula for any of the traditional health worker types.

(18) "Verifiable evidence" means a pay statement, services contract, student practicum, volunteer time log or other documentation reflecting hours worked or volunteered.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0310
Community Health Worker, Peer Wellness Specialist, Personal Health Navigator Certification Requirements

(1) To be certified as a community health worker, peer wellness specialist, or personal health navigator, an individual shall:

(a) Complete all required training offered by an Authority approved training program for that individual's traditional health worker (THW) type.

(b) Complete an Authority approved oral health training.

(c) Complete all application requirements to be in the state registry;

(d) Complete the Authority certification process; and

(e) Be successfully accepted into the state registry.

(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body, may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0312
Peer Support Specialist Certification Requirements

(1) To be certified as a peer support specialist, an individual shall:

(a) Complete all required training offered by an Authority approved training program for peer support specialists;

(b) Complete an Authority approved oral health training.

(c) Complete all application requirements to be in the state registry;

(d) Complete the Authority certification process; and

(e) Be successfully accepted into the state registry.

(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body, may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665

Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0315
Birth Doula Certification Requirements

(1) To be certified as a birth doula, an individual shall:

(a) Complete all required training specified in OAR 410-180-0375 through:

(i) An Authority approved birth doula training program; or

(ii) A combination of programs that results in meeting all the requirements through equivalent credit.

(b) Complete an Authority approved oral health training.

(c) Be CPR-certified for children and adults.

(d) Create a community resource list on an Authority approved form.

(e) Document attendance at a minimum of three births and three postpartum visits using an Authority approved form.

(f) Complete all application requirements to be in the state registry;

(g) Complete the Authority certification process; and

(h) Be successfully accepted into the state registry.

(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body, may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0320
Traditional Health Worker Continuing Education Requirements

(1) To maintain certification status, all THWs shall complete at least 20 hours of Authority approved continuing education during every three year renewal period.

(2) Continuing education hours taken in excess of the total number required may not be carried over to the next renewal period.

(3) Requests for approval of continuing education courses may come from the hosting organization or from a certified THW attending the training or event.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0325
Application and Renewal Process for Traditional Health Worker (THW) Certification and Registry Enrollment

(1) Individuals seeking THW certification and registry enrollment shall:

(a) Be at least 18 years of age;

(b) Not be listed on the Medicaid provider exclusion list;

(c) Successfully complete all training requirements for certification in a traditional health worker category as outlined in these rules;

(d) Pass a background check as described in OAR 410-180-0326;

(e) Beginning October 1, 2017, successfully complete an Authority approved oral health training;

(f) Submit to the Authority all required documentation and a completed application on an Authority prescribed form;

(2) An individual applying for certification or renewal as a peer support specialists as that term is defined in OAR 410-180-0305(11)(b), (c) may have their background check completed by an outside entity pursuant to 410-180-0326 and be certified by that entity.

(a) The entity's certification requirements shall include all peer support specialists certification and renewal requirements set forth in these rules.

(b) For Authority certification or renewal and entry into the registry, peer support specialists shall either:

(A) Have the outside entity submit their certification and background check information to the Authority; or

(B) Submit to the Authority all required documentation and a completed application on an Authority prescribed form.

(2) Individuals seeking THW certification and registry enrollment as a grandfathered community health worker, peer wellness specialist, personal health navigator, or peer support specialist shall:

(a) Be at least 18 years of age;

(b) Not be listed on the Medicaid provider exclusion list;

(c) Pass a background check as described in OAR 410-180-0326;

(d) Submit to the Authority all required documentation and a completed application on an Authority prescribed form by June 30, 2019 including;

(i) A minimum of one letter of recommendation from any previous employer for whom THW services were provided between January 1, 2008 and June 30, 2016; and

(ii) Verifiable evidence of working or volunteering in the capacity of a community health worker, peer wellness specialist, or personal health navigator for at least 3000 hours between January 1, 2008 to June 30, 2016; or

(iii) Verifiable evidence of working or volunteering in the capacity of a peer support specialist for at least 2000 hours between January 1, 2008 and June 30, 2016;

(3) Registry applications are available on the THW program webpage or by request to the Oregon Health Authority Office of Equity and Inclusion.

(4) An individual may withdraw from the application process for certification and enrollment or from the registry by submitting written notification to the Authority unless a complaint investigation or revocation proceeding is underway.

(5) Except for birth doulas, applicants shall apply for certification within three years of completing a training program to be eligible for certification and registry enrollment.

(6) Except for birth doulas, applicants denied certification because they completed a training program more than three years prior to application may file an appeal with the Authority for an exemption.

(7) If the Authority determines that an applicant has met the requirements of this section, the Authority shall notify the applicant in writing granting the individual certification as a THW and add the individual to the registry.

(8) Certification is valid for 36 months from the date of certification.

(9) A THW seeking certification renewal shall:

(a) Submit a completed renewal application on an Authority prescribed form, no less than 30 days before the expiration of the current certification period;

(b) Pass a background check as described in OAR 410-180-0326;

(c) Provide written verification indicating that the certificate holder has met the applicable requirements for continuing education set forth in OAR 410-180-0320; and

(d) During the renewal period occurring between October 2017 and October 2020:

(i) Complete Authority approved oral health training; and

(ii) Submit proof of completion with their renewal application.

(12) The Authority shall remove a THW from the registry if the THW fails to renew certification within the renewal period.

(13) THWs removed from the registry following certification expiration shall be denied renewal unless they file an appeal with the Authority within 60 calendar days of certification expiration and are granted an exemption.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 3-2014, f. & cert. ef. 1-15-14; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0326
Background Check Requirements

(1) For all new or renewal applications for THW certification, the Authority shall:

(b) Conduct a background check in accordance with 943-007-0010 through 0501 specifically incorporating and limited to 407-007-0200 to 407-007-0250, and 407-007-0340 to 407-007-0370 and expressly not incorporating 407-007-0275 and 407-007-0277.

(b) Consult with the Office of the Inspector General to determine if the applicant is excluded from participation in the medical assistance program.

(2) New or renewal THW applicants may be denied certification or renewal of certification based on a fitness determination that applies a weighing test for potentially disqualifying convictions or conditions.

(3) New or renewal THW applicants shall be denied certification if they are excluded from participating in the medical assistance program.

(4) To be certified, enrolled in the registry, and eligible for reimbursement under Medicaid, peer support specialists as defined in OAR 410-180-0305(11)(b) and (c) are required to pass a background check. The background check may be conducted by the Authority or by an entity contracting with the Authority to provide background checks.

(a) If the Authority conducts the background check, the Authority's fitness determination shall comply with the provision of section (1) and shall include the application of a weighing test for potentially disqualifying convictions or conditions.

(b) If a contracting entity conducts the background check, the provisions of 407-007-0277 shall apply.

(c) Peer support specialists described in this section may choose which entity conducts the background check.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 181.537, 414.635 & 414.665
Hist.: DMAP 3-2014, f. & cert. ef. 1-15-14; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0340
Standards of Professional Conduct

(1) An Authority certified THW, shall comply with Standards of Professional Conduct set forth in this rule. The violation of the standards may result in the suspension or revocation of certification or denial of an application for renewal.

(2) THWs shall:

(a) Acquire, maintain and improve professional knowledge and competence using scientific, clinical, technical, psychosocial, governmental, cultural and community-based sources of information.

(b) Represent all aspects of professional capabilities and services honestly and accurately.

(c) Ensure that all actions with community members are based on understanding and implementing the core values of caring, respect, compassion, appropriate boundaries, and appropriate use of personal power.

(d) Develop positive collaborative partnerships with community members, colleagues, and other health care providers to provide care, services, and supports that are safe, effective, and appropriate to a community member's needs.

(e) Regardless of clinical diagnosis, develop and incorporate respect for diverse community member backgrounds when planning and providing services, including lifestyle, sexual orientation, race, gender, ethnicity, religion, age, marital status, political beliefs, socioeconomic status or any other preference or personal characteristic, condition or state.

(f) Act as an advocate for community members and their needs.

(g) Support self-determination for community members in a culturally competent, trauma informed manner.

(h) Make decisions and act based on sound ethical reasoning and current principles of practice in a way that supports empowerment and respect for community members' culture and self-defined health care goals.

(i) Maintain individual confidentiality.

(j) Comply with laws and regulations involving mandatory reporting of harm, abuse, or neglect while making every effort to involve the individuals in planning for services and ensuring that no further harm is done to family members as the result of the reporting.

(k) Recognize and protect an individual's rights as described in section (3) of this rule.

(3) Individuals have the right to:

(a) Dignity and respect;

(b) Freedom from theft, damage, or misuse of personal property;

(c) Freedom from neglect and abuse, whether verbal, mental, emotional, physical, or sexual;

(d) Freedom from financial exploitation;

(e) Freedom from physical restraints;

(f) Freedom from discrimination in regard to race, color, national origin, disability, gender, sexual orientation, socioeconomic status, size, type of diagnosis criminal history or religion;

(g) Confidentiality of their information and records; and

(h) To give voice to grievances or complaints regarding services or any other issue without discrimination or reprisal for exercising their rights.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0345
Denial, Suspension or Revocation of Certification

(1) The Authority may deny, suspend, or revoke certification when an applicant or certificate holder fails to comply with these rules.

(2) The Authority shall deny, suspend, or revoke certification pursuant to ORS 183.411 through 183.470 and the applicant or certificate holder may request a contested case hearing.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0350
Training Program Requirements

(1) All Authority approved training programs shall:

(a) Meet the curriculum requirements for the THW type being trained.

(b) Demonstrate active efforts to establish equivalency for students who have previously completed training that meets one or more training requirements for their THW type.

(c) Require experienced THWs be involved in developing and teaching the core curriculum.

(d) Be a culturally diverse community based organization (CBO) or include collaboration with at least one culturally diverse CBO.

(e) Demonstrate the use of various teaching methodologies, including but not limited to popular education and adult learning;

(f) Demonstrate the use of various training delivery formats, including but not limited to classroom instruction, group, and distance learning.

(g) Demonstrate efforts to make training inclusive and accessible to individuals with different learning styles, education backgrounds, and needs.

(h) Demonstrate efforts to remove barriers to enrollment for students.

(i) Include any combination of written, oral or practical cognitive examinations to evaluate and document the acquisition of knowledge and mastery of skills required by the curriculum designed to instruct in the THW competencies.

(j) Demonstrate the inclusion of a method or process for individuals trained by the program to evaluate and give feedback on the training experience.

(k) Maintain an accurate record of each individual's attendance and participation in training for at least five years after course completion.

(l) Agree to verify and provide the Authority with names of individuals who successfully completed the training program when those individuals apply for certification and registry enrollment.

(m) Agree to issue a certificate of completion to all successful training program graduates.

(2) Individuals or entities applying to become an Authority approved training program shall submit information to the Authority that includes at minimum:

(a) Contact information for the individual or entity, including director name and contact information;

(b) Syllabus and course materials that demonstrate the curriculum covers the required competencies;

(c) Indication of the training type and curriculum, including specialized training to be offered for community health workers, peer wellness specialists, peer support specialists, personal health navigators, and birth doulas;

(d) An overview of the teaching philosophy and methodology;

(e) A description of the method of final examinations;

(f) A list of instructors, including experienced THWs;

(g) A description of the geographic area served;

(h) A signed agreement describing a CBO partnership, if the applicant is not a CBO;

(i) A description of the approach for recruiting and enrolling a diverse student population to meet the needs of the community, including any strategies for reducing barriers to enrollment; and

(j) An indication of whether academic credit may be given for successful completion of training program.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0355
Application and Renewal Process for Authority Training Program Approval

(1) Training program applications are available on the THW program webpage or by request from the Oregon Health Authority Office of Equity and Inclusion.

(2) Training program applicants shall submit an application at least 90 days in advance of the first expected class day.

(3) If an application is incomplete, the Authority shall send notice requesting the additional materials required.

(a) The notice shall specify the date by which additional materials must be submitted.

(b) Unless an extension is granted, the Authority shall return the application and take no further action if the applicant does not respond within the specified time frame.

(4) If the Authority determines that an applicant has met all training program requirements, the Authority shall send written notice of program approval.

(5) Written notice of Authority approval shall be made available to any student or partnering organization upon request.

(6) The Authority shall maintain and make available to the public a list of approved training programs.

(7) Training programs shall apply for renewed approval status every three years.

(a) Renewal applications are available on the THW program webpage or by request from the Oregon Health Authority Office of Equity and Inclusion.

(b) Training programs shall complete and submit the renewal application no less than six months prior to the expiration of the current approval period.

(8) Training programs seeking renewal shall provide at a minimum:

(a) A summary of any proposed changes to the curriculum; and

(b) The number of students trained in the three year approval period

(9) Training programs that fail to submit a renewal application at least six months before their renewal date will be required to submit a new application rather than apply for renewal.

(10) The Authority may conduct site visits of training programs, either prior to approving or renewing a training program application, or at any time during the three year approval period.

(11) Any change made to an approved training program shall be reported to the Authority within 30 days of the decision, including:

(a) Changes to the:

(A) Training program director or primary contact;

(B) Teaching methodology;

(C) Curriculum; or

(b) Any change not consistent with or represented in the initial application for approval.

(12) If the Authority determines that the reported changes meet the training program requirements described in OAR 410-180-0350, the Authority shall approve the change.

(a) The Authority may request additional information and justification for the reported change.

(b) If the Authority determines that the reported changes do not comply with the training program requirements described in OAR 410-180-0350, the Authority may deny the change or revoke training program approval.

(13) A training program applicant or approved training program may request a temporary waiver from a requirement in these rules. A request for a waiver shall:

(a) Be submitted to the Authority in writing;

(b) Identify the specific rule for which a waiver is requested;

(c) Identify the special circumstances relied on to justify the waiver;

(d) Describe alternatives that were considered, if any, and why alternatives, including compliance, were not selected;

(e) Demonstrate that the proposed waiver is desirable to maintain or improve the training of THWs; and

(f) Indicate the proposed duration of the waiver, not to exceed one year.

(14) If the Authority determines that the applicant or program has satisfied the conditions of this rule, the Authority may grant a waiver.

(15) An applicant or an approved training program may not act on or implement a waiver until it has received written approval from the Authority.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0360
Denial, Suspension or Revocation of Training Program Approval

(1) The Authority may deny, suspend or revoke training program approval when an applicant or approved program has failed to comply with statute or these rules.

(2) If the Authority denies, suspends, or revokes approval it shall send written notice and explain the basis for its decision.

(3) An applicant or approved training program may request that the Authority reconsider its decision and may request a meeting with Authority staff.

(a)The request for reconsideration and a meeting, if requested, shall be submitted in writing within 30 days of the date the Authority mailed the written decision of denial, suspension or revocation.

(b) The request shall contain a detailed statement with supporting documentation explaining why the requestor believes the Authority's decision is in error.

(4) The Authority shall issue a written decision on reconsideration following review of the materials submitted by the applicant or training program and a meeting with the applicant or training program, if applicable.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13; DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0365
Oral Health Training Requirements

(1) The Authority shall approve oral health training that includes coursework in:

(a) Basic dental anatomy;

(b) Caries and periodontal disease process;

(c) Infection and communicable disease;

(d) Basic oral hygiene and disease prevention for different ages; and

(e) Healthcare system navigation, access and coverage, including Medicaid

(2) The Authority shall include members of the dental care community in the development of requirements for and approval of Authority approved oral health training.

(3) Individuals or entities creating or providing oral health training for approval by the Authority are not required to meet the full qualifications of a training program outlined in OAR 410-180-0350.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0370
Community Health Workers, Peer Wellness Specialists, Personal Health Navigators, and Peer Support Specialists Certification Curriculum Standards

(1) All community health workers, peer wellness specialists and personal health navigators shall receive training from an Authority approved training program whose curriculum includes:

(a) A minimum of 80 contact hours addressing the core curriculum set forth in section (2) of this rule and any additional curriculum topics specific to the type of worker being trained.

(b) All the major roles and core competencies listed and defined in the Oregon Health Policy Board Report "The Role of Non-Traditional Health Workers in Oregon's Health Care System". (https://www.oregon.gov/oha/oei/Documents/nthw-report-120106.pdf)

(2) An Authority approved core curriculum for community health workers, peer wellness specialists and personal health navigators shall, at a minimum, introduce students to the key principles of the following topics:

(a) Community engagement, outreach methods and relationship building;

(b) Communication, including cross-cultural communication, active listening, and group and family dynamics;

(c) Empowerment techniques;

(d) Identification of community resources;

(e) Cultural competency and cross-cultural relationships, including bridging health system and community cultures;

(f) Conflict identification and problem solving;

(g) Conducting individual strength and needs based assessments;

(h) Advocacy;

(i) Ethical responsibilities in a multicultural context;

(j) Legal responsibilities;

(k) Crisis identification and problem-solving;

(l) Professional conduct, including culturally appropriate relationship boundaries and maintaining confidentiality;

(m) Navigating public and private health and human service systems, including state, regional, and local systems;

(n) Working with caregivers, families, and support systems, including paid care workers;

(o) Trauma-informed care, including screening and assessment, recovery from trauma, and minimizing re-traumatization;

(p) Self-care;

(q) Social determinants of health;

(r) Building partnerships with local agencies and groups;

(s) The role and certified scope of practice for traditional health workers;

(t) Roles, expectations, and supervisory relationships for working in multidisciplinary teams, including supervisory relationships;

(u) Data collection and types of data;

(v) Organization skills, documentation and use of health information technology;

(w) Introduction to disease processes, including chronic diseases, mental health, tobacco cessation, and addictions, including warning signs, basic symptoms, and when to seek medical help;

(x) Health across the life-span;

(y) Adult learning principles, including teaching and coaching;

(z) Stages of change;

(aa) Best practices for health promotion; and

(bb) Health literacy issues.

(3) In addition to the core curriculum set forth in section (2) of this rule, training programs for community health workers shall include the following topics:

(a) Self-efficacy;

(b) Community organizing;

(c) Group facilitation skills;

(d) Conducting community needs assessments;

(e) Popular education methods; and

(f) Principles of motivational interviewing.

(4) In addition to the core curriculum, set forth in section (2) of this rule, training programs for peer wellness specialists shall include the following topics:

(a) Self-efficacy;

(b) Group facilitation skills;

(c) Cultivating individual resilience;

(d) Recovery, resilience and wellness models; and

(e) Principles of motivational interviewing.

(5) An Authority approved curriculum for peer support specialists shall include a minimum of 40 contact hours that include:

(a) The core curriculum set forth in section (2)(a) through (p);

(b) The role and scope of practice for peer support specialists; and

(c) Recovery, resilience and wellness.

(6) An Authority approved curriculum for family support specialists and youth support specialists shall include the following topics:

(a) The role of the family support specialist and youth support specialist in the system serving children and youth;

(b) Collaborative problem solving;

(c) Protective factors and developmental assets to promote resilience; and

(d) Multi-systems services and payment navigation.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13: DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0375
Birth Doula Certification Curriculum Standards

(1) All birth doulas seeking certification with the state shall complete a minimum of 40 contact hours that include the following:

(a) A minimum of 28 in-person contact hours addressing the core curricula topics set forth in section (2) of this rule through an Authority approved training program for birth doulas or through another training program provided by a birth doula certification organization;

(b) Six contact hours in cultural competency training; and

(c) Six contact hours in one or more of the following topics as they relate to doula care:

(A) Inter-professional collaboration;

(B) Health Insurance Portability and Accountability Act (HIPAA) compliance; and

(C) Trauma-informed care.

(2) All core curriculum for training birth doulas shall, at a minimum, introduce students to the key principles of the following topics:

(a) Anatomy and physiology of labor, birth, maternal postpartum, neonatal transition, and breastfeeding;

(b) Labor coping strategies, comfort measures and non-pharmacological techniques for pain management;

(c) The reasons for, procedures of, and risks and benefits of common medical interventions, medications, and Cesarean birth;

(d) Emotional and psychosocial support of women and their support team;

(e) Birth doula scope of practice, standards of practice, and basic ethical principles;

(f) The role of the doula with members of the birth team;

(g) Communication skills, including active listening, cross-cultural communication, and inter-professional communication;

(h) Self-advocacy and empowerment techniques;

(i) Breastfeeding support measures;

(j) Postpartum support measures for the mother and baby relationship;

(k) Perinatal mental health;

(l) Family adjustment and dynamics;

(m) Evidence-informed educational and informational strategies;

(n) Community resource referrals;

(o) Professional conduct, including relationship boundaries and maintaining confidentiality; and

(p) Self-care.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13: DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

410-180-0380
THW and Training Program Complaints and Investigations

(1) Any individual may make a complaint to the Authority, verbally or in writing about the:

(a) Care or services provided by a certified THW;

(b) Violation of statutes or these rules by an approved THW training program.

(2) The identity of an individual making a complaint shall be kept confidential to the extent allowed by law but may be disclosed as necessary to conduct the investigation; this may include disclosing the complainant's identity to the THW's employer.

(3) If a complaint involves an allegation of criminal conduct or conduct within the jurisdiction of another local, state, or federal agency, the Authority shall refer the matter to the appropriate agency.

(4) The Authority shall investigate complaints and take any actions that are necessary for resolution. An investigation may include but is not limited to:

(a) Interviews of the complainant, program management or staff, and students;

(b) Interviews of the complainant, caregivers, THW clients, client representatives, client family members, witnesses, and employer management and staff;

(c) On-site observations of the training program, the client, THW performance and client environment; and

(d) Review of documents and records.

(5) The Authority may utilize complaint and investigation findings to identify trends and potential areas for quality improvement.

(6) The results of complaint investigation may be published to the public by the Authority.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13: DMAP 56-2016, f. 9-30-16, cert. ef. 10-1-16

DIVISION 200

OFFICE OF CLIENT AND COMMUNITY SERVICES MEDICAL PROGRAMS

410-200-0010
Overview

These rules, OAR 410-200-0010 through 0510, describe eligibility requirements for the Office of Client and Community Services (OCCS) medical programs.

Stat. Auth.: ORS 411.402, 411.404 & 413.042
Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706
Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15

410-200-0015
General Definitions

(1) "Action" means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.

(2) "Address Confidentiality Program (ACP)" means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.

(3) "AEN" means Assumed Eligible Newborn (OAR 410-200-0115).

(4) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56).

(5) "Agency" means the Oregon Health Authority and Department of Human Services.

(6) "American Indian and Alaska Native income exceptions" means:

(a) Distributions from Alaska Native Corporations and Settlement Trusts;

(b) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;

(c) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:

(A) Rights of ownership or possession in any lands described in section (b) of this part; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.

(d) Distributions resulting from real property ownership interests related to natural resources and improvements:

(A) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests.

(e) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;

(f) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(7) "Applicant" means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.

(8) "Application" means:

(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or

(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.

(9) "APTC" means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

(10) "Assumed eligibility" means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual's eligibility.

(11) "Authorized Representative" means an individual or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).

(12) "Beneficiary" means an individual who has been determined eligible and is currently receiving OCCS medical program benefits, Aging and People with Disability medical program benefits, or APTC.

(13) "BRS" means Behavior Rehabilitation Services.

(14) "Budget Month" means the calendar month from which financial and nonfinancial information is used to determine eligibility.

(15) "Caretaker" means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child's care.

(16) "Caretaker Relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living who assumes primary responsibility for the child's care, which may but is not required to be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;

(c) An individual described in this section who is a relative of the child based on blood, including those of half-blood, adoption, or marriage.

(17) "CAWEM" means Citizen/Alien-Waived Emergency Medical, which is Medicaid coverage for emergency medical needs for individuals who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements (OAR 410-200-0240).

(18) "CAWEM Prenatal" means medical services for pregnant CAWEM beneficiaries.

(19) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn. Child includes a natural or biological, adopted, or step child.

(20) "Children's Health Insurance Program" also called "CHIP" means Oregon medical coverage under Title XXI of the Social Security Act.

(21) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.

(22) "Claim" means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.

(23) "Claimant" means an individual who has requested a hearing or appeal.

(24) "Code" means Internal Revenue Code of 1986 as amended.

(25) "Combined eligibility notice" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the OCCS Medical Programs for which a determination or denial was made by the Authority.

(26) "Community partner" means all external entities that partner with the Authority and enter into formal agreement with the Authority to conduct outreach or enrollment assistance, whether or not they are funded or compensated by the Authority. Insurance agents are not considered community partners.

(27) "Coordinated content" means information included in eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.

(28) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent for whom:

(a) If living with one parent, a court order or binding separation, divorce, or custody agreement establishes physical custody controls; or

(b) If living with one parent and there is no such order or agreement described in section (a), or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights;

(c) If a child does not live with either parent, the parent who claims the child as a tax dependent is treated as the custodial parent for the purposes of OCCS medical program eligibility.

(29) "Date of Request" means the earlier of:

(a) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or

(b) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.

(30) "Decision notice" means a written notice of a decision made regarding eligibility for an OCCS medical program benefit. A decision notice may be a:

(a) "Basic decision notice" mailed no later than:

(A) The date of action given in the notice; or

(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.

(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;

(c) "Timely continuing benefit decision notice" informs the client of the right to continued benefits and is mailed no later than ten calendar days prior to the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change.

(31) "Department" means the Department of Human Services.

(32) "Dependent child" means a child who is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if before attaining age 19 the child may reasonably be expected to complete the school or training.

(33) "ELA" (Express Lane Agency) means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.

(34) "ELE" (Express Lane Eligibility) means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.

(35) "Electronic account" means an electronic file that includes all information collected and generated by the Agency regarding each individual's Medicaid or CHIP eligibility and enrollment, including all required documentation and including any information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.

(36) "Electronic application" means an application electronically signed and submitted through the Internet.

(37) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.

(38) "Expedited appeal" also called "expedited hearing" means a hearing held within five working days of the Authority's receipt of a hearing request, unless the claimant requests more time.

(39) "Family size" means the number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the household group and each unborn child of any pregnant members of the household group.

(40) "Federal data services hub" means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including SSA, the Department of Treasury, and the Department of Homeland Security.

(41) "Federal poverty level (FPL)" means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).

(42) "Federally Facilitated Marketplace" also called "FFM" means a website used by consumers.

(43) "Hearing Request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority or FFM decision or action.

(44) "Household group" consists of every individual whose income is considered for determining each medical applicant's eligibility as defined in OAR 410-200-0305.

(45) "Inmate" means:

(a) An individual living in a public institution that is:

(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;

(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;

(C) Residing involuntarily in a facility that is under governmental control; or

(D) Receiving care as an outpatient while residing involuntarily in a public institution.

(b) An individual is not considered an inmate when:

(A) The individual is released on parole, probation, or post-prison supervision;

(B) The individual is on home or work-release, unless the individual is required to report to a public institution for an overnight stay;

(C) The individual is receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate;

(D) The individual is staying voluntarily in a detention center, jail, or county penal facility after his or her case has been adjudicated and while other living arrangements are being made for the individual; or

(E) The individual is in a public institution pending other arrangements as defined in 42 CFR 435.1010.

(46) "Insurance affordability program" means a program that is one of the following:

(a) Medicaid;

(b) CHIP;

(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;

(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.

(47) "Lawfully present" means an individual:

(a) Is a qualified non-citizen, as defined in this section;

(b) Has valid non-immigrant status, as defined in 8 U.S.C. 1101(a) (15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a) (17));

(c) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection, or pending removal proceedings; or

(d) Belongs to one of the following classes:

(A) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

(B) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a and individuals with pending applications for TPS who have been granted employment authorization;

(C) Granted employment authorization under 8 CFR 274a.12(c);

(D) Family Unity beneficiaries in accordance with section 301 of Public Law 101–649, as amended;

(E) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(F) Granted Deferred Action status;

(G) Granted an administrative stay of removal under 8 CFR part 241; (viii) Beneficiary of approved visa petition that has a pending application for adjustment of status.

(e) Is an individual with a pending application for asylum under 8 U.S.C. 158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who:

(A) Has been granted employment authorization; or

(B) Is under the age of 14 and has had an application pending for at least 180 days.

(f) Has been granted withholding of removal under the Convention Against Torture;

(g) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a) (27) (J);

(h) Is lawfully present in American Samoa under the immigration laws of American Samoa;

(i) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106–386, as amended (22 U.S.C. 7105(b)); or

(j) Exception: An individual with deferred action under the Department of Homeland Security's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, may not be considered to be lawfully present with respect to any of the above categories in sections (a) through (i) of this rule.

(48) "Legal Argument" has the meaning given that term in OAR 137-003-0008(c).

(49) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.

(50) "MAGI" means Modified Adjusted Gross Income and has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:

(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:

(A) Children, regardless of age, who are included in the household of a parent;

(B) Tax dependents.

(b) In applying subsection (a) of this section, IRC § 6012(a)(1) is used to determine who is required to file a tax return.

(51) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:

(a) American Indian and Alaska Native income exceptions;

(b) Child support;

(c) Life insurance proceeds;

(d) Non-taxable Veterans' benefits;

(e) Non-taxable workers' compensation benefits;

(f) Scholarships, awards, or fellowship grants used for educational expenses;

(g) Supplemental Security Income (SSI);

(h) An amount received as a lump sum is counted as income only in the month received. Lump sum income includes but is not limited to:

(A) Winnings;

(B) Countable educational income;

(C) Capital gains;

(D) Dividends, interest, royalties.

(i) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses;

(j) Self-employment and business entity income is determined by adding gross receipts and other business income and subtracting deductions described in Internal Revenue Code (IRC) §§ 161 through 249. Items not deductible are described in IRC §§ 261 through 280 include, but are not limited to, most capital expenditures, such as business start-up costs, buildings, and furniture and payments or deductions for personal, living, or family use. Business structures are determined by state statutes and are dependent on elections made by business owners. Each state may use different regulations for business structures. Salaries and wages paid to employees, including those who are owners or stockholders, are countable income to the employees. Business income is countable to owners and stockholders as described below:

(A) Sole proprietors, independent contractors, and Limited Liability Companies (LLC) who choose to file federal taxes as a sole proprietor: The necessary and ordinary costs of producing income are subtracted from gross receipts and other business income to determine countable income. Expenses related to costs for both business and personal use are prorated according to the proportions used for each purpose. Costs are limited to those described in IRC §§161 through 199 and Treasury Regulations §§ Sec. 1.162 through 1.263;

(B) Partnerships that are not publicly traded and LLCs who choose to file federal taxes as a partnership: Owners' income is determined as follows:

(i) The distributive share of income, gain, and loss is determined proportionately according to the partnership agreement or the LLC agreement;

(ii) Income from other partnerships, estates, and trusts is added to the amount in paragraph (A) of this subsection;

(iii) The costs of producing income described in subsection (4) (a) except for oil and gas depletion and costs listed below are proportionately subtracted from gross receipts to determine each partner's countable income:

(I) Bad debts;

(II) Guaranteed payments to partners;

(III) Losses from other partnerships, farms, estates, and trusts;

(IV) Retirement plans.

(C) S Corporations and LLCs who choose to file federal taxes as an S Corporation: Shareholders' income is determined as follows:

(i) The distributive share of profits, gain, and loss are determined proportionately on the basis of the stockholders' shares of stock;

(ii) The costs of producing income described in subsection (a) are proportionately subtracted from gross receipts to determine each stockholder's countable income;

(iii) The distributive share of profits is countable income to the shareholders whether or not it is actually distributed to the shareholders.

(D) C Corporations and LLCs who choose to file taxes as C Corporations: Shareholders' income is countable when it is distributed to them through dividends.

(52) "MAGI income standard" means the monthly income standard for the relevant program and family size described in OAR 410-200-0315.

(53) "Minimum essential coverage" means medical coverage under:

(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CAWEM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;

(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;

(c) Plans in the individual market;

(d) Grandfathered health plans; and

(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.

(54) "Non-applicant" means an individual not seeking an eligibility determination for him or herself and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.

(55) "Non-citizen" has the meaning given the term "alien" as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

(56) "OCCS" means the Office of Client and Community Services, part of the Health Systems Division, Medical Assistance Programs (Division) under the Oregon Health Authority.

(57) "OCCS Medical Programs" means all programs under the Office of Client and Community Services including:

(a) "CEC" means Continuous Eligibility for OHP-CHP pregnant women. Title XXI medical assistance for a pregnant non-CAWEM child found eligible for the OHP-CHP program who, for a reason other than moving out of state or becoming a recipient of private major medical health insurance, otherwise would lose her eligibility;

(b) "CEM" means Continuous Eligibility for Medicaid: Title XIX medical assistance for a non-CAWEM child found eligible for Medicaid who loses his or her eligibility for a reason other than turning 19 years of age or moving out of state;

(c) "EXT" means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;

(d) "MAA" means Medical Assistance Assumed;

(e) "MAF" means Medical Assistance to Families. The Medical Assistance to Families program provides medical assistance to people who are ineligible for MAA but are eligible for Medicaid using ADC program standards and methodologies that were in effect as of July 16, 1996;

(f) "OHP" means Oregon Health Plan. The Oregon Health Plan program provides medical assistance to many low-income individuals and families. The program includes five categories of individuals who may qualify for benefits. The acronyms for these categories are:

(A) "OHP-CHP" Persons under 19. OHP coverage for persons under 19 years of age who qualify at or below the 300 percent income standard;

(B) "OHP-OPC" Children. OHP coverage for children who qualify under the 100 percent income standard;

(C) "OHP-OPP" Pregnant Females and their newborn children. OHP coverage for pregnant females who qualify under the 185 percent income standard and their newborn children;

(D) "OHP-OPU" Adults. OHP coverage for adults who qualify under the 100 percent income standard. A person eligible under OHP-OPU is referred to as a health plan new/non-categorical (HPN) client;

(E) "OHP-OP6" Children under 6. OHP coverage for children under age 6 who qualify under the 133 percent income standard.

(g) "Substitute Care" means medical coverage for children in BRS or PRTF;

(h) "BCCTP" means Breast and Cervical Cancer Treatment Program;

(i) "FFCYM" means Former Foster Care Youth Medical;

(j) "MAGI Medicaid/CHIP" means OCCS Medical Programs for which eligibility is based on MAGI, including:

(A) MAGI Child;

(B) MAGI Parent or Other Caretaker Relative;

(C) MAGI Pregnant Woman;

(D) MAGI Children's Health Insurance Program (CHIP);

(E) MAGI Adult.

(58) "OCWP" means Office of Child Welfare Programs.

(59) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.

(60) "Parent" means a natural or biological, adopted, or step parent.

(61) "Personal Injury" means a physical or emotional injury to an individual including, but not limited to, assault, battery, or medical malpractice arising from the physical or emotional injury.

(62) "Pregnant woman" means a woman during pregnancy and the postpartum period that begins on the date the pregnancy ends, extends 60 days and ends on the last day of the month in which the 60-day period ends.

(63) "Primary contact" means the primary person the Agency shall communicate with and:

(a) Is listed as the case name; or

(b) Is the individual named as the primary contact on the application.

(64) "Private major medical health insurance" means a comprehensive major medical insurance plan that at a minimum provides physician services, inpatient and outpatient hospitalization, outpatient lab, x-ray, immunizations, and prescription drug coverage. This term does not include coverage under the Kaiser Child Health Program or Kaiser Transition Program but does include policies that are purchased privately or are employer-sponsored.

(65) "PRTF" means Psychiatric Residential Treatment Facility.

(66) "Public institution" means any of the following:

(a) A state hospital (ORS 162.135);

(b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours;

(c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility;

(d) A youth correction facility (ORS 162.135):

(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or

(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order.

(e) As used in this rule, the term public institution does not include:

(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);

(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or

(C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.

(67) "Qualified Hospital" means a hospital that:

(a) Participates as an enrolled Oregon Medicaid provider;

(b) Notifies the Authority of their decision to make presumptive eligibility determinations;

(c) Agrees to make determinations consistent with Authority policies and procedures;

(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and

(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).

(68) "Reasonable opportunity period:"

(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status;

(b) Begins on and shall extend 90 days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows that he or she did not receive the notice within the five-day period;

(c) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.

(69) "Redetermination" means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date are considered renewals.

(70) "Renewal" means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(71) "Required documentation" means:

(a) Facts to support the Agency's decision on the application; and

(b) Either:

(A) A finding of eligibility or ineligibility; or

(B) An entry in the case record that the applicant voluntarily withdrew the application, and the Agency sent a notice confirming the decision, that the applicant has died, or that the applicant cannot be located.

(72) "Secure electronic interface" means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.

(73) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.

(74) "Sibling" means natural or biological, adopted, or half or step sibling.

(75) "Spouse" means an individual who is legally married to another individual under:

(a) The statutes of the state where the marriage occurred;

(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or

(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.

(76) "SSA" means Social Security Administration.

(77) "Tax dependent" has meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

(78) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0100

Coordinated Eligibility and Enrollment Process with the Department of Human Services and the Federally Facilitated Marketplace

(1) This rule describes Oregon Health Authority's (Authority) coordination of eligibility and enrollment with the Department of Human Services (Department), and the FFM. The Authority shall:

(a) Minimize the burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for insurance affordability programs;

(b) Ensure determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards described in OAR 410-200-0110 based on the application date;

(c) Provide coordinated content for those household members whose eligibility status is not yet determined; and

(d) Screen every applicant or beneficiary who submits an application or renewal form, or whose eligibility is being renewed under a change in circumstance for criteria that identify individuals for whom MAGI-based income methods do not apply.

(2) For individuals undergoing eligibility determination for OCCS Medical Programs, the Authority, consistent with the timeliness standards described in OAR 410-200-0110, shall:

(a) Determine eligibility for MAGI Medicaid/CHIP on the basis of having household income at or below the applicable MAGI-based standard; or

(b) If ineligible under section (a) or if eligible for CAWEM-level benefits only, direct as appropriate to the FFM.

(3) If ineligible for OCCS Medical Programs, the Authority shall, consistent with the timeliness standards described in OAR 410-200-0110:

(a) Screen for eligibility for non-MAGI programs as indicated by information provided on the application or renewal form;

(b) Transfer the individual's electronic account information to the Department via secure electronic interface, as appropriate;

(c) If transferred to the Department, the Authority shall provide notice to the individual that contains the following information:

(A) The Authority has determined the individual ineligible for OCCS Medical Programs;

(B) The Department is continuing to evaluate Medicaid eligibility on one or more other bases;

(C) The notice shall include coordinated content relating to the transfer of the individual's electronic account to the Department, as appropriate; and

(D) There is a right to a hearing to challenge the eligibility decision.

(d) Provide or assure that the Department has provided the individual with notice of the final determination of eligibility on one or more other bases.

(4) For beneficiaries found ineligible for ongoing OCCS medical program benefits who are referred to the Department for a non-MAGI Medicaid eligibility review, the Authority shall maintain OCCS medical program benefits while eligibility is being determined by the Department and may not take action to close benefits until determination of eligibility is complete.

(5) Coordination among agencies:

(a) The Authority shall maintain a secure electronic interface through which the Authority can send and receive an individual's electronic account from the Department and the FFM;

(b) The Authority may not request information or documentation from the individual included in the individual's electronic account or provided to the Agency; and

(c) If information is available through electronic data match and is useful and related to eligibility for OCCS Medical Programs, the Authority shall obtain the information through electronic data match.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0105
Hospital Presumptive Eligibility

This rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP, BCCTP, and Former Foster Care Youth Medical (OAR 410-200-0407) based on the determination of a qualified hospital.

(1) The qualified hospital shall determine Hospital Presumptive Eligibility for MAGI Medicaid/CHIP, BCCTP, or Former Foster Care Youth Medical based on the following information attested by the individual:

(a) Family size;

(b) Household income;

(c) Receipt of other health coverage;

(d) US citizenship, US national, or non-citizen status.

(2) To be eligible via Hospital Presumptive Eligibility, an individual must be a US citizen, US National, or meet the citizenship and alien status requirements found in 410-200-0215 and one of the following:

(a) A child under the age of 19 with income at or below 300 percent of the federal poverty level;

(b) A parent or caretaker relative of a dependent child with income at or below the MAGI Parent or Other Caretaker Relative income standard for the appropriate family size in OAR 410-200-0315;

(c) A pregnant woman with income at or below 185 percent of the federal poverty level;

(d) A non-pregnant adult between the ages of 19 through 64 with income at or below 133 percent of the federal poverty level; or

(e) A woman under the age of 65 who has been determined eligible for the Breast and Cervical Cancer Treatment Program (OAR 410-200-0400);

(f) An individual under the age of 26 who was in Oregon foster care on their 18th birthday.

(3) To be eligible via Hospital Presumptive Eligibility, an individual may not:

(a) Be receiving Supplemental Security Income benefits;

(b) Be a Medicaid/CHIP beneficiary; or

(c) Have received a Hospital Presumptive Eligibility approval start date within the year (365 days) prior to a new Hospital Presumptive Eligibility period start date.

(4) In addition to the requirements outlined in sections (2) and (3) above, the following requirements also apply:

(a) To receive MAGI Adult benefits via Hospital Presumptive Eligibility, an individual may not be entitled to or enrolled in Medicare benefits under part A or B of Title XVIII of the Act;

(b) To receive MAGI CHIP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage that is accessible (OAR 410-200-0410(2)(c));

(c) To receive BCCTP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage.

(5) The Hospital Presumptive Eligibility period begins on the earlier of:

(a) The date the qualified hospital determines the individual is eligible; or

(b) The date that the individual received a covered medical service from the qualified hospital, if the hospital determines the individual is eligible and submits the decision to the Authority within five calendar days following the date of service.

(6) The Hospital Presumptive Eligibility period ends:

(a) For individuals on whose behalf a Medicaid/CHIP application has been filed by the last day of the month following the month in which the hospital presumptive eligibility period begins, the day on which the state makes an eligibility determination for MAGI Medicaid/CHIP and sends basic decision notice; or

(b) If subsection (a) is not completed, the last day of the month following the month in which the hospital presumptive eligibility period begins.

(7) A Hospital Presumptive Eligibility decision does not qualify a beneficiary for continuous eligibility (OAR 410-200-0135).

(8) A baby born to a woman receiving benefits during a Hospital Presumptive Eligibility period is not assumed eligible (OAR 410-200-0135).

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0110
Application and Renewal Processing and Timeliness Standards

(1) General information as it relates to application processing is as follows:

(a) An individual may apply for one or more medical programs administered by the Authority, the Department, or the FFM using a single streamlined application;

(b) An application may be submitted via the Internet, the FFM, by telephone, by mail, in person, or through other commonly available electronic means;

(c) The Agency shall ensure that an application form is readily available to anyone requesting one and that community partners or Agency staff are available to assist applicants to complete the application process;

(d) If the Agency requires additional information to determine eligibility, the Agency shall send the applicant or beneficiary written notice that includes a statement of the specific information needed to determine eligibility and the date by which the applicant or beneficiary shall provide the required information in accordance with section (7) of this rule.

(e) If an application is filed containing the applicant or beneficiary's name and address, the Agency shall send the applicant or beneficiary a decision notice within the time frame established in section (7) of this rule;

(f) An application is complete if all of the following requirements are met:

(A) All information necessary to determine the individual's eligibility and benefit level is provided on the application for each individual in the household group;

(B) The applicant, even if homeless, provides an address where they can receive postal mail;

(C) The application is signed in accordance with section (6) of this rule;

(D) The application is received by the Agency.

(g) To complete the application process, the applicant shall:

(A) With the exception of sections (5) and (6) of this rule, complete and sign an application; and

(B) Provide necessary information to the Agency within the time frame established in section (7) of this rule.

(2) General information as it relates to renewal and redetermination processing is as follows:

(a) The Authority shall redetermine eligibility at assigned intervals and whenever a beneficiary's eligibility becomes questionable;

(b) When renewing or redetermining medical benefits, the Agency shall, to the extent feasible, determine eligibility using information found in the beneficiary's electronic account and electronic data accessible to the Agency;

(c) If the Agency is unable to determine a beneficiary's eligibility using information found in the beneficiary's electronic account and electronic data accessible to the Agency, then the Agency shall provide a pre-populated renewal form to the beneficiary containing information known to the Agency, a statement of the additional information needed to renew eligibility, and the date by which the beneficiary must provide the required information in accordance with section (7) of this rule;

(d) The Agency shall assist applicants seeking assistance to complete the pre-populated renewal form or gather information necessary to renew eligibility;

(e) The pre-populated renewal form is complete if it meets the requirements identified in section (1) (e) of this rule;

(f) If the Agency provides the individual with a pre-populated renewal form to complete the renewal process, the individual must:

(A) Complete and sign the form in accordance with section (6) of this rule;

(B) Submit the form via the Internet, by telephone, via mail, in person, and through other commonly available electronic means, and

(C) Provide necessary information to the Agency within the time frame established in section (7) of this rule.

(g) An individual may withdraw their pre-populated renewal form at any time.

(3) Except for individuals found eligible for MAGI Medicaid/CHIP through the Fast-Track enrollment process (OAR 410-200-0505), for renewals due between July 1, 2014 and December 31, 2014, the Authority shall:

(a) Utilize a pre-populated Expedited Renewal form to determine if the individual has experienced:

(A) A change in household members; or

(B) A change in income.

(b) Renew eligibility based on the individual's attested information on the Expedited Renewal form if:

(A) There is no change in household members; and

(B) The attested income allows all beneficiaries to remain eligible for Medicaid/CHIP.

(c) If unable to renew eligibility based on the individual's attested information on the Expedited Renewal form, the Authority shall send the beneficiary an application in order to complete a full eligibility review.

(4) A new application is required when:

(a) An individual requests medical benefits and no member of the household group currently receives OCCS medical program benefits;

(b) A child turns age 19, is no longer claimed as a tax dependent, and wishes to retain medical benefits;

(c) The Authority determines that an application is necessary to complete an eligibility determination.

(5) A new application is not required when:

(a) The Agency determines an applicant is ineligible in the month of application and:

(A) Is determining if the applicant is eligible the following month; or

(B) Is determining if the applicant is eligible retroactively (OAR 410-200-0130).

(b) Determining initial eligibility for OCCS Medical Programs via Fast-Track enrollment pursuant to OAR 410-200-0505;

(c) Benefits are closed and reopened during the same calendar month;

(d) An individual's medical benefits were suspended because they became an inmate and met the requirements of OAR 410-200-0140;

(e) An assumed eligible newborn (AEN) is added to a household group receiving medical program benefits;

(f) An individual not receiving medical program benefits is added to an on-going household group receiving medical program benefits, and eligibility can be determined using information found in the individual or beneficiary's electronic account and electronic data available to the Agency;

(g) Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program;

(h) During the ninety-day reconsideration period for eligibility following closure:

(A) The Authority shall redetermine in a timely manner (OAR 410-200-0110) the eligibility of an individual who:

(i) Lost OCCS medical program eligibility because they did not return the pre-populated renewal form or were requested to provide additional information and did not submit the information needed to renew eligibility; and

(ii) Within 90 days of the medical closure date, submits the pre-populated renewal form or the requested additional information.

(B) The date the pre-populated renewal form or requested additional information was provided within the ninety-day reconsideration period establishes a new date of request:

(i) A new application is not required when the requirements set forth in (a)(A) and (a)(B) of this section are met; and

(ii) In the event that the pre-populated renewal form is submitted within the ninety-day reconsideration period and additional information is requested for which the due date lands outside of the ninety-day reconsideration period, a new application is not required.

(C) If the individual is found to meet OCCS medical program eligibility based on the completed redetermination, the effective date of medical benefits is as described in 410-200-0115 (3) and (4).

(6) Signature requirements are as follows:

(a) For an application submitted via the Oregon Eligibility (ONE) system Applicant Portal, the individual identified as the primary applicant must electronically sign the application;

(b) For an application submitted by means other than the Oregon Eligibility (ONE) system Applicant Portal, the application must be signed by one of the following:

(A) The primary contact;

(B) At least one caretaker relative or parent in the household group;

(C) The primary contact when there is no parent in the household group; or

(D) An authorized representative.

(c) Signatures accepted by the Agency may be:

(A) Handwritten;

(B) Electronic; or

(C) Telephonic.

(d) Hospital Presumptive Eligibility may be determined without a signature described in section (a) through (c);

(e) When renewing eligibility, if the Agency is unable to determine eligibility using information found in the beneficiary's electronic account and electronic data accessible to the Agency, a signature is required on the pre-populated renewal form sent to the beneficiary for additional information;

(f) Signatures may be submitted and shall be accepted by the Agency via Internet, mail, telephone, in person, or other electronic means.

(7) Application and renewal processing timeliness standards are as follows:

(a) At initial eligibility determination, the Agency shall inform the individual of timeliness standards, make an eligibility determination, and send a decision notice not later than the 45th calendar day after the Date of Request if:

(A) All information necessary to determine eligibility is present; or

(B) The application is not completed by the applicant within 45 days after the Date of Request.

(b) At initial eligibility determination, the Agency may extend the 45-day period described in section (a) if there is an administrative or other emergency beyond the control of the Agency. The Agency must document the emergency;

(c) At periodic renewal of eligibility, if additional information beyond data available to the Agency on the beneficiary's electronic account or electronic data is required, the Authority shall provide the beneficiary at least 30 days from the date of the renewal form to respond and provide necessary information.

(8) Individuals may apply through the FFM. If the FFM determines the individual potentially eligible for Medicaid, the FFM shall transfer the individual's electronic account to the Agency for OCCS medical program eligibility determination or referral to the Department.

(9) Medical program eligibility is determined in the following order:

(a) For a child applicant, the order is as follows:

(A) Assumed eligibility for OCCS Medical Programs (OAR 410-200-0135);

(B) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (PRTF) (OAR 410-200-0405);

(C) MAGI Parent or Other Caretaker Relative (OAR 410-200-0420);

(D) MAGI Pregnant Woman program (OAR 410-200-0425);

(E) MAGI Child (OAR 410-200-0415);

(F) Continuous Eligibility (OAR 410-200-0135);

(G) MAGI CHIP (OAR 410-200-0410);

(H) Former Foster Care Youth Medical (OAR 410-200-0407);

(I) EXT (OAR 410-200-0440).

(b) For an adult applicant, the order is as follows:

(A) Assumed eligibility for OCCS Medical Programs (OAR 410-200-0135);

(B) Substitute Care (OAR 410-200-0405);

(C) MAGI Parent or Other Caretaker Relative (OAR 410-200-0420);

(D) EXT (OAR 410-200-0440);

(E) MAGI Pregnant Woman (OAR 410-200-0425);

(F) MAGI Adult (OAR 410-200-0435);

(G) Former Foster Care Youth Medical (OAR 410-200-0407);

(H) BCCTP (OAR 410-200-0400).

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0111
Authorized Representatives

(1) The following individuals may designate an authorized representative:

(a) A caretaker;

(b) The primary contact when there is no caretaker in the household group;

(c) An adult in the household group; or

(d) The Agency, if an authorized representative is needed but has not been designated by the individual.

(2) The Agency shall accept an applicant or beneficiary's designation of an authorized representative via any of the following methods which must include either a handwritten or electronic signature of both the applicant or beneficiary and designated authorized representative:

(a) The Internet;

(b) E-mail;

(c) Mail;

(d) Telephonic recording;

(e) In person; or

(f) Other electronic means.

(3) Applicants and beneficiaries may authorize their authorized representative to:

(a) Sign an application on the applicant's behalf;

(b) Complete and submit a renewal form;

(c) Receive copies of the applicant or beneficiary's notices and other communications from the Agency; or

(d) Act on behalf of the applicant or beneficiary in any or all other matters with the Agency.

(4) The authorized representative must:

(a) Fulfill all responsibilities encompassed within the scope of the authorized representation as identified in section (3) to the same extent as the individual represented; and

(b) Maintain the confidentiality of any information regarding the applicant or beneficiary provided by the Authority.

(5) In addition to authorized representatives as designated in sections (1) through (4) above, an individual is treated as an authorized representative if the individual has been given authority under state law. Such authority includes but is not limited to:

(a) A court order establishing legal guardianship;

(b) A health care representative, when the individual is unable to make their own decisions; or

(c) A court order establishing power of attorney.

(6) As a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization with a service-providing relationship to the beneficiary must affirm that he or she shall adhere to the regulations in 45 CFR 431, subpart F and at 45 CFR 155.260(f) and at 45 CFR 447.10 as well as other

relevant state and federal laws concerning conflicts of interest and confidentiality of information.

(7) The power to act as an authorized representative is valid until the Agency is notified via any of the methods described in section (2) of any of the following:

(a) The applicant or beneficiary modifies the authorization or notifies the Agency that the representative is no longer authorized to act on his or her behalf;

(b) The authorized representative informs the Agency that he or she no longer is acting in such capacity; or

(c) There is a change in the legal authority upon which the individual or organization's authority was based.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0115
OCCS Medical Programs—Effective Dates

(1) Date of Request:

(a) For all OCCS Medical Programs, the applicant or an individual authorized to act on behalf of the applicant must contact the Authority, the Department, or the FFM to request medical benefits. The request may be via the Internet, by telephone, community partner, by mail, by electronic communication, or in person;

(b) For new applicants, the Date of Request is the earlier of the following:

(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or

(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.

(c) For current beneficiaries of OCCS Medical Programs, the Date of Request is one of the following:

(A) The date the beneficiary reports a change requiring a redetermination of eligibility; or

(B) The date the Agency initiates a review, except that the automatic mailing of an application does not constitute a Date of Request.

(d) The Date of Request starts the application processing time frame;

(e) If the application is required under OAR 410-200-0110 and is not received within 45 days after the Date of Request or within the extended time that the Authority has allowed under OAR 410-200-0110, the new Date of Request is the date the application is submitted to the Agency.

(2) For EXT, the effective date is determined according to OAR 410-200-0440.

(3) Except for EXT, the effective date of medical benefits for new applicants for OCCS Medical Programs is whichever comes first:

(a) The earliest date of eligibility within the month in which the Date of Request is established; or

(b) If ineligible within the month in which the Date of Request was established, the first day within the following month on which the client is determined to be eligible.

(4) The effective date for retroactive medical benefits (OAR 410-200-0130) for MAGI Medicaid/CHIP and BCCTP is the earlier of:

(a) The first day of the earliest of the three months preceding the month in which the Date of Request was established; or

(b) If ineligible pursuant to section (a), the earliest date of eligibility within the three months preceding the month in which the Date of Request was established.

(5) Establishing a renewal date:

(a) Except for EXT and MAGI Pregnant Woman, as provided in subsection (b) for all OCCS Medical Programs, eligibility shall be renewed every 12 months. The renewal date is the last day of the month determined as follows:

(A) For initial eligibility, the renewal date is established by counting 12 full months, including the initial month of eligibility;

(B) For renewals that are regularly scheduled, the new renewal date is established by counting 12 full months following the current renewal month.

(b) For redeterminations that are initiated by a reported change, outside of the established renewal date, the renewal date is not adjusted.

(6) Acting on Reported Changes (also see Changes That Must Be Reported OAR 410-200-0235):

(a) When the beneficiary reports a change in circumstances at any time other than the renewal month, eligibility shall be redetermined for all household group members;

(b) Except for reports of pregnancy, and changes that result in a CAWEM recipient becoming eligible for Plus benefits, if the beneficiary is determined to be eligible for another OCCS medical program or loses eligibility as a result of the reported change, the effective date for the change is:

(A) If the determination is made on or before the 15th of the month, the first of the next month; or

(B) If the determination is made on or after the 16th of the month, the first of the month following the next month.

(c) For beneficiaries who report a pregnancy, the effective date of MAGI Pregnant Woman, MAGI Parent or Other Caretaker Relative for pregnant women, or MAGI CHIP for pregnant individuals is the earlier of:

(A) The Date of Request; or

(B) The date that a prenatal service related to the pregnancy was received.

(d) For beneficiaries of CAWEM-level benefits who report a change that results in eligibility for Plus level benefits, the effective date of the change is the Date of Request.

(7) Suspending or Closing Medical Benefits:

(a) The effective date for closing OCCS medical program benefits is the earliest of:

(A) The date of a beneficiary's death;

(B) The last day of the month in which the beneficiary becomes ineligible and a timely continuing benefit decision notice is sent;

(C) The day prior to the start date for Office of Child Welfare Programs or OSIPM for beneficiaries transitioning from an OCCS medical program;

(D) The date the program ends; or

(E) The last day of the month in which a timely continuing benefit decision notice is sent if on-going eligibility cannot be determined because the beneficiary does not provide required information within 30 days.

(b) Prior to closing medical benefits, the Agency shall:

(A) Determine eligibility for all other OCCS Medical Programs; or

(B) Refer the beneficiary to the Department, if applicable, and confirm that the Department has made an eligibility decision.

(c) For beneficiaries of OCCS medical program benefits who become incarcerated (OAR 461-200-0140), the effective date of suspension is the day following the date on which the individual became incarcerated.

(8) Denial of Benefits. The effective date for denying OCCS medical program benefits is the earlier of the following:

(a) The date the decision is made that the applicant is not eligible and notice is sent; or

(b) The end of the application processing time frame, unless the time period has been extended to allow the applicant more time to provide required verification.

Stat. Auth.: ORS, 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15;

DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0120
Notices

(1) Except as provided in this rule, the Authority shall send:

(a) A basic decision notice whenever an application for OCCS medical program benefits is approved or denied;

(b) A timely continuing benefit decision notice whenever OCCS medical program benefits are reduced or closed.

(2) For a beneficiary who is placed in a public institution or a correctional facility, the Authority shall send a basic decision notice to close, reduce, or suspend OCCS medical program benefits.

(3) For a beneficiary who has been placed in skilled nursing care, intermediate care, or long-term hospitalization, the Authority shall send a basic decision notice to close, suspend, or reduce OCCS medical program benefits.

(4) The Authority shall send a basic decision notice to close OCCS medical program benefits for a beneficiary who has received them for less than 30 days and who is ineligible for any insurance affordability program.

(5) When returned mail is received without a forwarding address and the beneficiary's whereabouts are unknown, the Authority shall send a basic decision notice to end benefits if the mail was sent by postal mail. If the returned mail was sent electronically, the Authority shall resend by postal mail within three business days. The date on the notice shall be the date the notice is sent by postal mail.

(6) The Authority shall send one of the following notices when a beneficiary ceases to be an Oregon Resident:

(a) A timely continuing benefit notice; or

(b) A basic decision notice if the beneficiary is eligible for benefits in the other state.

(7) Except as provided in section (9) of this rule, to close medical program benefits based on a request made by the beneficiary, another adult member of the household group, or the authorized representative, the Authority shall send the following decisions notices:

(a) A timely continuing benefit decision notice when an oral request is made to close benefits;

(b) A basic decision notice when a request to withdraw, end, or reduce benefits is made with written signature or recorded verbal signature;

(c) A basic decision notice when an individual who is not a recipient of any Medicaid/CHIP benefits makes an oral request to withdraw an application for benefits.

(8) No other notice is required when an individual completes a voluntary agreement if all of the following are met:

(a) The Authority provides the individual with a copy of the completed agreement; and

(b) The Authority acts on the request by the date indicated on the form.

(9) No decision notice is required in the following situations:

(a) The only individual in the household group dies;

(b) A hearing was requested after a notice was received and either the hearing request is dismissed or a final order is issued.

(10) Decision notices shall be written in plain language and be accessible to individuals who are limited English proficient and individuals with disabilities. In addition:

(a) All decision notices shall include:

(A) A statement of the action taken;

(B) A clear statement listing the specific reasons why the decision was made and the effective date of the decision;

(C) Rules supporting the action;

(D) Information about the individual's right to request a hearing and the method and deadline to request a hearing;

(E) A statement indicating under what circumstances a default order may be taken;

(F) Information about the right to counsel at a hearing and the availability of free legal services.

(b) A decision notice approving OCCS medical program benefits including retroactive medical shall include:

(A) The level of benefits and services approved;

(B) If applicable, information relating to premiums, enrollment fees, and cost sharing; and

(C) The changes that must be reported and the process for reporting changes.

(c) A decision notice reducing, denying, or closing OCCS medical program benefits shall include information about a beneficiary's right to continue receiving benefits.

(11) The Authority may amend:

(a) A decision notice with another decision notice; or

(b) A contested case notice.

(12) Except as the notice is amended, or when a delay results from the client's request for a hearing, a notice to reduce or close benefits becomes void if the reduction or closure is not made effective on the date stated on the notice.

(13) The Authority shall provide individuals with a choice to receive decision notices and information referenced in this rule in an electronic format or by postal mail. If an individual chooses to receive notices and information electronically and has established an online account with the Applicant Portal of Oregon Eligibility (ONE), the Authority shall:

(a) Send confirmation of this decision by postal mail;

(b) Post notices to the individual's electronic account within one business day of the date on the notice;

(c) Send an email or SMS text message alerting the individual that a notice has been posted to their electronic account;

(d) At the request of the individual, send by postal mail any notice or information delivered electronically;

(e) Inform the individual of the right to stop receiving electronic notices and information and begin receiving these through postal mail; and

(f) If any electronic communication referenced above is undeliverable, send the notice by postal mail within three business days of the failed communication.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534
Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706
Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0125
Acting on Reported Changes

(1) When an OCCS medical program beneficiary or authorized representative makes a timely report of a change in circumstances at any time between regular renewals of eligibility that may affect the beneficiary's eligibility (any changes reported per OAR410-200-0235), the Authority shall promptly redetermine eligibility before reducing or ending medical benefits.

(2) The Authority shall limit requests for information from the individual to information related to the reported change.

(3) If a beneficiary remains eligible as a result of a redetermination due to a reported change, a new 12-month eligibility period is not established; the original renewal date is maintained.

(4) If the Authority has information about anticipated changes in a beneficiary's circumstances that may affect eligibility, it shall redetermine eligibility at the appropriate time based on the changes.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534
Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706
Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0130
Retroactive Medical

(1) The Authority may evaluate for retroactive medical eligibility for the three calendar months preceding the month in which the Date of Request was established for the following individuals:

(a) Applicants requesting OCCS Medical Programs who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP in the months described in section (1); or

(b) Deceased individuals who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP in the months described in section (1), who would have been eligible for Medicaid covered services had they, or someone acting on their behalf, applied.

(2) If eligible for retroactive medical, the individual's eligibility may not start earlier than the date indicated by OAR 410-200-0115 Effective Dates.

(3) The Authority reviews each month individually for retroactive medical eligibility.

(4) Retroactive medical eligibility may only be determined on the basis of a medical service received during a Hospital Presumptive Eligibility period (OAR 410-200-0105) if the medical service received is not covered by Hospital Presumptive Eligibility.

Stat. Auth.: ORS 411.402, 411.404 & 414.534
Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.534, 414.536 & 414.706
Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0135
Assumed Eligibility and Continuous Eligibility for Children and Pregnant Women

(1) Assumed Eligibility – A child born to a mother who is eligible for and receiving Medicaid/CHIP benefits is assumed eligible for the MAGI Child program until the end of the month in which the child turns one year of age, unless:

(a) The child dies;

(b) The child is no longer a resident of Oregon; or

(c) The child's representative requests a voluntary termination of the child's eligibility.

(2) Continuous Eligibility for children – Children under age 19 who are eligible for and receiving medical assistance under any OCCS Medicaid or CHIP program who lose eligibility for all Medicaid or CHIP programs prior to the 12-month renewal date shall remain eligible until the end of the renewal month, regardless of any change in circumstances, except for the following:

(a) No longer an Oregon resident;

(b) Death;

(c) Incarceration;

(d) Turning age 19;

(e) For children in the CHIP program, receipt of minimum essential coverage; or

(f) When an adult in the household group requests the medical benefits are closed.

(3) Continuous Eligibility for pregnant women – Pregnant women who are eligible for and receiving medical assistance under any Medicaid program who lose eligibility for the medical program shall receive Continuous Eligibility through the two calendar months following the month in which the pregnancy ends, except in the following circumstances:

(a) She is no longer an Oregon resident;

(b) She becomes incarcerated;

(c) Death; or

(d) An adult in the household group requests the medical benefits are closed.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025 & 414.534
Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706
Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0140
Eligibility for Inmates

(1) An inmate of a public institution may not receive benefits with OCCS Medical Programs.

(2) If an OCCS medical program beneficiary becomes an inmate of a public institution with an expected stay of no more than 12 months, medical benefits shall be suspended for up to 12 full calendar months during the incarceration period.

(3) The effective date of the suspension of benefits is the day following the date on which the individual became incarcerated.

(4) Suspended benefits shall be restored to the release date without the need for a new application when:

(a) The individual reports their release to the Agency within ten calendar days of the release date;

(b) The individual reports their release to the Agency more than ten calendar days from the release date, and there is good cause for the late reporting; or

(c) The inmate is released to a medical facility and begins receiving treatment as an inpatient, providing the facility is not associated with the institution where the individual was an inmate.

(5) When released, benefits shall be restored as described in section (4), and:

(a) If the individual is released prior to their eligibility renewal date, the eligibility renewal date may not be changed; or

(b) If the individual is released after the eligibility renewal date has passed, benefits shall be restored and a redetermination of eligibility processed.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025 & 414.534
Stats. Implemented: ORS, 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049 & 414.426
Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0145
Contested Case Hearing

(1) For the purposes of this rule, timely means within 90 days of the date the notice of adverse action is received.

(2) This rule applies to contested case hearings for programs described in OAR chapter 410 division 200. Contested case hearings are conducted in accordance with the Attorney General's model rules OAR 137-003-0501 and following ORS Ch. 183 except to the extent that Authority rules provide for different procedures.

(3) The Authority's contested case hearings governed by this rule are not open to the public and are closed to nonparticipants, except nonparticipants may attend subject to the parties' consent and applicable confidentiality laws.

(4) A claimant may request a contested case hearing upon the timely completion of a hearing request in medical assistance programs in the following situations:

(a) The Authority has not approved or denied an application within 45 days of the date of request for benefits or the extended time the Authority has allowed for processing;

(b) The Authority acts to deny, reduce, close, or suspend medical assistance, including the denial of continued benefits pending the outcome of a contested case hearing;

(c) The Authority claims that an earlier medical assistance payment was an overpayment;

(d) A claimant claims that the Authority previously under issued medical assistance;

(e) A claimant disputes the current level of benefits.

(5) An officer or employee of the Authority or the Department of Human Services may appear on behalf of the Authority in medical assistance hearings described in this rule. The Authority's lay representative may not make legal argument on behalf of the Authority.

(6) The Authority representative is subject to the Code of Conduct for Non-Attorney Representatives at Administrative Hearings, which is maintained by the Oregon Department of Justice and available on its website at http://www.doj.state.or.us. An Authority representative appearing under this rule shall read and be familiar with it.

(7) When an Authority representative is used, requests for admission and written interrogatories are not permitted.

(8) The Authority representative and the claimant may have an informal conference in order to:

(a) Provide an opportunity to settle the matter;

(b) Review the basis for the eligibility determination, including reviewing the rules and facts that serve as the basis for the decision;

(c) Exchange additional information that may correct any misunderstandings of the facts relevant to the eligibility determination; or

(d) Consider any other matters that may expedite the orderly disposition of the hearing.

(9) A claimant who is receiving medical assistance benefits and who is entitled to a continuing benefit decision notice may, at the option of the claimant, receive continuing benefits in the same manner and amount until a final order resolves the contested case. In order to receive continuing benefits, a claimant must request a hearing not later than:

(a) The tenth day following the date the notice is received; and

(b) The effective date of the action proposed in the notice.

(10) The continuing benefits are subject to modification based on additional changes affecting the claimant's eligibility or level of benefits.

(11) When a claimant contests the denial of continuing benefits, the claimant shall receive an expedited hearing.

(12) In computing timeliness under sections (1) and (9) of this rule:

(a) Delay caused by circumstances meeting the good cause criteria described in OAR 137-003-0501(7) may not be counted; and

(b) The notice is considered to be received on the fifth day after the notice is sent unless the claimant shows the notice was received later or was not received.

Stat. Auth.: ORS 411.404, 411.816, 412.014, 412.049 & 413.042

Stats. Implemented: ORS 183.452, 411.060, 411.404, 411.816, 412.014 & 412.049

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 50-2014(Temp), f. 8-14-14, cert. ef. 8-15-14 thru 2-11-15; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15

410-200-0146
Final Orders, Dismissals and Withdrawals

(1) When the Authority refers a contested case under chapter 410 division 200 to the Office of Administrative Hearings (OAH), the Authority must indicate on the referral:

(a) Whether the Authority is authorizing a proposed order, a proposed and final order, or a final order; and

(b) If the Authority establishes an earlier deadline for written exceptions and argument because the contested case is being referred for an expedited hearing.

(2) When the Authority authorizes either a proposed order or a proposed and final order:

(a) The claimant may file written exceptions and written argument to be considered by the Authority. The exceptions and argument must be received at the location indicated in the OAH order not later than the 20th day after service of the proposed order or proposed and final order, unless section (1)(b) of this rule applies;

(b) The Authority shall issue the final order after OAH issues a proposed order unless the Authority requests that OAH issue the final order pursuant to OAR 137-003-0655.

(c) The proposed and final order becomes a final order on the 21st day after the service of the proposed and final order, if the claimant does not submit timely exceptions or arguments following a proposed and final order, unless:

(A) The Authority has issued a revised order; or

(B) The Authority has notified the claimant and OAH that the Authority shall issue the final order.

(d) The Authority shall issue the final order when the Authority receives timely exceptions or argument unless the Authority requests that OAH issue the final order.

(3) In a contested case hearing, if the OAH is authorized to issue a final order on behalf of the Authority, the Authority may issue the final order in the case of default.

(4) A petition by a claimant for reconsideration or rehearing must be filed with the individual who signed the final order unless stated otherwise on the final order.

(5) A final order is effective immediately upon being signed or as otherwise provided in the order. Delay due to a postponement or continuance granted at the claimant's request may not be counted in computing time limits for a final order. A final order shall be issued or the case otherwise shall be resolved no later than:

(a) Ninety days following the date of the hearing for the standard hearing time frame;

(b) Three working days after the date the OAH hears an expedited hearing.

(6) In the event a request for a hearing is not timely or the claimant has no right to a contested case hearing on an issue, and there are no factual disputes about whether this division of rules provides a right to a hearing, the Authority may issue an order accordingly. The Authority may refer an untimely request to the OAH for a hearing on timeliness or on the question of whether the claimant has the right to a contested case hearing.

(7) If the Authority serves a decision notice on the claimant by postal or electronic mail and the Authority receives an untimely hearing request from the claimant within 75 days from the date the decision notice became a final order, then one of the following shall occur:

(a) If the Authority finds that the claimant did not receive the decision notice and did not have actual knowledge of the notice, the Authority shall refer the hearing request to the OAH for a contested case hearing on the merits of the Authority's action described in the notice; or

(b) If there is a factual dispute regarding the claimant's receipt or knowledge of the notice, the Authority shall refer the hearing request to the OAH for a contested case hearing to determine whether the claimant received or had actual knowledge of the notice. The Authority has the burden to prove by a preponderance of the evidence that the claimant had actual knowledge of the notice or that the Authority mailed the notice to the claimant's correct mailing address or sent an electronic notice to the claimant's correct electronic mail address according to the information the claimant provided to the Authority.

(8) If the Authority receives an untimely hearing request from the claimant, regardless of the manner in which the Authority served the decision notice on the claimant, then:

(a) If the Authority finds that the claimant's hearing request was untimely for good cause as defined in OAR 137-003-0501(7), the Authority shall refer the hearing request to the OAH for a contested case hearing on the merits of the Authority's action described in the notice; or

(b) If there is a factual dispute regarding the existence of good cause, the Authority shall refer a hearing request to the OAH for a contested case hearing to determine whether there was good cause as defined in OAR 137-003-0501(7) for the claimant's delay in submitting the hearing request to the Authority.

(c) Any hearing request is treated as timely when required under the Servicemembers Civil Relief Act.

(d) The Authority may dismiss a hearing request as untimely if the claimant does not qualify for a hearing under sections (8)(a), (b), or (c).

(9) A claimant may withdraw a hearing request at any time before a final order has been issued on the contested case. When a claimant withdraws a hearing request:

(a) The Authority shall send an order confirming the withdrawal to the claimant's last known address;

(b) The claimant may cancel the withdrawal in writing. The withdrawal must be received by the Authority hearing representative no later than the tenth working day following the date the Authority sent the order confirming the withdrawal.

(10) A hearing request is dismissed by order by default when neither the claimant nor the claimant's representative 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 claimant on a showing that the claimant was unable to attend the hearing and unable to request a postponement due to circumstances meeting the good cause criteria described in OAR 137-003-0501(7).

Stat. Auth.: ORS 183.341, 413.042, 411.060, 411.404, 411.408, 411.816, 412.014 & 412.049

Stats. Implemented: ORS 183.341, 411.060, 411.404, 411.408, 411.816, 412.014 & 412.049

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 50-2014(Temp), f. 8-14-14, cert. ef. 8-15-14 thru 2-11-15; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15

410-200-0200
Residency Requirements

(1) To be eligible for OCCS Medical Programs, an individual must be a resident of Oregon.

(2) An individual is a resident of Oregon if the individual lives in Oregon except:

(a) An individual 21 years of age or older who is placed in a medical facility in Oregon by another state is considered to be a resident of the state that makes the placement if:

(A) The individual is capable of indicating intent to reside; or

(B) The individual became incapable of indicating intent to reside after attaining 21 years of age (see section (6)).

(b) For an individual less than 21 years of age who is incapable of indicating intent to reside or an individual of any age who became incapable of indicating that intent before attaining 21 years of age, the state of residence is one of the following:

(A) The state of residence of the individual's parent or legal guardian at the time of application;

(B) The state of residence of the party who applies for benefits on the individual's behalf if there is no living parent or the location of the parent is unknown, and there is no legal guardian;

(C) Oregon, if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981, or is from a state with which Oregon has an interstate agreement that waives the residency requirement;

(D) When a state agency of another state places the individual, the individual is considered to be a resident of the state that makes the placement.

(3) There is no minimum amount of time an individual must live in Oregon to be a resident. The individual is a resident of Oregon if:

(a) The individual intends to remain in Oregon; or

(b) The individual entered Oregon with a job commitment or is looking for work.

(4) An individual is not a resident if the individual is in Oregon solely for a vacation.

(5) An individual continues to be a resident of Oregon during a temporary period of absence if he or she intends to return when the purpose of the absence is completed.

(6) An individual is presumed to be incapable of indicating intent to reside if the individual falls under one or more of the following:

(a) The individual is assessed with an IQ of 49 or less based on a test acceptable to the Authority;

(b) The individual has a mental age of seven years or less based on tests acceptable to the Authority;

(c) The individual is judged legally incompetent by a court of competent jurisdiction;

(d) The individual is found incapable of indicating intent to reside based on documentation provided by a physician, psychologist, or other professional licensed by the State of Oregon in the field of intellectual disabilities.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0205
Concurrent and Duplicate Program Benefits

(1) An individual receiving OCCS medical program benefits may not receive the following medical benefits at the same time:

(a) Any other OCCS medical program;

(b) Office of Child Welfare Medical;

(c) Oregon Youth Authority Medical;

(d) Oregon Supplemental Income Program-Medical (OSIPM); or

(e) Refugee Medical Assistance (REFM);

(2) An individual may not receive OCCS medical program benefits and medical benefits from another state unless the individual's provider refuses to submit a bill to the Medicaid/CHIP agency of the other state and the individual would not otherwise receive medical care.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15

410-200-0210
Requirement to Provide Social Security Number

(1) The Agency may collect a Social Security Number (SSN) for the following purposes:

(a) The determination of eligibility for benefits. The SSN is used to verify income and other assets and to match with other state and federal records such as the Internal Revenue Service (IRS), Medicaid, spousal support, Social Security benefits, and unemployment benefits;

(b) The preparation of aggregate information and reports requested by funding sources for the program providing benefits;

(c) The operation of the program applied for or providing benefits;

(d) Conducting quality assessment and improvement activities;

(e) Verifying the correct amount of payments, recovering overpaid benefits, and identifying any individual receiving benefits in more than one household.

(2) As a condition of eligibility, except as provided in section (6) below, each applicant (including children) requesting medical benefits shall:

(a) Provide a valid SSN; or

(b) Apply for an SSN if the individual does not have one and provide the SSN when it is received.

(3) The agency may not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN or if the individual meets one of the exceptions identified in section (6).

(4) Except as provided in section (6) below, if an applicant does not recall their SSN or has not been issued an SSN and the SSN is not available to the Agency, the Agency shall:

(a) Obtain required evidence under SSA regulations to establish the age, the citizenship, or alien status and the true identity of the applicant; and

(b) Either assist the applicant in completing an application for an SSN or, if there is evidence that the applicant has previously been issued an SSN, request SSA to furnish the number.

(5) The Agency may request that non-applicants provide an SSN on a voluntary basis. The Agency shall use the SSN for the purposes outlined in section (1).

(6) An applicant is not required to apply for or provide an SSN if the individual:

(a) Does not have an SSN and the SSN may be issued only for a valid-non-work reason;

(b) Is not eligible to receive an SSN;

(c) Is a member of a religious sect or division of a religious sect that has continuously existed since December 31, 1950 and the individual adheres to its tenets or teachings that prohibit applying for or using an SSN; or

(d) Is a newborn that is assumed eligible based on the eligibility of the mother of the newborn and who is under one year of age.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15

410-200-0215
Citizenship and Alien Status Requirements

(1) To meet the citizen or alien status requirements for an OCCS medical program, an individual must be:

(a) A citizen of the United States;

(b) A non-citizen who meets the alien status requirements in section (4) of this rule;

(c) A citizen of Puerto Rico, Guam, the Virgin Islands or Saipan, Tinian, Rota or Pagan of the Northern Mariana Islands; or

(d) A national from American Samoa or Swains Islands.

(2) An individual is a qualified non-citizen if the individual is any of the following:

(a) A non-citizen lawfully admitted for permanent residence under the INA (8 U.S.C. 1101 et seq);

(b) A refugee admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(c) A non-citizen granted asylum under section 208 of the INA (8 U.S.C. 1158);

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1253(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 1231(b)(3)) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996));

(e) A non-citizen paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year;

(f) A non-citizen granted conditional entry pursuant to section 203(a) (7) of the INA (8 U.S.C. 1153(a) (7)) as in effect prior to April 1, 1980;

(g) A non-citizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(h) An Afghan or Iraqi alien granted Special Immigration Status (SIV) under Section 8120 of the December 19, 2009 Defense Appropriations Bill (Public Law 111-118); or

(i) A battered spouse or child who meets the requirements of 8 U.S.C. 1641(c) as determined by the U.S. Citizenship and Immigration Services.

(3) A non-citizen meets the alien status requirements if the individual is:

(a) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) (8 U.S.C. 1359) apply;

(b) A member of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(c) A veteran of the United States Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty service requirements described in 38 U.S.C. 5303A(d);

(d) A member of the United States Armed Forces on active duty (other than active duty for training);

(e) The spouse or a child of an individual described in subsection (c) or (d) of this section.

(f) A qualified non-citizen and meets one of the following criteria:

(A) Effective October 1, 2009 is an individual under 19 years of age;

(B) Was a qualified non-citizen before August 22, 1996;

(C) Physically entered the United States before August 22, 1996, and was continuously present in the United States between August 22, 1996, and the date qualified non-citizen status was obtained. An individual is not continuously present in the United States if the individual is absent from the United States for more than 30 consecutive days or a total of more than 90 days between August 22, 1996, and the date qualified non-citizen status was obtained;

(D) Has been granted any of the following alien statuses:

(i) Refugee under section 207 of the INA;

(ii) Asylum under section 208 of the INA;

(iii) Deportation being withheld under section 243(h) of the INA;

(iv) Cubans and Haitians who are either public interest or humanitarian parolees;

(v) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988;

(vi) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112;

(vii) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112);

(viii) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a) (27) of the INA.

(g) Under the age of 19 and is one of the following:

(A) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S;

(B) An individual described in 8 CFR section 103.12(a)(4) who belongs to one of the following classes of aliens permitted to remain in the United States because the Attorney General has decided for humanitarian or other public policy reasons not to initiate deportation or exclusion proceedings or enforce departure:

(i) An alien currently in temporary resident status pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a);

(ii) An alien currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 USC 1229b);

(iii) Cuban-Haitian entrants, as defined in section 202(b) Pub. L. 99–603 (8 USC 1255a), as amended;

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101–649 (8 USC 1255a), as amended;

(v) An alien currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) An alien currently in deferred action status pursuant to Department of Homeland Security Operating Instruction OI 242.1(a) (22); or

(vii) An alien who is the spouse or child of a United States citizen whose visa petition has been approved and who has a pending application for adjustment of status.

(C) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including those individuals as specified in section 101(a)(15) of the INA (8 USC 1101);

(D) An alien in non-immigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(E) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(F) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(G) An alien who has been granted withholding of removal under the Convention Against Torture;

(H) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(I) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(J) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

(4) Individuals 19 and older who are described in sections (2)(a), (2)(e), (2)(f), and (2)(i) of this rule who entered the United States or were given qualified non-citizen status on or after August 22, 1996 meet the alien status requirement five years following the date the non-citizen received the qualified non-citizen status.

(5) Individuals described in sections (2)(a) through (g), (2)(i), (3)(g)(B)(ii), (3)(g)(B)(iv), (3)(g)(B)(v), (3)(g)(B)(vii), and (3)(g)(D) through (J) with deferred action under Deferred Action for Childhood Arrivals (DACA) process do not meet the non-citizen requirement for OCCS Medical Programs.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.534, 414.536 & 414.706

Hist.: DMAP 54-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 4-2014(Temp), f. & cert. ef. 1-15-14 thru 3-30-14; DMAP 20-2014, f. & cert. ef. 3-28-14; DMAP 67-2014(Temp), f. 11-14-14, cert. ef. 11-15-14 thru 5-13-15; DMAP 3-2015, f. & cert. ef. 1-30-15; DMAP 78-2015(Temp), f. & cert. ef. 12-22-15 thru 6-18-16; DMAP 24-2016, f. & cert. ef. 6-2-16

410-200-0220
Requirement to Pursue Assets

(1) As a condition of on-going eligibility, an applicant or beneficiary shall make a good faith effort to obtain an asset to which they have a legal right or claim, except an applicant or beneficiary is not required to:

(a) Apply for Supplemental Security Income (SSI) from the Social Security Administration;

(b) Borrow money;

(c) Make a good faith effort to obtain such asset if the individual can show good cause for not doing so (see section (4).

(2) Pursuable assets include, but are not limited to:

(a) Claims related to an injury;

(b) Disability benefits;

(c) Healthcare coverage;

(d) Retirement benefits;

(e) Survivorship benefits;

(f) Unemployment compensation; and

(g) Veteran's compensation and pensions.

(3) Except for beneficiaries in the OHP-CHP or MAGI CHIP programs, caretakers shall obtain available health insurance coverage and cash medical support for household group members receiving medical assistance:

(a) Each caretaker in the household group shall assist the Agency and the Division of Child Support (DCS) in establishing paternity for each child receiving medical assistance and in obtaining an order directing the non-custodial parent of a child receiving benefits to provide cash medical support and health care coverage for that child;

(b) For a parent receiving medical assistance who fails to meet the requirements of section (3) (a), a penalty is applied as identified in section (3) (e) or section (3) (f) after providing the beneficiary with notice and opportunity to show the provisions of section (4) of this rule apply;

(c) Each applicant, including a parent for their child, shall make a good faith effort to obtain available coverage under Medicare. The Authority may not penalize children for non-cooperation;

(d) With the exception of OHP-CHP, MAGI CHIP, and OHP-OPU, caretakers who are OCCS medical program beneficiaries shall apply for, accept, and maintain cost-effective employer-sponsored health insurance as set forth in OAR 461-155-0360 unless they have good cause;

(e) For MAA, MAF, EXT, CEM, and Substitute Care medical programs, a parent who fails to meet the requirements of section (3) is excluded from the family size;