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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 1

PROCEDURAL RULES

410-001-0000

Model Rules of Procedure

TheDepartmentofHuman Resources hereby adopts the October 1989, Attorney General's Model Rules of Procedure under the Administrative Procedure Act, applicable to rulemaking functions.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the office of the Attorney General or Department of Human Resources.]

Stat. Auth.: ORS Ch. 183

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

410-001-0005

Notice of Proposed Rule

In addition to the means of notifications specified in OAR 137-001-0000 of the Attorney General's Model Rules of Procedure, pursuant to ORS 183.335(1)(a), all individuals and groups which the Director believes would have a substantial interest in the proposed rules shall be notified by mail or telephone of the Director's intention to adopt, amend, or repeal the rule.

Stat. Auth.: ORS Ch. 183

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

410-001-0010

Fees

In carrying out the requirements of ORS 183.335(6), relating to a mailing list and copies of notices of intended action under these rules, the Department of Human Resources by subsequent rule shall establish fees necessary to defray the costs of mailings and maintenance of the lists.

Stat. Auth.: ORS Ch. 183

Hist.: HR 3(Temp), f. & ef. 12-29-76; HR 5, f. & ef. 3-10-77

410-001-0020

Delegation of Rulemaking Authority

The Director of the Department of Human Resources is vested with the authority to adopt, amend, or repeal administrative rules. Such authority will be delegated to the Assistant Directors of the Department upon a finding by the Director that such action is proper. This determination will be made after a review of each proposed action, according to internal procedures. Upon adoption of this rule, the temporary rule is rescinded.

Stat. Auth.: ORS Ch. 183 & 184

Hist.: HR 6(Temp), f. & ef. 7-1-77; HR 7, f. & ef. 9-1-77

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DIVISION 2

SUSPENSION OF ENFORCEMENT FEE

410-002-0000

Suspension of Enforcement Service Fee Authorized But Not Mandated by ORS 23.765 (5)(a)

(1) The Department of Human Resources hereby suspends the assessing and deducting of the $10 automatic support enforcement service fee from the support money received on behalf of the obligee.

(2) All service fees assessed prior to August 2, 1976, will be recovered by deduction from support money received after August 2, 1976.

Stat. Auth.: ORS Ch. 23

Hist.: HR 2(Temp), f. & ef. 8-2-76 through 11-29-76; HR 4, f. & ef. 2-16-77

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DIVISION 3

CONDITIONS UNDER WHICH DIVISIONS OF THE DEPARTMENT MAY ISSUE GRANTS OR ENTER INTO CONTRACT

410-003-0000

Issuance of Grants or Contracts

Effective January 1, 1978, any contract or grant made or issued by any Division with any corporation, partnership, firm, association, or business proprietor-ship, whose annual total budget is $100.000 or more and which receives at least 75 percent of its gross income from the Division making the contract or grant, shall contain assurances that meetings of the governing bodies shall hold their meetings open to the public as if it were a public body. The recipient of the grant or contract agrees that it will comply with all relevant portions of ORS 192.410 to 192.500 and 192.610 to 192.690 with respect to transactions involving the money from the contract or grant, as if it were a public body. The affected entities shall also be guaranteed the same privilege of confidentiality granted to public agencies under the aforementioned laws, including the right to limit disclosure of information which may jeopardize competition in future offers to provide services.

Stat. Auth.: ORS Ch. 183 & 184

Hist.: HR 8, f. 12-28-77, ef. 1-1-78

410-003-0001

Cancellation

Any such contracts or grants shall also contain a provision for cancellation upon a finding by a Division that a recipient has not complied substantially with the terms of the contract or grant as it relates to the aforementioned laws.

Stat. Auth.: ORS Ch. 183 & 184

Hist.: HR 8, f. 12-28-77, ef. 1-1-78

410-003-0002

Applicability

This rule does not apply with respect to contracts or grants for the furnishing of bids or supplies or the construction, maintenance, or repair of public works or buildings.

Stat. Auth.: ORS Ch. 183 & 184

Hist.: HR 8, f. 12-28-77, ef. 1-1-78

410-003-0003

Expiration

This rule shall expire December 31, 1978.

Stat. Auth.: ORS Ch. 183 & 184

Hist.: HR 8, f. 12-28-77, ef. 1-1-78

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DIVISION 4

REGULATION OF COUNTY CAPACITY OF RESIDENTIAL CARE FACILITIES

410-004-0001

Residential Facilities

(1) Effective September 1, 1988, and except as otherwise provided in this rule, the capacity of all **Residential Facilities** or home for adults, including foster care homes, group care facilities or residential treatment, training or care facilities, located throughout the state shall not exceed a target based on the number of beds available in 1979, updated at the rate of ten percent per year, as distributed on the basis of the Oregon population by county. The distribution shall be determined by the Department of Human Resources annually.

(2) Where a county possesses less than one percentile of the State population, then the county with the lowest percentile within a Department of Human Resources' region shall be grouped until such time as the group reaches one percentile of the State population in determining the distribution target.

(3) Nothing in this rule is intended to prevent placement of a person who was not initially a resident of the county in a domiciliary care facility in the county. The targeted number of beds shall not require reduction in any domiciliary care facility capacity existing on October 4, 1977. No domiciliary care facility will be required to suspend operations, nor will the Department of Human Resources support be denied such facilities on the basis of the facility being located in a county or county grouping which exceeds the distribution target.

(4) Adult Foster Care Homes as described in section (1) of this rule does not include Adult Foster Care Homes in which the clients of these homes are directly related by blood or marriage to the operator of the homes.

(5) In cases for which the distribution target for residential facilities, except Adult Foster Care Homes, allows for additional capacity in a county or county grouping and such additional capacity is less than ten beds, then one additional facility of the same type of ten-bed capacity may be authorized.

(6) This rule applies only to those residential care facilities as described in sections (1) and (4) of this rule which are established by, contracted for, or operated by the Department of Human Resources or any of its divisions.

(7) Nothing in this rule will exempt any residential facility from the regulations of funding limitations of the Department

of Human Resources or any of its divisions.

(8) Subject to the appropriate licensing requirements, the governing body of a county may authorize a residential facility located in the county to exceed the capacity limit upon:

(a) Request of an individual or organization operating or proposing to operate a residential facility;

(b) Consultation with an advisory committee appointed by the governing body and consisting of persons who are particularly interested in the type of residential facility contemplated; and

(c) Finding of good cause following notice and public hearing.

[ED NOTE The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources]

Stat. Auth.: ORS Ch. 184

Hist.: HR 1-1978, f. & ef. 2-16-78; HR 17-1979, f. & ef. 11-19-79; HR 5-1988, f. & cert. ef. 9-1-88

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DIVISION 5

RESIDENTIAL CARE, TREATMENT, AND TRAINING FACILITIES

Providing Services to Residential Care Clients

410-005-0080

Purpose

(1) OAR 410-005-0085 through 410-005-0100 establish a long-range goal wherein ultimately residential care and adult foster home clients of the Department of Human Resources, whose primary service needs are associated with mental retardation or other developmental disabilities, or mental or emotional disturbance, or alcohol or drug abuse or dependence, will reside in Adult Residential Care Facilities and Adult Foster Homes under the jurisdiction of the Mental Health and Developmental Disability Services Division serving only such category of residents. Those clients not having such primary service needs will reside in facilities under the jurisdiction of the Senior and Disabled Services Division, serving only such category of residents.

(2) The goal is realized by assigning certain facilities to the jurisdiction of the Mental Health and Developmental Disability Services Division with interim procedures for case management of mixed clients and by prescribing those facilities to which new placements will be made.

Stat. Auth.: ORS Ch. 410, 430 & 443

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85

410-005-0085

Definitions

As used in OAR 410-005-0080 through 410-005-0100:

(1) "Mental Retardation" means:

(a) A person with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **Manual on Terminology and Classification in Mental Retardation** of the American Association on Mental Deficiency, **1977Revision**, by this reference made a part hereof. Mental retardation is synonymous with mental deficiency;

(b) For community case management and program purposes, mental retardation includes those persons of borderline intelligence who have a history of residency in a state training center.

(2) "Developmental Disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions which require training similar to that required by mentally retarded individuals, and the disability:

(a) Originates before the individual attains age 22 except that in the case of mental retardation the condition must be manifested before the age of 18;

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the individual's ability to function in society.

(3) "Mental or Emotional Disturbance" means a disorder of emotional reactions, thought processes, behavior, or relationships (excluding mental retardation, alcoholism and drug abuse or dependency) which results in substantial subjective distress, impaired perceptions of reality, or impaired ability to control or appreciate the consequences of one's behavior, and which constitutes a substantial impairment of personal, interpersonal, work, educational or civic functioning. If a medical diagnosis is made, classification shall be consistent with the current **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association 1980, by this reference made a part hereof.

(4) "Alcohol or Drug Abuse" or "Dependence" means a person who has lost the ability to control the use of alcohol or controlled substances or other substances with abuse potential, or who uses alcohol or such substances to the extent that the person's health or that of others is substantially impaired or endangered or the person's social or economic functions are substantially disrupted. An alcohol or drug dependent person may be physically dependent, a condition in which the body requires a continuing supply of alcohol, a drug, or controlled substance to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of alcohol, a drug, or a controlled substance.

(5) "Residents" mean persons who are clients of the Department of Human Resources who reside in Adult Residential Care Facilities and Adult Foster Homes.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 410, 430 & 443

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85

410-005-0090

Jurisdiction Over Homes and Centers

(1) The Mental Health and Developmental Disability Services Division shall have jurisdiction over and shall license all Adult Residential Care Homes and Centers and certify Adult Foster Homes having residents 60 percent or more of which have primary service needs associated with mental retardation or other developmental disabilities, or mental or

emotional disturbance or alcohol or drug abuse dependence.

(2) Adult Residential Care Homes and Centers and Adult Foster Homes not within the criteria in section (1) of this rule shall be under the jurisdiction of and be licensed or certified by the Senior and Disabled Services Division.

Stat. Auth.: ORS Ch. 410, 430 & 443

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85

410-005-0095

Case Management

(1) Those residents in homes and centers under the jurisdiction of Mental Health and Developmental Disability Services Division, whose primary service needs are not associated with mental retardation or other developmental disabilities, or mental or emotional disturbances or alcohol or drug abuse or dependence shall be Senior and Disabled Services Division clients and shall receive case management from such Division. All other residents in such facilities shall be Mental Health and Developmental Disability Services Division clients and shall receive case management from such Division.

(2) Those residents in Adult Residential Care Homes and Centers and Adult Foster Homes under the jurisdiction of the Senior and Disabled Services Division whose primary service needs are associated with mental retardation or other developmental disabilities, or mental or emotional disturbance or alcohol or drug abuse or dependence, shall be Mental Health and Developmental Disability Services Division clients and shall receive case management from such Division. All other residents in such facilities shall be Senior and Disabled Services Division clients and receive case management from such Division.

Stat. Auth.: ORS Ch. 410, 430 & 443

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85

410-005-0100

Placement

(1) Residential Care and Adult Foster Home clients shall be newly placed on the basis of primary service needs -- Those having such needs as those described in OAR 410-005-0090(1) will be placed in the facilities described in that paragraph and those not having such needs shall be placed in those facilities described in OAR 410-005-0090(2).

(2) Exceptions may be made only when a client cannot be placed because of the unavailability of an appropriate facility and the facility in which the client is placed is capable of serving the needs of the client. Exceptions will be granted by the Division responsible for the receiving facility.

Stat. Auth.: ORS Ch. 410, 430 & 443

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85

410-005-0105

Effective Date

OAR 410-005-0080 through 410-005-0100 are prospective as well as retroactive to July 1, 1982. Such prospective and retroactive effect is each severable of the other.

Stat. Auth.: ORS Ch. 410, 430 & 443

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85

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DIVISION 7

CRIMINAL RECORDS CHECKS FOR DEPARTMENT OF HUMAN RESOURCES EMPLOYEES

Oregon Criminal Records Checks and Federal Criminal Records Checks

410-007-0000

Statement of Purpose and Statutory Authority

(1) Purpose. It is the intent of the Department of Human Resources ("Department" or "DHR") to ensure that persons employed by the Department or any of the Department's divisions have not engaged in criminal behavior so incompatible with their duties and the Department's mission as to pose a danger to the people the Department serves, or to make them otherwise unfit to perform the functions of a position. In addition, the Department has a strong interest in taking reasonable precautions to provide a safe workplace for its employees and to protect the State's other resources. Therefore, the Department will conduct criminal history checks as described in these rules.

(2) These rules establish the process by which the Department obtains criminal offender information on persons who apply for employment or are employed by the Department, and how the Department uses such information in making employment decisions.

(3) These rules also provide guidelines under which the Department:

(a) Receives criminal offender information when the information is required to implement a federal or state statute, executive order, or rule that expressly refers to criminal conduct, or for agency employment purposes, or licensing purposes, or other demonstrated and legitimate needs;

(b) Communicates decisions made based on criminal offender information; and/or

(c) Disseminates criminal offender information to authorized persons.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0010

Definitions

(1) "Administrator" means the Director or Deputy of the Department of Human Resources, or a person who is an Assistant Director of the Department of Human Resources, and who is the Administrator of a division of the Department, or the Director of a major program office within the Department.

(2) "Agency" means the Department or Human Resources or any division of the Department of Human Resources, including the Director's Office.

(3) "Agency Agreement" means a written agreement between the Department of Oregon State Police and an agency authorized to receive criminal offender information, and which specifies the terms and conditions of accessing and receiving Oregon Computerized Criminal History information.

(4) "Agency LEDS Representative" means agency employees who have been designated by agency Appointing Authorities and have been cleared by the Oregon State Police to have access to the Law Enforcement Data System. These representatives serve as the primary contacts for matters regarding the Law Enforcement Data System and are responsible for authorizing other users of the Law Enforcement Data System.

(5) "Applicant" means an individual who applies for appointment to a paid position of employment with an agency. An individual who applies for initial appointment to state service, or transfer to the Department or any of its Divisions from outside the Department, or transfer between any of the Department's Divisions, for promotion, demotion, re-employment, or temporary appointment is an "applicant" for purposes of these rules. This would not include intra-Division appointments.

(6) "Appointing Authority" means an agency head and any designated employee who has power to make appointments to positions in the state service and take other personnel actions.

(7) "Authorized Employee" means an agency employee who has been cleared by the Oregon State Police by means of a computerized criminal history record check and fingerprinting to review Oregon and federal criminal offender information, and who is authorized to make determinations regarding a subject individual's fitness for a position and make recommendations regarding such determinations.

(8) "Computerized Criminal History (CCH) System" means the administration and maintenance of online computer files of significant criminal offender information by the Oregon State Police.

(9) "Crime" means a felony or a misdemeanor as designated in statute.

(10) "Criminal Offender Information" means records, including fingerprints and photographs, received, compiled, and disseminated by the Oregon State Police for purposes of identifying criminal offenders and alleged offenders, and maintained as to such persons' records of arrest, the nature and disposition of criminal charges, sentencing, confinement, and release. This includes the Oregon State Police Computerized Criminal History (CCH) System.

(11) "Designated Agency" means the Department or any DHR division required to access Oregon criminal offender information to implement a federal or state statute, executive order or administrative rule that expressly refers to criminal conduct, and contains requirements or exclusions expressly based on such conduct, or for agency employment

purposes, or licensing purposes, or other demonstrated and legitimate needs when designated by order of the Governor.

(12) "Employee" means an individual currently employed by the Department or any Division of the Department.

(13) "FBI" means the Federal Bureau of Investigation.

(14) "Federal Criminal Offender Information" means criminal offender information compiled and maintained by the Bureau of Criminal Identification regarding persons who have been arrested for crimes where law enforcement agencies have submitted fingerprints and other identifying data as required by ORS 181.515 and/or federal statutes, or as deemed appropriate by the submitting law enforcement agency for the purpose of identification.

(15) "Law Enforcement Data System (LEDS)" means a program organized within the Oregon State Police, Law Enforcement Data System Division, which provides a criminal justice telecommunications and information system for the State of Oregon, and is the control point for access to similar programs operated by other states and the federal government.

(16) "Offense" means conduct for which a sentence to a term of imprisonment or to a fine is provided by any law of this State or by any law or ordinance of a political subdivision of this State. An offense is either a crime or a violation or an infraction.

(17) "OSP" means the Department of Oregon State Police and includes the Identification Services Section and the Law Enforcement Data System.

(18) "Subject Individual" means:

(a) An applicant;

(b) A person who has been offered and accepted paid employment to a position in the Department or any division of the Department; or

(c) Current employees of the Department or any division of the Department.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0020

Process for Oregon Criminal Records Check

(1) The Department and its divisions will use criminal offender information in making employment decisions regarding subject individuals.

(2) Criminal offender information will be obtained through the Oregon LEDS system. In conducting Oregon criminal records checks on subject individuals, the Department shall act in accordance with its obligations under ORS 181.010 - 181.991, OAR 257-010-0010 to 257-010-0050, and the agency LEDS and CCH agreements.

(3) Prior to conducting an Oregon criminal records check, an agency shall document that it has either:

(a) Obtained written consent from the subject individual to make a criminal offender record check through the Oregon State Police; or

(b) Provided the subject individual notice that a criminal offender record check may be made through the Oregon State Police. The notice shall include the manner in which the subject individual may be informed of the procedures adopted under ORS 181.555(3) for challenging inaccurate criminal offender information; and notice of the manner in which the individual may become informed of rights, if any, under Title VII of the Civil Rights Act of 1965, and notice that discrimination by an employer on the basis of arrest records alone may violate federal civil rights law and that the individual may obtain further information by contacting the Bureau of Labor and Industries.

(4) The Department may forward fingerprint cards to OSP for a positive identification verification where a subject individual's Oregon record indicates a conviction for a crime listed in these rules.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0030

Process for Federal Criminal Records Check

(1) The Department shall conduct a federal criminal history check on any subject individual who meets the following circumstances:

(a) The subject individual has lived outside the state of Oregon any time during the five years prior to application; or

(b) The subject individual has lived in Oregon more than five consecutive years, but the subject individual's Oregon record indicates a criminal offender history outside the state of Oregon.

(2) A federal criminal records check is subject to the following conditions:

(a) A subject individual who is an applicant and is applying for initial appointment to state service shall not be required to submit to fingerprinting until the individual is offered employment; and

(b) The federal criminal records check must be conducted for the purpose of determining whether the subject individual has been convicted of a crime that bears upon the subject individual's fitness to have responsibility for the safety and well-being of children, the elderly or individuals with disabilities.

(3) Prior to conducting a federal criminal record check, the subject individual shall provide a set of fingerprints and complete and sign a statement that:

(a) Contains the name, address and date of birth of the subject individual;

(b) The subject individual has not been convicted of a crime and, if the subject individual has been convicted of a crime, contains a description of the crime and the particulars of the conviction;

(c) Notifies the subject individual that the agency may request a background check under federal law;

(d) Notifies the subject individual of the subject individual's rights:

(A) To obtain a copy of any federal background check report; and

(B) To challenge the accuracy and completeness of any information contained in a federal background check report and obtain a prompt determination as to the validity of such challenge before a final determination is made by the authorized agency.

(e) Notifies the subject individual that prior to the completion of the federal background check the agency may choose to deny unsupervised access to a person to whom the agency provides care.

(4) Upon receipt of a federal background check report lacking disposition data, an agency shall conduct research in whatever state and local record keeping systems are available in order to obtain complete data.

(5) Any federal background check shall be handled in accordance with the requirements of Public Law 92-544.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0040

Responsibilities in Maintenance and Use of Information

(1) The Department shall assure strict compliance with federal and state laws, rules, and procedures in obtaining and handling criminal offender information.

(2) Criminal offender information obtained from the OSP and/or the FBI shall not be used for any purpose other than that for which it was obtained; nor shall it be disseminated to unauthorized persons or agencies. Any violation may cause immediate suspension of the Department's authorization to access such information.

(3) Only authorized employees shall have access to and review criminal offender information of subject individuals.

(4) All criminal offender information is confidential and shall be maintained in locked file cabinets, accessible only for purposes directly connected with the administration of these rules, until it is destroyed. This includes any summaries or facsimiles of the criminal offender information.

(5) Destruction of Information: The Department shall destroy all criminal offender information, including fingerprint cards, within 180 days from the date the criminal record was printed unless required as evidence where a subject individual has appealed the decision of an appointing authority to disqualify or terminate the subject individual from employment. Criminal offender information used in contested cases or other appeal processes shall be destroyed within 90 days following case resolution.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0050

Crimes to be Considered

(1) The Department has determined that employing persons convicted of certain crimes listed in 410-007-0050(2), where the conviction is relevant to the fitness of the subject individual to fill the position at issue, would be inconsistent with the Department's interests in protecting the safety and well-being of its clients and employees, as well as protecting the State's other resources.

(2) Specific Crimes:

(a) ORS 162.025, Bribe Receiving;

(b) ORS 162.065, Perjury;

(c) ORS 162.155, Escape II;

(d) ORS 162.165, Escape I;

(e) ORS 162.185, Supplying Contraband;

(f) ORS 162.205, Failure to Appear I;

(g) ORS 162.235, Obstructing Governmental or Judicial Administration;

(h) ORS 162.265, Bribing a Witness;

(i) ORS 162.275, Bribe Receiving By a Witness;

(j) ORS 162.285, Tampering With a Witness;

(k) ORS 162.305, Tampering With Public Records;

(l) ORS 162.325, Hindering Prosecution;

(m) ORS 163.095, Aggravated Murder;

(n) ORS 163.115, Murder;

(o) ORS 163.118, Manslaughter I;

(p) ORS 163.125, Manslaughter II;

(q) ORS 163.145, Criminally Negligent Homicide;

(r) ORS 163.160, Assault IV;

(s) ORS 163.165, Assault III;

(t) ORS 163.175, Assault II;

(u) ORS 163.185, Assault I;

(v) ORS 163.190, Menacing;

(w) ORS 163.195, Recklessly Endangering Another;

(x) ORS 163.200, Criminal Mistreatment II;

(y) ORS 163.205, Criminal Mistreatment I;

(z) ORS 163.225, Kidnaping II;

(aa) ORS 163.235, Kidnaping I;

(bb) ORS 163.275, Coercion;

(cc) ORS 163.355, Rape III;

(dd) ORS 163.365, Rape II;

(ee) ORS 163.375, Rape I;

(ff) ORS 163.385, Sodomy III;

(gg) ORS 163.395, Sodomy II;

(hh) ORS 163.405, Sodomy I;

(ii) ORS 163.408, Unlawful Sexual Penetration II;

(jj) ORS 163.411, Unlawful Sexual Penetration I;

(kk) ORS 163.415, Sexual Abuse III;

(ll) ORS 163.425, Sexual Abuse II;

(mm) ORS 163.427, Sexual Abuse I;

(nn) ORS 163.435, Contributing to the Sexual Delinquency of a Minor;

(oo) ORS 163.445, Sexual Misconduct;

(pp) ORS 163.455, Accosting for Deviate Purposes;

(qq) ORS 163.465, Public Indecency;

(rr) ORS 163.515, Bigamy;

(ss) ORS 163.525, Incest;

(tt) ORS 163.535, Abandonment of a Child;

(uu) ORS 163.545, Child Neglect II;

(vv) ORS 163.547, Child Neglect I;

(ww) ORS 163.555, Criminal Nonsupport;

(xx) ORS 163.575, Endangering the Welfare of a Minor;

(yy) ORS 163.670, Using Child in Display of Sexually Explicit Conduct;

(zz) ORS 163.673, Dealing in Depictions of Sexual Conduct Involving a Child;

(aaa) ORS 163.675, Sale of Exhibition of Visual Reproduction of Sexual Conduct by Child;

(bbb) ORS 163.680, Paying for Viewing Sexual Conduct;

(ccc) ORS 163.732, Stalking;

(ddd) ORS 164.043, Theft III;

(eee) ORS 164.045, Theft II;

(fff) ORS 164.055, Theft I;

(ggg) ORS 164.057, Aggravated Theft I;

(hhh) ORS 164.075, Theft by Extortion;

(iii) ORS 164.225, Burglary I;

(jjj) ORS 164.325, Arson I;

(kkk) ORS 164.395, Robbery III;

(lll) ORS 164.405, Robbery II;

(mmm) ORS 164.415, Robbery I;

(nnn) ORS 165.013, Forgery in the First Degree;

(ooo) ORS 165.022, Criminal Possession of a Forged Instrument in the First Degree;

(ppp) ORS 165.032, Criminal Possession of a Forgery Device;

(qqq) ORS 165.055, Fraudulent Use of Credit Card (Over $750);

(rrr) ORS 165.065, Negotiating a Bad Check (Class Felony Clause);

(sss) ORS 165.070, Possession a Fraudulent Communication Device;

(ttt) ORS 165.074, Unlawful Factoring of a Credit Card Transaction;

(uuu) ORS 165.085, Sports Bribery;

(vvv) ORS 165.090, Sports Bribe Receiving;

(www) ORS 166.015, Riot;

(xxx) ORS 166.085, Abuse of Corpse II;

(yyy) ORS 166.087, Abuse of Corpse I;

(zzz) ORS 166.155, Intimidation II;

(aaaa) ORS 166.165, Intimidation I;

(bbbb) ORS 166.220, Unlawful Use of Weapon;

(cccc) ORS 166.270, Felon in Possession of Firearm;

(dddd) ORS 166.272, Unlawful Possession of Machine Guns, Certain Short-barreled Firearms & Firearms Silencers;

(eeee) ORS 166.275, Possession of Weapons by Inmates of Institutions;

(ffff) ORS 166.370, Discharging Firearm at School/Possession of Firearm or Dangerous Weapon in Public Building;

(gggg) ORS 166.382, Possession of Destructive Device;

(hhhh) ORS 166.384, Unlawful Manufacture of Destructive Device;

(iiii) ORS 166.429, Use of Firearms in Felony;

(jjjj) ORS 166.480, Sale or Gift of Explosives to Children;

(kkkk) ORS 166.660, Unlawful Paramilitary Activity;

(llll) ORS 166.720, Racketeering;

(mmmm) ORS 167.007, Prostitution;

(nnnn) ORS 167.012, Promoting Prostitution;

(oooo) ORS 167.017, Compelling Prostitution;

(pppp) ORS 167.062, Sadomasochistic Abuse or Sexual Conduct in Live Show (engaging in);

(qqqq) ORS 167.062, Sadomasochistic Abuse or Sexual Conduct in Live Show (directing, managing, financing, or presenting);

(rrrr) ORS 167.065, Furnishing Obscene Materials to Minors;

(ssss) ORS 167.070, Sending Obscene Materials to Minors;

(tttt) ORS 167.075, Exhibiting an Obscene Performance to a Minor;

(uuuu) ORS 167.080, Displaying Obscene Materials to Minors;

(vvvv) ORS 167.087, Disseminating Obscene Material;

(wwww) ORS 167.090, Publicly Displaying Nudity or Sex for Advertising Purposes;

(xxxx) ORS 167.212, Tampering with Drug Records;

(yyyy) ORS 167.262, Adult Using Minor in Commission of Controlled Substance Offense (Less Than Five Grams Marijuana);

(zzzz) ORS 411.630, Unlawfully Obtaining of Public Assistance;

(aaaaa) ORS 411.840, Unlawfully Using Stamps or Commodities;

(bbbbb) ORS 471.410, Providing Liquor to a Person Under 21 or to Intoxicated Person; Mandatory Minimum Penalties;

(ccccc) ORS 475.992, Prohibited Acts Generally; Penalties; Affirmative Defense for Certain Peyote Uses;

(ddddd) ORS 475.993, Prohibited Acts for Registrants; Penalties;

(eeeee) ORS 475.994, Prohibited Acts Involving Records and Fraud; Penalties;

(fffff) ORS 475.995, Distribution of Controlled Substance to Minors;

(ggggg) ORS 475.996, Crime Category Classification for Violation of ORS 475.992; Proof of Commercial Drug Offense;

(hhhhh) ORS 475.999, Manufacture or Delivery of Controlled substance to Minor or Student Within 1,000 Feet of

School;

(iiiii) ORS 811.140, Reckless Driving;

(jjjjj) ORS 811.182, Criminal Driving While Suspended or Revoked or in Violation of a Permit;

(kkkkk) ORS 811.540, Fleeing or Attempting to Elude Police;

(llllll) ORS 811.700, Failure to Perform duties of Driver When Property is Damaged;

(mmmmm) ORS 811.705, Hit and Run Vehicle (Injury);

(nnnnn) ORS 813.010, Driving Under the Influence of Intoxicants;

(ooooo) Any conviction for an attempt, solicitation, or conspiracy to commit any crime listed in subsection (2) of this section.

(3) Evaluations of crimes shall be based on Oregon laws in effect at the time of conviction, regardless of the jurisdiction in which the conviction occurred.

(4) If any subject individual was convicted of a crime other than those listed in Section (2) of this rule, or the charge on one of those crimes was dismissed, all intervening circumstances and other background information related to criminal activity shall be reviewed by the agency.

(5) Under no circumstances shall a subject individual be barred from employment because of the existence or contents of a juvenile record which has been expunged pursuant to ORS 419A.260 to 419A.262.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0060

Determining Fitness for a Position

(1) Employees authorized by the Director of the Department of Human Resources shall review all criminal offender information, determine fitness for employment, and make recommendation to the Division's Appointing Authority of such determination.

(2) Subject individuals who refuse to be fingerprinted or who make false statements as to the non-conviction of a crime shall not be employed or shall be terminated from employment.

(3) Subject individuals who have been convicted of any crime(s) listed in OAR 410-007-0050(2) (or the substantial equivalent of any crimes if the conviction occurred in another jurisdiction or in Oregon under a different statutory name or number) shall, subject to Section (4) of OAR 410-007-0050, be disqualified and denied employment or terminated from employment.

(4) In determining whether a subject individual is fit for a position, the authorized employee shall consider the nature of the crime for which the subject individual was convicted and the relevancy, if any, of the crime to the position for which the subject individual has applied. A subject individual shall not be denied employment or dismissed from employment solely for the reason that the subject individual has been convicted of a crime, but the authorized employee may consider the relationship of the facts which support the conviction and all intervening circumstances to the specific

position at issue. Factors to be considered in making a fitness determination include, but are not limited to:

(a) Type and number of offenses;

(b) Passage of time since the offense was committed;

(c) Circumstances surrounding the commission of the offense which would demonstrate that repetition is unlikely;

(d) Intervening circumstances since commission of the offense; and

(e) Relationship of the facts under subsections (4)(a) through (d) of this section to the purpose and responsibilities of the position at issue.

(5) A subject individual may, at the discretion of the Appointing Authority, commence the performance of work upon satisfactory completion of the Oregon criminal record check, but prior to the return of the federal criminal record check.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0070

Notice of Disqualification

The Department shall inform subject individuals who have been determined not to be employable, via certified mail, of such disqualification. The notice will indicate that the subject individual:

(1) Has a right to inspect and challenge their Oregon criminal offender information in accordance with the OSP procedures as adopted per ORS 181.555(3) and OAR 257-010-0035;

(2) May challenge the accuracy or completeness of any entry on the subject individual's criminal records obtained from the FBI by filing a challenge with the Assistant Director of the FBI Identification Division, Washington, DC, 20537-9700; and

(3) May appeal the Department's determination of employability as a contested case hearing as set forth in OAR 410-007-0070.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

410-007-0080

Contested Case Rights for Subject Individuals

(1) Subject individuals must notify the Department of their request for a contested case hearing not later than ten calendar days from the date the subject individual received this denial notice. The Department shall conduct contested case hearings per ORS 183.413 to 183.470, and in accordance with the Oregon Attorney General's Model Rules of Procedure (OAR 137-001-0001 to 137-003-0010).

(2) The Department has no jurisdiction in a contested case hearing over allegations that the criminal offender information received from OSP or the FBI is inaccurate, incomplete, or maintained in violation of any federal or state law.

(3) The Department is entitled to rely on the criminal offender information supplied by OSP or the FBI until OSP or the FBI notifies the Department the information has been changed or corrected.

(4) Any contested case hearing under this rule is not open to the public.

(5) Prior to the contested case hearing being scheduled, a mandatory pre-hearing conference between the Department and the subject individual shall be convened to review all available information and determine the need for a contested case hearing. The subject individual may bring legal counsel or other representation. At the pre-hearing conference, the subject individual must verify whether the individual has used the right to inspect or challenge their criminal offender information record(s) or has declined to do so.

(6) The issues at a contested case hearing shall be limited to:

(a) Whether the subject individual has made a false statement as to the non-conviction of a crime; or

(b) Whether the criminal offender information provided to the agency by OSP or the FBI describes any crime which the Department has determined is relevant to employment; and

(c) Whether the agency's determination that the nature of the crime for which the subject individual was convicted is relevant to the position of employment which the subject individual is seeking or holds; and

(d) Whether the agency considered the relationship of the facts which support the conviction and all intervening circumstances to the position at issue in determining the fitness of the subject individual to hold the position.

(7) The role of the hearings officer is limited to conducting the hearing and making recommendations to the Director of the Department of Human Resources.

(8) All criminal offender information required for evidence in a contested case hearing, including fingerprint cards, shall be destroyed within 90 days following case resolution.

Stat. Auth.: ORS 181.537 & 409.015

Stats. Implemented: ORS 181.537, 181.010 - 181.560 & 409.015

Hist.: HR 9-1997, f. 3-24-97, cert. ef. 5-1-97

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 8

STANDARDS FOR MARIJUANA EVALUATION SPECIALISTS

410-008-0000

Definitions

As used in this Division, unless the context requires otherwise:

(1) "Assistant Director" means the Assistant Director, Oregon Department of Human Resources, responsible for the Office.

(2) "Client" means an individual who is a first-time violator of ORS 475.992(3)(f) and who has signed a written consent which complies with **Section 2.35** of the federal confidentiality regulations (**42 CFR Part 2**), and is either:

(a) An adult who has a Marijuana Diversion Agreement; or

(b) A juvenile who has been referred under ORS 419.507 (10).

(3) "Evaluation Specialist" means an individual who possesses a valid Letter of Approval issued under this Division.

(4) "Letter of Approval" means the letter issued to an individual by the Office which states that the person meets the standards set out in this Division.

(5) "Level I Services" means certain designated education services approved by the Office for use in a marijuana education program under OAR Division 410-009.

(6) "Level II Services" means certain designated education and treatment services approved by the Office for use in a marijuana treatment program under OAR Division 410-009.

(7) "Marijuana Diversion Agreement" means a petition for possession of marijuana agreement which has been signed and dated by a court pursuant to Chapter 1075, Oregon Laws 1989, (Enrolled House Bill 2479).

(8) "Office" means the Office of Alcohol and Drug Abuse Programs in the Director's Office of the Department of Human Resources.

[ED NOTE: The publication(s) referred to or incorporated by this rule are available from the office of the Department of Human Resources.]

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0005

Required Duties of an Evaluation Specialist

(1) Evaluation: An evaluation specialist shall promptly evaluate referred clients using, at a minimum, assessment instruments designated by the Assistant Director. Based upon the evaluation, the evaluation specialist shall determine whether Level I or Level II services are appropriate for a client and what program meets the client's needs.

(2) Referral: On the basis of the evaluation, the evaluation specialist shall promptly refer the client to a program providing the appropriate Level I services or Level II services. Whenever possible, referrals of juveniles to programs providing Level II services shall be to programs with juvenile treatment capacity. All referrals must be made on a form approved by the Office. If the service provider and the evaluation specialist disagree as to the appropriate level of treatment for a client, the service provider and the evaluation specialist shall collectively agree on an appropriate program for the client.

(3) Monitoring: The evaluation specialist shall:

(a) Directly contact each client's service provider at least once a month to verify that the client is fully participating in the service program and complying with its requirements;

(b) Communicate promptly with appropriate judicial or other justice system staff concerning the client's compliance with service program requirements; and

(c) Where a client is in a Level I services program, confer with the service provider between the third and sixth week of service to determine if the client should be placed in a Level II services program, and take appropriate actions, if necessary.

(4) Records: The evaluation specialist shall maintain a file on each individual which includes:

(a) Evaluation results and evaluation instruments used in the evaluation;

(b) Evidence of indigency, if appropriate, consisting of a document signed and dated by the Adult and Family Services Division indicating eligibility for the federal food stamp program;

(c) A record of the fee payments made and balance owed on the client's account;

(d) Documentation showing compliance with all provisions of this Division;

(e) Copies of reports on the client made to the Office; and

(f) A copy of the written consent signed by the client for compliance with **Section 2.35** of **42 CFR Part 2**;

(g) Other relevant information as required by the Office.

(5) Record Retention: The evaluation specialist shall retain all records regarding each client for a period of seven years following the date of completion or discontinuance of treatment or services.

(6) Reports: The evaluation specialist shall send complete reports to the Office on forms and by dates prescribed by the

Office.

(7) Confidentiality: The evaluation specialist shall comply with all federal and state confidentiality laws, including those contained in **42 CFR Part 2**.

(8) Continuing Education: The evaluation specialist shall fulfill all continuing education requirements prescribed by the Office.

(9) Cooperation: The evaluation specialist shall assist the Office by:

(a) Providing all information requested by the Office at the time and place and in the form designated by the Office;

(b) Assisting in the conduct of all reviews of the evaluation specialist's job performance and compliance with this Division;

(c) Promptly undertaking and completing all corrective actions required in writing by the Office.

(10) Sobriety: During all working hours, an evaluation specialist shall not be under the influence of nor use or have present in any amounts in his or her body any alcohol or controlled substance, unless pursuant to a current prescription from a licensed physician.

[ED NOTE: The publication(s) referred to or incorporated by this rule are available from the office of the Department of Human Resources.]

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0010

Reimbursement for Service to Indigent Clients

(1) A marijuana evaluation specialist is eligible to seek reimbursement in the manner required by the Office for services provided to an indigent client under this Division if the following is in the client's record:

(a) Documentation, dated and signed by the Adult and Family Services Division, verifying the client's eligibility for the federal food stamp program over the period included in the reimburse-ment request; and

(b) Documentation that the crime or violation committed by the client leading to the need for the evaluation for which reimbursement is sought was possession of less than an ounce of marijuana.

(2) Reimbursement for evaluation under this rule is subject to the availability of funds for that purpose under Chapter 1075, Oregon Laws 1989, (Enrolled House Bill 2479), and to the maximum rate for evaluation approved by the Ways and Means Committee and/or Emergency Board of the Oregon Legislative Assembly for this purpose.

(3) The marijuana evaluation specialist will promptly and fully return any payments made when an Office audit reveals that the program was ineligible to seek reimbursement for service to a client.

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0015

Applications and Requirements

Any applicant requesting a Letter of Approval as an Evaluation Specialist must submit an application form which demonstrates compli-ance with the following:

(1) Education or Experience:

(a) Graduation from an accredited four-year college or university with a Bachelors degree in social sciences, psychology, sociology, substance abuse, or related field with course work specific to alcohol or other drug education, treatment, or counseling; or

(b) Two years of full-time supervised experience in alcohol or other drug treatment, evaluation, education, or counseling; or

(c) Two years of training in alcohol or drug treatment, evaluation, education, or counseling.

(2) Reference Letters: Three acceptable letters of reference from persons in the human services field with personal knowledge of the applicant who attest to the applicant's character, work habits, and qualifications. An applicant proposing to serve adolescents under this Division must submit, as one of the three letters, a letter of recommendation from a youth serving agency.

(3) Court Designation: A written statement from a court which designates the applicant to perform marijuana evaluations for the court.

(4) Sobriety Requirement: A statement that the applicant is not suffering from acute alcoholism or drug dependency.

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0020

Approval for Training; Training

(1) The Office shall review applications for compliance with applicable requirements and notify the applicant within 60 days of the date the application is received as to whether the applicant has been approved for training.

(2) An applicant who is approved for training may receive training by the Office on the following subjects:

(a) Evaluation techniques for use with adult and adolescent offenders;

(b) Methods for determining appropriate education and treatment service levels;

(c) Referral procedures and reports;

(d) Client supervision and monitoring;

(e) Data reporting and program evaluation;

(f) Confidentiality laws;

(g) The criminal justice and juvenile court systems;

(h) Urinalysis monitoring; and

(i) Other information as appropriate.

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0025

Letters of Approval; Renewal

(1) After approval of an applicant for training and successful completion of a training program outlined in OAR 410-008-0020, the Office may issue a Letter of Approval which is valid for six months from the date of issuance.

(2) During the six-month period, the Office will review the evaluation specialist's job performance and compliance with this Division. If the job performance and compliance with this Division are satisfactory, the Office may extend the validity of the Letter of Approval for an additional period, not to exceed 18 months.

(3) Prior to expiration of a Letter of Approval, an evaluation specialist may request renewal of any Letter of Approval which has been extended pursuant to section (2) of this rule or previously renewed. Unless revoked, suspended, or denied under OAR 410-008-0030, the Office may renew a Letter of Approval for a two-year period.

Stat. Auth.: ORS 184. 759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0030

Revocation; Suspension, or Denial of Letter of Approval; Appeal

(1) The Office shall deny, suspend, revoke, or refuse to renew a Letter of Approval where it finds that:

(a) There has been substantial failure to comply with part or all of any rules in this Division or there has been a substantial noncompliance with relevant federal or state law;

(b) The applicant, within the previous three years, has been convicted of:

(A) Any crime or violation under ORS Chapter 475, including but not limited to the Uniform Controlled Substances Act, or under ORS 813.010, driving under the influence of intoxicants;

(B) A substantially similar crime or violation in any other state; or

(C) Any felony.

(c) The applicant has entered into within the past three years, a diversion agreement under ORS 813.230 or section 7 of 1989 Oregon Laws Chapter 1075, or a diversion agreement under a substan-tially similar law in any other state;

(d) Subsequent to the time of issuance of any letter of Approval, and regardless of the current validity of that letter, the person who was issued the letter is convicted of any of the crimes or violations referred to in subsection (1)(b) or (c) of this rule.

(2) The Office may deny, suspend, revoke or refuse to renew a Letter of Approval where it finds that an applicant or holder of a Letter of Approval:

(a) Submits fraudulent or untrue information to the Office;

(b) Has a prior denial, suspension, revocation, or refusal to renew a Letter of Approval;

(c) Has jeopardized or injured the health, safety, or welfare of any client; or

(d) Has at any time been convicted of any of the crimes or violations referred to in subsection (1)(b) or (c) of this rule.

(3) When a Letter of Approval is denied, suspended, or revoked, or the Office refuses to renew it, notice of that action shall be sent by certified mail, and shall include a statement that a contested case hearing to challenge the action may

be requested, but that such request must be made within 15 days of the date of mailing of the letter.

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

410-008-0035

Variances

(1) The Assistant Director may grant variances to rules in this Division for a period of time, not to exceed two years.

(2) An individual requesting a variance shall submit, in writing, through the Community Mental Health Program to the Assistant Director, a request containing:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the Community Mental Health Program indicating its review and comment on the proposed variance.

(3) Variances may be granted only in cases where selected sections or subsections of the rules in this Division can be met only by a waiver of such provisions, or in cases where such variances can be reasonably expected to improve services to clients. Variance shall not be granted when such variance would be in violation of any existing state or federal law or could be detrimental to the health, safety, or welfare of clients.

(4) The Office shall notify the individual requesting the variance and the Community Mental Health Program of the decision.

(5) Appeal of the denial of the variance request shall be to the Assistant Director, whose decision shall be final.

(6) A variance granted by the Office shall be attached to, and become part of, the Letter of Approval for as long as the letter is valid.

Stat. Auth.: ORS 184.759

Hist.: HR 2-1989(Temp), f. & cert. ef. 10-16-89; HR 11-1990, f. & cert. ef. 4-13-90

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 9

MARIJUANA EDUCATION AND TREATMENT PROGRAMS

410-009-0000

Definitions

As used in this Division 410-009, unless the context requires otherwise:

(1) "Assistant Director" means the Assistant Director, Oregon Department of Human Resources, responsible for the Office.

(2) "Certificate of Completion" means a letter or certificate issued to a client by a Level I or Level II marijuana education or treatment program when the client successfully completes the program.

(3) "Client" means an individual who is a first time violator of ORS 475.992(3)(f), and who has signed a written consent which complies with **Section 2.35** of the federal confidentiality regulations (**42 CFR Part 2**), and is either:

(a) An adult who has a Marijuana Diversion Agreement; or

(b) A juvenile who has been referred under ORS 419.507 (10).

(4) "Evaluation Specialist" means an individual who possesses a valid Letter of Approval issued under this Division.

(5) "Letter of Approval" means the letter issued to a Level I or Level II marijuana education or treatment program by the Office which states that the program meets the standards and is authorized to provide the services and perform the duties set out in this Division.

(6) "Level I Marijuana Education Program" means a program which possesses a valid Letter of Approval to provide designated education services to clients.

(7) "Level II Marijuana Treatment Program" means a program which possess a valid Letter of Approval to provide designated education and treatment services to clients.

(8) "Office" means The Office of Alcohol and Drug Abuse Programs in the Director's Office of the Department of

Human Resources.

(9) "Successful Completion" means that a Level I or Level II marijuana education or treatment program has documentation in its records verifying that for the period of service deemed necessary by the program, the client has:

(a) Participated appropriately;

(b) Produced no evidence of the consumption of alcohol or controlled substances, other than those prescribed by a licensed physician, during the last half of the service period;

(c) Produced no evidence of the commission of any illegal act;

(d) Passed tests reflecting satisfactory knowledge gained;

(e) Progressed satisfactorily towards clinical goals (if appropriate); and

(f) Paid all service fees (unless indigent).

(10) "Urinalysis Test" means an initial test and, if positive, a confirmatory test. An initial test shall, at a minimum, include a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration. A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a difference analytical method from that of the initial test to ensure reliability and accuracy. All urinalysis tests shall be performed by laboratories licensed under OAR 333-024-0305 to 333-024-0350; further, all tests must include at least amphetamines, cocaine, and marijuana.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0005

Requirements for Level I and Level II Marijuana Education and Treatment Programs

(1) Instructional Materials: The program shall provide any needed printed materials to each client in order to facilitate the required curricula. To the degree practicable, these materials shall be in the client's native language.

(2) Class Schedules: The program shall maintain a schedule of classes/meetings that are held regularly and at times reasonably accessible by clients. A copy of the schedule must be sent to the Office, the local evaluation specialists, the local Community Mental Health Program, and any other requesting agencies or persons.

(3) Resolving Level of Treatment Disputes: When the program and the evaluation specialist disagree as to the appropriate level of treatment for a client, the program and the evaluation specialist shall collectively agree on an appropriate program for the client.

(4) Program or Staff Changes: All program or staff changes must be reported in writing to the Office within 30 days of the changes and are subject to approval by the Office.

(5) Attendance: The program shall keep current records of attendance for each class and meeting. Absences and any substantial tardiness shall be promptly recorded in each client's file. Class and meeting attendance records shall be retained for seven years.

(6) Reporting: The program will report to the Office on forms and by dates prescribed by the Office. The program will

promptly report to the appropriate evaluation specialist all instances where a client has violated any of the conditions stated in OAR 410-009-0000(9)(a) through (f) of this Division.

(7) Confidentiality: The program shall comply with all federal and state confidentiality laws, including those contained in **42 CFR Part 2**.

(8) Certifying Completion: The program shall issue a Certificate of Completion to a client when all conditions for successful completion has been fulfilled.

(9) Records: The program shall maintain a file on each client which includes:

(a) Dates of referral, admission, completion/ termination, and information of any subsequent referral;

(b) Evidence of indigency, if appropriate, consisting of a document signed and dated by the Adult and Family Services Division indicating eligibility for the federal food stamp program;

(c) Status of fee payments, urinalysis results, and all information necessary to determine whether the diversion program is being or has been successfully completed;

(d) Attendance records for all classes and meetings which show all absences and incidents of substantial tardiness;

(e) Pre-test and post-test results for the program of educational services;

(f) Documentation of compliance with reporting and confidentiality requirements including a copy of the written consent signed by the client for compliance with **Section 2.35** of **42 CFR Part 2**;

(g) Other information required by adminis-trative rules for Level II marijuana treatment programs;

(h) Other information as required by the Office.

(10) Client Record Retention: The program shall retain all records regarding each client for a period of seven years following the date of completion or termination of treatment or services.

(11) Financial and Other Records: The program shall maintain financial records and other records pertinent to operation of the program. All financial records shall be maintained pursuant to generally accepted accounting principles. Other pertinent records shall be maintained to the extent necessary to clearly and accurately reflect actions taken. The program shall freely provide access upon demand to any books, documents, papers, and records of the program which are pertinent to this program for purposes of audit or examination, and allow the making of excerpts and photocopies. All such records shall be retained and kept accessible for three years following final payment and conclusion of all pending matters. In addition, records involving matters in litigation shall be kept no less than one year after resolution of such litigation.

(12) Continuing Education: The program staff shall comply with education requirements prescribed by the Office.

(13) Cooperation: The program shall assist the Office by:

(a) Providing all information requested by the Office at the time and place and in the form designated by the Office;

(b) Assisting in the conduct of all audits and reviews of the program; and

(c) Promptly undertaking and completing all corrective actions required in writing by the Office.

(14) Sobriety: While on the job during working hours, no staff person employed by the program shall be under the influence of or have present in any amounts in his or her body any alcohol or controlled substance, unless pursuant to a current prescription from a licensed physician.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0010

Additional Requirements for Level I Marijuana Education Programs

(1) Staff Qualifications: Instructors shall have a minimum of one year of education, experience, and/or training in one or more of the following: social science, psychology, counseling, alcohol or drug rehabilitation, education, traffic safety, or other related field.

(2) Program Content: A Level I program shall include a minimum of eight sessions over an eight-week period and provide 12 to 20 hours of education which includes:

(a) Pre-tests and post-tests approved by the Office;

(b) The model curriculum provided by the Office, or an alternative curriculum approved by the Office which covers the same subject areas as the model curriculum; and

(c) Urinalysis Testing: A minimum of four urinalysis samples shall be observed and collected during the course of a client's Level I program. The samples shall be tested for at least amphetamines, cocaine, and marijuana using the process set out in the definition of "urinalysis testing" in OAR 410-009-0000(10). At least one of the four samples is to be collected and tested in the first two weeks of the program and at least one is to be collected and tested in the last two weeks of the program.

(3) Client Evaluation: The Level I program shall establish and follow a procedure to assure communication with an evaluation specialist about whether a client should be referred to a treatment program.

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0015

Additional Requirements for Level II Marijuana Treatment Programs

(1) Other Applicable Rules:

(a) A Level II program must also be approved by the Office as meeting the requirements for outpatient drug abuse treatment programs, OAR 309-053-0050 through 309-053-0120;

(b) If a level II program that is not approved by the Office as a provider of adolescent treatment services admits an adolescent, then the program must serve that client in accordance with the adolescent treatment requirements of the Office.

(2) Evaluation:

(a) The Level II program shall establish and follow a procedure for further evaluations of each client referred by an evaluation specialist. The purpose of further evaluation is to carry out treatment planning and to make referrals to other treatment programs as necessary. The procedure shall include documentation of such evaluations;

(b) When further evaluation indicates that a client would benefit from residential treatment and the marijuana evaluation specialist agrees to such a referral, then the Level II program may refer the client, but must retain the responsibilities of monitoring the client's clinical progress during the period of referral and, subsequently, determining whether to issue a certificate of completion or require further treatment on an outpatient basis. In no case, however, may the period of residential and outpatient service total to less than four months.

(3) Program Content: The Level II program must serve the client on a direct face-to-face basis for a minimum total of 24 hours over a four-month period. Services must be therapeutically oriented and include the educational services required in OAR 410-009-0010 for Level I marijuana education programs. A Level II program may extend the length of a client's service period if the program determines that the client needs services beyond the minimum number of hours.

(4) Urinalysis Testing: A minimum of eight urinalysis samples shall be observed and collected during the period of service deemed necessary by a client's Level II program. The samples shall be tested for at least amphetamines, cocaine, and marijuana using the process set out in the definition of "urinalysis testing" in OAR 410-009-0000(10). At least one of the eight samples is to be collected and tested in the first two weeks of the program and at least one is to be collected and tested in the last two weeks of the program.

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0020

Reimbursement for Services to Indigent Clients

(1) A marijuana education or treatment program is eligible to seek reimbursement in the manner required by the Office for services provided to an indigent client under this Division if the following is in the client's record:

(a) Documentation, dated and signed by the Adult and Family Services Division, verifying the client's eligibility for the federal food stamp program over the entire period included in the reimbursement request; and

(b) Documentation that the crime or violation committed by the client leading to the need for the services for which reimbursement is sought was possession of less than an ounce of marijuana.

(2) Reimbursement for services under this rule is subject to the availability of funds for that purpose under Chapter 1075, Oregon Laws 1989, and to the maximum number of units of service and/or maximum rate per unit of service approved by the Ways and Means Committee and/or Emergency Board of the Oregon Legislative Assembly for this purpose.

(3) The education or treatment program will promptly and fully return any payments made when an Office audit reveals that the program was ineligible to seek reimbursement for service to a client.

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0025

Applications

The application of any organization or individual seeking a Letter of Approval as a Level I or II marijuana education or treatment program must be reviewed and commented on by the Community Mental Heath Program Director and the

Local Alcohol and Drug Planning Committee and must contain the following items:

(1) Description of the applicant organization or program.

(2) Fee schedule.

(3) Description of procedures for reporting to the evaluation specialist, court, and other agencies.

(4) Assurances of and methods for compliance with all federal and state confidentiality laws, including those contained in **42 CFR Part 2**.

(5) Verification of review by the Community Mental Health Program and the Local Alcohol and Drug Planning Committee.

(6) List of staff and their qualifications.

(7) Description of the urinalysis testing procedures to be used to meet the requirements of this Division.

(8) Description of the methods, materials, and procedures to be used to meet the Levels I and II marijuana education or treatment program requirements.

(9) Three acceptable letters of reference from persons in the human services field with personal knowledge of the applicant which comment on the applicant in general and where possible, attest to the character and performance of the applicant's program and staff. An applicant proposing to serve adolescents under these rules must submit, as one of the three letters, a letter of recommendation from a youth serving agency.

(10) A written statement from a court which states that the applicant has been designated to do the program services for which a Letter of Approval is sought.

(11) A statement that neither the applicant nor any of the staff employed by or working for the applicant are suffering from acute alcoholism or other drug dependency.

(12) Other relevant information as required by the Office.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0030

Approval; Letter of Approval; Renewal

(1) The Office shall review applications for compliance with applicable requirements and make appropriate notification to the applicant within 60 days of the date the application is received.

(2) If an application is approved, the Office may issue a Letter of Approval which is valid for six months from the date of issuance.

(3) During the six-month period, the Office will review the marijuana education or treatment program's performance and compliance with this Division. If the performance and compliance with this Division are satisfactory, the Office may extend the validity of the Letter of Approval for an additional period, not to exceed 18 months.

(4) Prior to the expiration of a Letter of Approval, a marijuana education or treatment program may request renewal of

any Letter of Approval which has been extended pursuant to section (3) of this rule or previously renewed. Unless revoked, suspended, or denied under OAR 410-009-0035, the Office may renew a Letter of Approval for a two-year period.

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0035

Revocation; Suspension or Denial of Letter of Approval; Appeal

(1) The Office shall deny, suspend, revoke, or refuse to renew a Letter of Approval where is finds that there has been a substantial failure to comply with part of all of any rules in this Division or there has been a substantial non-compliance with relevant federal or state law.

(2) The Office may deny, suspend, revoke, or refuse to renew a Letter of Approval where it finds that:

(a) Any of the program's staff, within the previous three years, has been convicted of:

(A) Any crime or violation under ORS Chapter 475, including but not limited to the Uniform Controlled Substances Act, or under ORS 813.010, driving under the influence of intoxicants;

(B) A substantially similar crime or violation in any other state; or

(C) Any felony.

(b) Any of the program's staff has entered into, within the past three years, a diversion agreement under ORS 813.230 or Section 7 of Chapter 1075, Oregon Laws 1989, or a diversion agreement under a substantially similar law in any other state;

(c) Submits fraudulent or untrue information to the Office;

(d) Has a prior denial, suspension, revocation or refusal to renew a Letter of Approval; or

(e) Has jeopardized or injured the health, safety, or welfare of any client.

(3) When a Letter of Approval is denied, suspended, or revoked, or the Office refuses to renew it, notice of that action shall be sent by certified mail, and shall include a statement that a contested case hearing to challenge the action may be requested, but that such request must be made within 15 days of the date of mailing of the letter.

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

410-009-0040

Variances

(1) The Assistant Director may grant variances to rules in this Division for a period of time, not to exceed two years.

(2) The marijuana education or treatment program requesting a variance shall submit, in writing, through the Community Mental Health Program to the Assistant Director, a request containing:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the Community Mental Health Program indicating its review and comment on the proposed variance.

(3) Variances may be granted only in cases where selected sections or subsections of the rules in this Division can be met only by a waiver of such provisions, or in cases where such variances can be reasonably expected to improve services to clients. Variance shall not be granted when such variance would be in violation of any existing state or federal law or could be detrimental to the health, safety, or welfare of clients.

(4) The Office shall notify the individual requesting the variance and the Community Mental Health Program of the decision.

(5) Appeal of the denial of the variance request shall be to the Assistant Director, whose decision shall be final.

(6) A variance granted by the Office shall be attached to, and become part of, the Letter of Approval for as long as the letter is valid.

Stat. Auth.: ORS 184.759

Hist.: HR 3-1989(Temp), f. & cert. ef. 10-16-89; HR 12-1990, f. & cert. ef. 4-13-90

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 10

STANDARDS FOR RESIDENTIAL PROGRAMS

410-010-0000

Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards for the development and operation of residential programs for persons with alcohol and drug abuse problems.

(2) Statutory Authority. These rules are authorized by ORS Chapter 183 and 430.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0010

Definitions

(1) "Administrator" means the person responsible for the daily operation and maintenance of the residential program.

(2) "Alcoholic" means any person who has lost the ability to control the use of alcoholic beverages, or uses alcoholic beverages to the extent that the health of the person or that of others is substantially impaired or endangered or the social or economic functioning of the person is substantially disrupted. An alcoholic may be physically dependent, a condition in which the body requires a continuing supply of alcohol to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of alcoholic beverages (ORS 430.306(2)). An alcoholic suffers from the disease of alcoholism.

(3) "Applicant" means the person or entity applying for program approval who is also the owner.

(4) "Children" mean unmarried persons who are at least 12 years old but have not reached their 18th birthday and who have not been emancipated by the Juvenile Court.

(5) "Department" means the Department of Human Resources or its designee.

(6) "Director" means the Director of the Department of Human Resources or his or her designee.

(7) "Drug Abuse" means repetitive, excessive use of a drug or controlled substance short of dependence, without medical supervision, which may have a detrimental effect on the individual or on society.

(8) "Drug-Dependent Person" means a person who has lost the ability to control the use of controlled substances or other substances with abuse potential, or uses such substances or controlled substances to the extent that the health of the person or that of others is substantially impaired or endangered or the social or economic functioning of the person is substantially disrupted. A drug-dependent person may be physically dependent, a condition in which the body requires a continuing supply of a drug or controlled substance to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of a drug or controlled substance.

(9) "Local Alcoholism Planning Committee" means a committee appointed or designated by a board of county commissioners. The committee shall identify needs and establish priorities for alcoholism services in the county. Members of the committee shall be representative of the geographic area and include a number of minority members reasonably reflecting the proportion of the need for alcoholism treatment and rehabilitation services of minorities in the community.

(10) "Major Alteration" means the total cost of modifications to an existing building which exceeds 25 percent of its replacement value within any 12-month period.

(11) "Owner" means the person(s) or entity legally responsible for the operation of the program.

(12) "Physician" means a physician licensed by the Oregon Board of Medical Examiners.

(13) "Problem Drinker" means a person who habitually or periodically uses alcoholic beverages to the extent that the person's health or that of others is substantially impaired or endangered or the person's social or economic functioning is substantially disrupted.

(14) "Resident" means an individual residing in a residential program for purposes of receiving care and/or treatment. A resident shall not be an individual in need of detoxification or ongoing nursing care or medical supervision or who displays a psychiatric disturbance of a severity that would preclude the individual from appropriately participating in, and gaining from, the treatment process.

(15) "Residential Program" means:

(a) Community Intensive Residential Treatment (CIRT) program: Publicly- or privately-operated programs that provide 24-hour supervision, care, and intensive treatment for persons with either a primary problem of alcohol abuse or alcoholism or a primary problem of drug abuse or addiction.

(b) Alcoholism Residential Treatment and Drug Residential Treatment programs: Publicly- or privately-operated programs that provide 24-hour supervision, care and treatment for persons with either a primary problem of alcohol abuse or alcoholism, or a primary problem of drug abuse or addiction.

(c) Drug Free Residential Transition programs: Publicly- or privately-operated programs that provide 24-hour supervision, room and board, and a planned, supervised rehabilitation program in an environment free of alcohol and illicit drugs for person with either a primary problem of alcohol abuse or alcoholism, or a primary problem of drug abuse or addiction.

(16) "Substantial Compliance" means the condition where a residential program does not meet all requirements established by administrative rule and/or statute, but the violations do not pose a threat to the health, safety, or welfare of the public or clients, and will be brought into compliance within a specific time period established by the Department.

(17) "Treatment Staff" means paid staff directly responsible for resident care and treatment.

(18) "Treatment" means the specific, non-medical therapeutic techniques employed to assist the resident to overcome alcoholism or drug dependence as described in these rules.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0020

Program Approval

(1) Letter of Approval: No person or governmental unit acting individually or jointly with any person or governmental unit shall, with public funds, establish, maintain, conduct, manage or operate residential programs for persons with alcohol and drug abuse problems without a letter of approval from the Department of Human Resources.

(2) Qualifications for Program Approval: In order to receive a letter of approval from the Department under the process set forth in OAR 309-012-0010, a residential program shall meet the standards set forth in these rules (OAR 410-010-0000 to 410-010-0170). The rules and requirements of other state agencies may apply to particular kinds of residents or methods of operation. Residential programs are responsible for identifying and complying with such other applicable rules and requirements.

(3) Effective Date: A letter of approval is effective for two years from the date issued and may be renewed, revoked, or suspended in accordance with OAR 309-012-0010.

(4) Site Reviews: The Director or his/her designee shall site visit every residential program at least once every two years to determine whether it is being operated in accordance with these rules.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0030

Administrative Requirements

(1) Administrative Rules: A residential program shall comply with:

(a) OAR 309-013-0030, Audit Guidelines;

(b) OAR 309-013-0075 to 309-013-0105, Fraud and Embezzlement; and

(c) OAR 309-014-0000 to 309-014-0040, General Administrative Standards for Mental Health Division Community Mental Health Contractors;

(d) All federal and state laws and rules applicable to the management and storage of resident records and the confidentiality of client information.

(2) Residential Abuse Policy: A residential program shall have a policy and procedure prohibiting resident abuse that is consistent with OAR 309-116-0000 to 309-116-0025, Abuse of Patients and Residents in State Institutions.

(3) Personnel Policies: A residential program shall have personnel policies that include sections on:

(a) The program's philosophical approach to treatment;

(b) Rules of employee conduct including ethical standards;

(c) Standards for employee use and abuse of alcohol and other drugs; and

(d) Methods for determining whether all personnel are free of communicable and infectious diseases where required by administrative rules of the Health Division.

(4) Personnel Regulations: A residential program shall comply with all federal and state employment discrimination and wage and hour laws as applicable.

(5) Personnel Records: Personnel records for each member of the residential program's staff shall be kept and shall include:

(a) Employee's resume and/or employment application, wage and salary information, and the employee's formal performance appraisals;

(b) Documentation verifying that the employee meets the qualifications for his or her position as set forth in these rules.

(c) Documentation of training/development needs of the employee and identification of specific methods for meeting those needs;

(d) Documentation of any formal corrective actions taken due to employee performance problems; and

(e) Documentation of any actions of commendation taken for the employee.

(6) Confidentiality: Personnel records shall be maintained and utilized in such a way as to ensure employee confidentiality.

(7) Retention Period: Personnel records shall be retained for a period of three years following the departure of the employee.

(8) Performance Appraisals: Performance appraisal procedures shall be implemented that:

(a) Base performance on pre-established performance criteria in terms of specific responsibilities of the position as stated in the job description; and

(b) Require appraisals at least annually;

(9) Performance Problems: A policy and procedure shall be implemented which specifies how employee performance problems are to be handled.

(10) Training: A program-wide employee development plan will be developed and implemented to address continuing training for staff members. The plan will provide orientation for new employees, on-the-job training, in-service education, and opportunities for continuing job-related education.

(11) Advisory Board: The residential program shall be advised by a board which includes representatives from the primary catchment area who have an interest or experience in developing programs for treatment of alcohol and drug abuse problems and are representative of minority members in proportion to the minorities residing in the catchment area. When some or all of the residential program's service capacity is approved for delivery to a specialty group only, such as women, youth, etc., the Board membership shall contain some representatives of that specialty group who are knowledgeable about the group's special treatment needs. The Board shall:

(a) Identify needs and establish priorities for program services coordinating its activities with other community alcohol and drug abuse treatment providers and with county governmental agencies responsible for contracting and monitoring alcohol and drug abuse treatment services;

(b) Meet at least quarterly; and

(c) Record minutes of the meetings to be retained by the residential program and be available for inspection.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0040

Resident's Rights

(1) Civil and Human Rights: Each resident shall be assured the same civil and human rights accorded to other citizens. The program shall provide residents the following rights and protection in addition to those described in OAR 309-014-0035. (Paragraph (1)(a)(F) of this rule does not apply when a person has been involuntarily committed to treatment by appropriate court order.):

(a) Informed Consent: Residents shall give written informed consent to treatment with the exception that resident children may only be admitted with the prior signed consent of the parent, guardian, or other legally authorized person;

(b) Resident Work Policy: The residential program shall establish and implement policies on resident work. Work done as part of the resident's treatment plan or standard program expectations shall be agreed to, in writing, by the resident.

(c) Resident Rights Policy: The residential program shall develop, implement, and inform residents of policies and procedures which protect residents' rights, including:

(A) Adequate food, housing, personal services, and treatment or care;

(B) Visits to and from family members, friends, advocates, and legal and medical professionals consistent with treatment plans and reasonable written program rules;

(C) Confidential communications;

(D) Personal property consistent with reasonable written rules;

(E) Privacy consistent with program resources;

(F) Freedom from involuntary treatment;

(G) Religious practices as personally preferred consistent with treatment plans and reasonable written rules;

(H) Voting; and

(I) Access to community resources, including recreation activities, social services agencies, employment and vocational services, and self-help groups consistent with the resident's treatment plan and reasonable written rules.

(2) Nondiscrimination:

(a) The residential program shall have a written statement of nondiscriminatory practice in outreach, admissions, and treatment and care. The written statement shall address nondiscrimination on the basis of:

(A) Race;

(B) Religion;

(C) Sex;

(D) Ethnicity;

(E) Age;

(F) Handicap; and

(G) Sexual preference.

(b) When some or all of a residential program's treatment capacity has been approved by the Department for services to particular groups only (e.g., women, adolescents, etc.), then the program may limit admissions accordingly.

(3) Behavior Problems Policy: The residential program shall develop, implement, and inform residents of policy and procedure regarding the management of behavior problems which:

(a) Prohibits physical punishment;

(b) Prohibits seclusion in a locked room;

(c) Prohibits the withholding of shelter, regular meals, clothing, or aids to physical functioning; and

(d) Prohibits the disciplining of one resident by another.

(4) Grievance Policy: The residential program shall develop, implement, and inform residents of policy and procedure regarding grievances, which provides for:

(a) Receipt of written grievances from residents or persons acting on their behalf;

(b) Investigation of the facts supporting or disproving the written grievance;

(c) The taking of a necessary action on substantiated grievances within 72 hours; and

(d) Documentation in the resident's record of the receipt, investigation, and action taken regarding the written grievance.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0050

Admission Policies and Procedures

(1) Admission Criteria: A residential program shall have written criteria for admission that also prohibit admission of individuals who need:

(a) Detoxification; or

(b) Ongoing nursing care or medical supervision; or

(c) Who display a psychiatric disturbance of a severity that would preclude them from appropriate participation in the

program.

(2) Written Intake Procedure: The residential program shall have written intake procedure to include:

(a) Determination that the residential program's services are appropriate to the needs of the resident;

(b) Procedure for referrals of individuals not admitted to the residential program;

(c) Procedure for accepting referrals from outside agencies; and

(d) A specific time limit which the initial assessment and evaluation must be completed, not to exceed five days from date of admission.

(3) Orientation Information: A residential program shall make available program orientation information to include:

(a) Residential program's philosophical approach to treatment;

(b) Resident rights and responsibilities while receiving services;

(c) Written description of the residential program's services; and

(d) Rules governing resident behavior and those infractions, if any, that may result in discharge or other disciplinary actions.

(4) Resident Record: The following information shall be recorded in each resident's record at the time of admission or as soon thereafter as possible:

(a) Resident's name, address, and telephone number;

(b) Name of individual completing intake;

(c) Information required by the Department's data system; and

(d) Emergency contact.

(5) Assessment and Evaluation: A residential program shall develop and implement a written procedure for assessing and evaluating each resident's treatment needs within five days of admission. The assessment shall be the responsibility of a member of the treatment staff and shall include:

(a) Alcohol/drug use and problems history;

(b) Family or interpersonal history;

(c) Educational/employment/vocational history;

(d) Medical history consistent with OAR 410-010-0060;

(e) Legal history;

(f) Psychological history;

(g) Presenting problem(s);

(h) History of previous treatment; and

(i) Diagnostic impression and treatment recommendation.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0060

Medical and Health Services

(1) Emergency Medical Service: A residential program shall have a written agreement with a physician who is licensed by the Oregon Board of Medical Examiners to ensure the provision of emergency medical services to residents.

(2) Policies: A residential program shall have a physician, licensed by the Oregon Board of Medical Examiners, review and approve in writing its written policies and procedures for the level of medical services provided including, but not limited to:

(a) The collection of medical histories;

(b) Designation of those medical symptoms identified in the medical history which, when found, require further attention including physical examination and laboratory testing;

(c) Management of prescribed medications;

(d) Management of persons with medical emergencies; and

(e) Management of person with infectious diseases.

(3) Medical Histories: A medical history shall be gained from the resident within 72 hours of admission. For purposes of screening and referral, when appropriate, the medical history at a minimum shall review the following areas:

(a) Infectious diseases;

(b) Alcohol and other drug withdrawal;

(c) Abnormal liver and/or kidney functioning;

(d) Heart or lung dysfunction;

(e) Skin infections;

(f) Psychotic symptoms;

(g) Diabetes; and

(h) Tuberculosis.

(4) Required Examinations and Tests: Medical policies and procedures shall require a physical examination and laboratory testing for individuals admitted to the program who:

(a) Are currently using a drug intravenously or have done so within the previous five years (self-reports are acceptable); or

(b) Are pregnant.

(5) Waiver of Examination or Testing: If a physical examination and laboratory testing have been recently performed

and are acceptable to a physician, the requirement for the examination and testing may be waived. Notation of this decision shall be made in the resident's treatment record.

(6) Administration of Medications: The following guidelines must be followed in policies on administration of medications:

(a) A written order signed by a physician, or a program medical policy approved in writing by a licensed physician, is required before any medication can be administered to, or self-administered by, any resident;

(b) Medications prescribed for one resident shall not be administered to, or self-administered by, another resident or employee; and

(c) In the cases where a resident self-administers medication, self-administration shall be approved in writing by a physician, and closely monitored by the residential program staff.

(7) Drug Stocks: A stock supply of prescription drugs may not be maintained in the residential program. The residential program may maintain a stock supply of nonprescription drugs.

(8) Unused or Outdated Drugs: No unused, outdated, or recalled drugs shall be kept in the residential program. On a monthly basis, any unused, outdated, or recalled drugs shall be disposed of in a manner that assures they cannot be retrieved, except that drugs under the control of the Food and Drug Administration shall be mailed with the appropriate forms by express, prepaid, or registered mail to the Oregon Board of Pharmacy, 1400 S.W. Fifth Avenue, Portland, OR 97201.

(9) Documentation of Drug Disposal: A written record of all disposals of drugs shall be maintained in the residential program and shall include:

(a) A description of the drug, including the amount;

(b) The resident for whom the medication was prescribed;

(c) The reason for disposal; and

(d) The method of disposal.

(10) Storage of Prescription Drugs: All prescription drugs stored in the residential program shall be kept in a locked stationary container. Those medications requiring refrigeration shall be stored in a refrigerator using a locked container which need not be stationary.

(11) Individual Prescription Drug Records: Individual records shall be kept for each resident for any prescription drugs administered to, or self-administered by any resident. The record will include:

(a) Resident's name;

(b) Prescribing physician's name;

(c) Description of medication, including prescribed dosage;

(d) Verification in writing by treatment staff that the medication was taken and the times and dates administered or self-administered;

(e) Method of administration;

(f) Any adverse reactions to the medication; and

(g) Continuing evaluation of the resident's ability to self-administer the medication.

(12) First-Aid: A residential program shall ensure that for all 24 hours per day at least one person is onsite, on duty, and certified by the Red Cross or other appropriate entity in first-aid methods including cardiopulmonary resuscitation.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0070

Use of Volunteers

(1) Policy:

(a) Each residential program utilizing volunteers, including medical students, interns, practicum students, and other trainees, shall have written policy regarding the use of volunteers that shall include:

(A) Philosophy, goals, and objectives of the volunteer program;

(B) Specific responsibilities and tasks of volunteers;

(C) Procedures and criteria used in selecting volunteers including sobriety requirements for individuals recovering from the disease of alcoholism and other drug addiction;

(D) Terms of service for volunteers;

(E) Specific accountability and reporting requirements of volunteers;

(F) Specific procedure for reviewing the performance of volunteers and providing direct feedback to them; and

(G) Specific procedure for discontinuing a volunteer's participation in the program.

(b) Residential programs may not use volunteers in place of treatment staff.

(2) Orientation and Training: There shall be documentation that volunteers complete an orientation and training program specific to their responsibilities before they participate in assignments. The orientation and training for volunteers shall:

(a) Include a thorough review of the residential program's philosophical approach to treatment;

(b) Include information on confidentiality regulations and resident's rights;

(c) Specify how volunteers are to respond to and follow procedures for unusual incidents;

(d) Explain the residential program's channels of communication and reporting requirements and the accountability requirements for volunteers;

(e) Explain the procedure for reviewing the volunteer's performance and providing feedback to the volunteer; and

(f) Explain the procedure for discontinuing a volunteer's participation.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0080

Treatment Services

(1) Self-Help Groups: A residential program shall expose residents to the tenets of Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Alateen, or other self-help groups and encourage participation when appropriate and to the extent available in the community.

(2) Treatment Plan: A residential program shall develop an individualized treatment plan for each resident accepted for treatment. The treatment plan shall:

(a) Identify the problems from the resident assessment and evaluation;

(b) Specify objectives for the treatment of each identified resident problem;

(c) Specify the treatment methods and activities to be utilized to achieve the specific objectives desired and define the responsibilities of the resident and treatment staff for each activity;

(d) Specify the necessary frequency of contact for resident services and activities;

(e) Specify the participation of significant others in the treatment planning process and the treatment itself where appropriate;

(f) Document the resident's participation in developing the content of the treatment plan and any modifications by, at a minimum, including the client's signature; and

(g) Be completed within five days of admission to the program.

(3) Documentation of Progress: The resident's record shall document with progress notes the resident's status in treatment activities and progress toward achieving objectives contained in the resident's treatment plan. The documentation shall be kept current, dated, be legible, and signed by the individual making the entry.

(4) Review: Treatment plans shall be reviewed by the treatment staff at the intervals specified below. Any modifications to the treatment plans shall be made in conjunction with the resident and be signed by the resident. The reviews shall occur:

(a) For CIRT programs, 15 days from the date of admission, and every 15 days thereafter.

(b) For other residential programs, 30 days from date of the first plan and every 30 days thereafter.

(5) Length of Stay: A residential program shall motivate and encourage residents to remain in treatment for an appropriate duration as determined by the treatment plan.

(6) Continued Treatment: Residential programs shall encourage all residents to enter programs appropriate for on-going recovery following discharge.

(7) Discharge and Aftercare Plan: A residential program shall conduct and document in the resident's record discharge planning for residents who complete treatment. The discharge plan shall include:

(a) Documentation of the referral for follow-up, aftercare, or other appropriate continued treatment;

(b) Referrals made to other services or agencies at the time of discharge;

(c) A plan for relapse prevention; and

(d) Documentation of participation by the resident in the development of the discharge plan.

(8) Final Evaluation: At discharge a treatment summary and final evaluation of the resident's progress toward treatment objectives shall be entered in the resident's record.

(9) Barriers to Treatment: Where there is a barrier to treatment (Including age, cultural, sexual, language, architectural, or other barriers), the residential program shall provide:

(a) Individuals capable of assisting the program to minimize barriers; or

(b) Referral to an agency capable of providing the necessary services.

(10) Clinical Supervision: A minimum of two hours per month of face-to-face clinical supervision or consultation for each treatment staff person and volunteer. The objective of clinical supervision or consultation is to increase the quality of service by increasing the knowledge and skills of treatment staff persons and volunteers.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0090

Building Requirements

(1) All buildings shall comply with applicable state and local building, fire, health, safety, sanitation, electrical, plumbing, and zoning codes appropriate to the size of the residential program.

(2) Construction and Alteration: Prior to construction of a new building or major alteration of, or addition to, an existing building:

(a) Three sets of plans and specifications shall be submitted to the Department and one set of plans and specifications to the State Fire Marshal for approval;

(b) Plans shall be in accordance with the current edition of the State of **Oregon Structural Specialty Code** and **Fire and Life Safety Regulations**;

(c) Plans shall be drawn to a scale of one-fourth inch or one-eighth inch to the foot and shall specify the date upon which construction, major alteration, or conversion is expected to be completed;

(d) Construction containing 4,000 square feet or more shall be prepared and bear the stamp of an Oregon licensed architect or engineer;

(e) The water supply, sewage, and garbage disposal system shall be approved by the agency having jurisdiction;

(f) All plumbing must comply with the **State Plumbing Code**; and

(g) Electrical systems must comply with the **National Electric Code**.

(3) Interiors: All rooms used by residents shall have floors, walls, and ceilings which meet the interior finish requirements of the **State of Oregon Structural Specialty Code** and **Fire and Life Safety Regulations**.

(4) Dining Room: A separate dining room or area shall be provided for exclusive use of residents, employees, and invited guests, and shall:

(a) Seat at least one-half of the residents at a time with a minimum of 15 square feet per occupant; and

(b) Be provided with adequate ventilation.

(5) Living Room: A separate living room or lounge area shall be provided for the exclusive use of residents, employees, and invited guests and shall:

(a) Provide a minimum of 15 square feet per occupant; and

(b) Be provided with adequate ventilation.

(6) Bedrooms: Bedrooms shall be provided for all residents and shall:

(a) Be separate from the dining, living, multi-purpose, laundry, kitchen, and storage areas;

(b) Be an outside room with an openable window of at least the minimum required by the State Fire Marshal;

(c) Have a ceiling height of at least seven feet, six inches;

(d) Provide a minimum of 60 square feet per resident, with at least three feet between beds;

(e) Provide permanently wired light fixtures located and maintained so as to give light to all parts of the room; and

(f) Provide a curtain or window shade at each window to assure privacy.

(7) Bathrooms: Bathrooms shall be provided and conveniently located in each building containing a resident bedroom and shall:

(a) Provide a minimum of one toilet and one handwashing sink for each eight residents, and one bathtub or shower for each ten residents;

(b) Provide one handwashing sink convenient to every room containing a toilet;

(c) Provide permanently wired light fixtures located and maintained so as to give adequate light to all parts of the room;

(d) Provide arrangements for individual privacy for residents;

(e) Provide a privacy screen at each window;

(f) Provide a mirror; and

(g) Be provided with adequate ventilation.

(8) Plumbing: A supply of hot and cold water, installed and maintained in compliance with current rules of the Health Division, shall be distributed to taps conveniently located throughout the residential program. All plumbing shall be in compliance with applicable codes.

(9) Laundry Facilities: Laundry facilities, when provided, shall be separate from:

(a) Resident living areas, including bedrooms;

(b) Kitchen and dining areas; and

(c) Areas used for the storage of unrefrigerated perishable foods.

(10) Storage Areas: Storage areas shall be provided appropriate to the size of the residential program. Separate storage areas shall be provided for:

(a) Food, kitchen supplies, and utensils;

(b) Clean linens;

(c) Soiled linens and clothing;

(d) Cleaning compounds and equipment; and

(e) Poisons, chemicals, rodenticides, insecticides, and other toxic materials, which shall be properly labeled, stored in the original container, and kept in a locked storaged area.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0100

Resident Furnishings

(1) Furniture: Furniture shall be provided for each resident and shall include:

(a) A bed with a frame and a clean mattress and pillow;

(b) A private dresser or similar storage area for personal belongings which is readily accessible to the resident; and

(c) Access to a closet or similar storage area for clothing.

(2) Linens: Linens shall be provided for each resident and shall include:

(a) Sheets and pillowcases;

(b) Blankets, appropriate in number and type for the season and the individual resident's comfort; and

(c) Towel and washcloth.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0110

Food Service

(1) A residential program shall meet the requirements of the **State of Oregon Sanitary Code for Eating and Drinking Establishments** relating to the preparation, storage, and serving of food.

(2) Menus: Menus shall be prepared in advance to provide a sufficient variety of foods served in adequate amounts for each resident at each meal and shall be adjusted for seasonal changes.

(a) Records of menus as served shall be filed and maintained in the residential program records for at least 30 days;

(b) All modified or special diets shall be ordered by a physician; and

(c) At least three meals shall be provided daily.

(3) Food Storage: Supplies of staple foods for a minimum of one week and of perishable foods for a minimum of a two-day period shall be maintained on the premises.

(4) Food shall be stored and served at proper temperature.

(5) All utensils, including dishes, glassware, and silverware used in the serving or preparation of drink or food for residents shall be effectively washed, rinsed, sanitized, and stored after each individual use to prevent contamination in accordance with Health Division standards.

(6) Forbidden Foods: Raw milk and home-canned vegetables, meats, and fish shall not be served or stored in a residential program.

(7) Residents in the Kitchen: All resident activities in food preparation areas shall be under the supervision of staff and shall be allowed only if part of the resident's planned treatment.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0120

Safety

(1) Approved Capacity: At no time shall the number of residents served exceed the approved capacity.

(2) Emergency Plan: A written emergency plan shall be developed and posted next to the telephone used by employees and shall include:

(a) Instructions for the employee or designated resident(s) in the event of fire, explosion, accident, death, or other emergency and the telephone numbers of the local fire department, law enforcement agencies, hospital emergency rooms, and the residential program's designated physician and on-call back-up treatment staff;

(b) The telephone number of the administrator or clinical supervisor and other persons to be contacted in case of emergency; and

(c) Instructions for the evacuation of residents and employees in the event of fire,explosion, or other emergency; and

(3) Fire Safety: The residential program shall provide fire safety equipment appropriate to the number of residents served, and meeting the requirements of the **State of Oregon Structural Specialty Code** and **Fire and Life Safety Regulations**.

(4) Fire detection and protection equipment shall be inspected as required by the State Fire Marshal.

(5) All flammable and combustible materials shall be properly labeled and stored in the original container in accordance with the rules of the State Fire Marshal.

(6) Documentation of Incidents: A written description of any injury, accident, or unusual incident involving any resident shall be placed in the individual's record.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0130

Sanitation

(1) All floors, walls, ceilings, window, furniture, and equipment shall be kept in good repair, clean, neat, orderly, and free from odors.

(2) Each bathtub, shower, handwashing sink, and toilet shall be kept clean and free from odors.

(3) Water Supply: The water supply in the residential program shall meet the requirements of the current rules of the Health Division governing domestic water supplies.

(4) Laundry: Soiled linens and clothing shall be stored in an area separate from kitchens, dining areas, clean linens and clothing, and unrefrigerated food.

(5) Insects: All measures necessary to prevent the entry into the program of mosquitoes and other insects shall be taken.

(6) Rodents: All measures necessary to control rodents shall be taken.

(7) Litter: The grounds of the program shall be kept orderly and free of litter, unused articles, and refuse.

(8) Garbage/Sewage:

(a) Garbage and refuse receptacles shall be clean, durable, water-tight, insect- and rodent-proof, and kept covered with a tight-fitting lid;

(b) All garbage solid waste shall be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality;

(c) Sewage and liquid waste shall be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

Community Intensive Residential Treatment CIRT Programs

410-010-0140

Treatment Services and Staffing

(1) Counseling: A CIRT resident shall receive at least 27 hours of structured, therapeutic/counseling services every seven-day week. The services shall include:

(a) Motivational counseling;

(b) Individual counseling;

(c) Group counseling; and

(d) Family and/or marriage counseling.

(2) Education: A CIRT resident shall receive at least six hours of planned, structured, alcohol- and drug-specific education every seven-day week. The program shall make such service available either through its own resources or those within the community.

(3) Recreation/Fitness: A CIRT resident shall receive at least seven hours of planned, structured recreational/physical fitness activities every seven-day week. The program shall make such services available either through its own resources or those within the community.

(4) Additional Services: To the extent of community resources available and when appropriate, a CIRT resident shall receive information and referral to the following services:

(a) Educational services;

(b) Pre-vocational, occupational, and vocational rehabilitation services; and

(c) Life skills training such as money management and nutrition.

(5) Staffing: Staff coverage must be provided 24 hours per day, seven days per week.

(6) There shall be employed a sufficient number of qualified treatment staff to ensure a ratio of at least one treatment staff per eight residents.

(7) If the CIRT administrator meets the qualifications of the clinical supervisor, the administrator may also be the clinical supervisor.

(8) Administrator Qualifications: A CIRT program shall be directed by a person with the following qualifications at the time of hire:

(a) For an individual recovering from the disease of alcoholism and/or drug addition, continuous sobriety under non-residential, independent living conditions for at least the immediate past three years; and

(b) One of the following combinations of education/experience:

(A) Five years of paid, full-time experience in the treatment of alcoholism and/or drug addition, with at least one year in a paid administrative capacity; and

(B) A Bachelor's Degree in a relevant field and four years of paid full-time experience, with at least one year in a paid administrative capacity; or

(C) A Master's Degree in a relevant field and three years of paid full-time experience, with at least one year in a paid administrative capacity.

(c) The administrator shall have knowledge and experience demonstrating competence in planning and budgeting, fiscal management, supervision, personnel management, employee performance assessment, data collection, and reporting.

(9) Clinical Supervisor Qualifications: A CIRT program shall have an identified clinical supervisor who has the following qualifications at the time of hire:

(a) For an individual recovering from the disease of alcoholism and/or drug addiction, continuous sobriety under non-residential, independent living conditions, for the immediate past three years; and

(b) One of the following combinations of education/experience:

(A) Five years of paid, full-time experience in the treatment of alcoholism and/or drug addiction, with a minimum of

two years of direct alcoholism and/or other drug abuse treatment experience; or

(B) A Bachelor's Degree in a relevant field and four years of paid full-time experience, with a minimum of two years of direct alcoholism and/or other drug abuse treatment experience; or

(C) A Master's Degree in a relevant field and three years of paid full-time experience, with a minimum of two years of direct alcoholism and/or other drug abuse treatment experience.

(c) Knowledge and experience demonstrating competence in the treatment of the disease of alcoholism and other drug addiction, including client evaluation; individual, group, family, and other counseling techniques; relapse prevention; and clinical supervision, including staff development, treatment planning, case management, and utilization of community resources including 12-step groups.

(10) Treatment Staff: The CIRT treatment staff shall:

(a) For individuals recovering from the disease of alcoholism and/or drug addiction, have maintained continuous sobriety under non-residential, independent living conditions for at least the immediate past two years at the time of hire; and

(b) Have training, knowledge and experience demonstrating competence in the treatment of the disease of alcoholism and other drug addiction, including client evaluation, relapse prevention, and individual, group, family, and other counseling techniques.

(11) Admission and Treatment of Children: If a CIRT program offers services to children, then in addition to the requirements of OAR 410-010-0000 through 410-010-0140 (1) through (10), a CIRT program must meet the following requirements relating to the admission and treatment of children:

(a) The CIRT program shall be licensed by the Children's Services Division in cooperation with the Office of Alcohol and Drug Abuse Programs of the Department of Human Resources;

(b) The CIRT program shall conduct unannounced fire evacuation drills at least monthly. At least once every three months, the monthly drill shall occur between 10 pm and 6 am. Written documentation of the dates of the drills, names of the employees present on the premises, time elapsed to evacuate, and staff conducting the drills shall be maintained;

(c) The Clinical Supervisor and those treatment staff members treating children shall have, as evidenced by previous work experience, academic background, and in-service and other training:

(A) A working knowledge of the normal process of child and adolescent growth and development;

(B) A working knowledge of the effects of alcohol and other drug abuse/addiction on children's growth and development; and

(C) A working knowledge of dysfunctional families and family systems counseling.

(d) Individualized treatment plans for children admitted for treatment shall:

(A) Be developed by the CIRT in cooperation with child care workers, other involved professionals, and the child and the child's family as appropriate;

(B) Include an educational component. The educational component should, as appropriate, provide the child with educational opportunities while in treatment, and shall include a plan for phasing the child into a community education program if appropriate and as soon as reasonable;

(C) Include recreational and leisure-time activities appropriate to the child;

(D) Include the involvement of the child's "significant others" in treatment (individuals, schools, agencies);

(E) Include access to self-help groups predominantly composed of, and focused on, children; and

(F) Include an aftercare plan which utilizes peer support groups of recovering children, and such other means as are necessary, appropriate, and available to assist the child's reintegration into his/her family, school, and community.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

Alcoholism or Drug Abuse Residential Treatment Program

410-010-0150

Treatment Services and Staffing

(1) Counseling: A treatment program shall provide each resident at least five hours of structured, therapeutic/counseling services every seven-day week. The services shall include:

(a) Motivational counseling;

(b) Individual counseling;

(c) Group counseling;

(d) Family and/or marriage counseling; and

(e) Alcohol and other drug educational materials;

(2) Education: An alcohol and drug residential treatment program shall provide planned, structured alcohol- and drug-specific education. The program shall make such services available either through its own resources or those within the community.

(3) Recreation/Fitness: A treatment program shall make available planned, structured recreational/physical fitness activities. The program shall make such services available either through its own resources or those within the community.

(4) Combination of Services: A treatment program shall provide each resident with as much service as is possible and as is indicated by the resident's needs and set forth in the resident's treatment plan. The minimum acceptable standard for each resident every seven-day week is at least fourteen hours of counseling, education, recreation, and self-help group participation -- Not less than five hours of which is counseling.

(5) Additional Services: To the extent of community resources available and when appropriate, a treatment program resident shall receive information and referral to the following services:

(a) Educational services;

(B) Pre-vocational, occupational, and vocational rehabilitation services; and

(c) Life skills training such as money management and nutrition.

(6) Staffing: A treatment program shall employ a sufficient number of qualified treatment staff to ensure a ratio of at

least 1 treatment staff per 15 residents.

(7) During hours when there is no on-site treatment staff coverage:

(a) Coverage will be provided by at least one resident who has been designated by the Clinical Supervisor as being capable of managing emergencies and other situations that require immediate attention. The Clinical Supervisor shall make such designation only after:

(A) Assessing the resident on the basis of length of sobriety, progress in treatment, demonstrated knowledge and such other factors deemed relevant by the Clinical Supervisor; and

(B) Fully recording this assessment and designation in the clinical record of the resident(s).

(b) The designated resident must satisfy the requirement set forth in OAR 410-010-0060(12);

(c) With the exceptions of lifesaving CPR and first aid assistance, the designated resident may not provide treatment or dispense medications. If there is an emergency, the designated resident shall promptly report the circumstances to the on-call treatment staff person and follow such other steps as are included in the program's policy and procedures for managing emergencies;

(d) The Clinical Supervisor shall ensure the availability of on-call back-up by treatment staff during all hours covered by designated residents.

(8) If the administrator of the treatment program meets the qualifications of the clinical supervisor, the administrator may also be the clinical supervisor.

(9) Administrator Qualifications: A treatment program shall be directed by a person with the following qualifications at the time of hire:

(a) For an individual recovering from the disease of alcoholism and/or drug addiction, continuous sobriety under non-residential, independent living conditions, for at least the immediate past three years; and

(b) One of the following combinations of education/experience:

(A) Four years of paid, full time experience in the treatment of alcoholism and/or drug addiction, with at least one year in a paid administrative capacity; or

(B) A Bachelor's Degree in a relevant field and three years of paid full-time experience in the field of alcoholism or drug addiction treatment, with at least one year in a paid administrative capacity; or

(C) A Master's Degree in a relevant field and two years of paid full-time experience in the field of alcoholism or drug addiction treatment, with at least one year in a paid administrative capacity.

(c) The administrator of a treatment program shall have knowledge and experience demonstrating competence in planning and budgeting, fiscal management, supervision, personnel management, employee performance assessment, data collection, and reporting.

(10) Clinical Supervisor Qualifications: A treatment program shall have an identified clinical supervisor who has the following qualifications at the time of hire:

(a) For an individual recovering from the disease of alcoholism and/or drug addiction, continuous sobriety under non-residential, independent living conditions for at least the immediate past three year; and

(b) One of the following combinations of education/experience:

(A) Four years of paid, full-time experience in the treatment of alcoholism and/or drug addiction, with a minimum of

two years of direct alcoholism and/or other drug abuse treatment experience; or

(B) A Bachelor's Degree in a relevant field and three years of paid full-time experience, with a minimum of two years of direct alcoholism and/or other drug abuse treatment experience; or

(C) A Master's Degree in a relevant field and two years of paid full-time experience, with a minimum of two years of direct alcoholism and/or other drug abuse treatment experience.

(c) Training, knowledge and experience demonstrating competence in the treatment of the disease of alcoholism and other drug addiction, including client evaluation; individual, group, family, and other counseling techniques; and clinical supervision, including staff development, treatment planning, case management, relapse prevention, and utilization of community resources including 12-step groups.

(11) Treatment Staff Qualifications: The treatment staff for treatment centers or facilities shall:

(a) For individuals recovering from the disease of alcoholism and/or drug addiction, have maintained continuous sobriety under non-residential independent living conditions for at least the immediate past two years at the time of hire; and

(b) Have training, knowledge and experience demonstrating competence in the treatment of the disease of alcoholism and other drug addiction, including client evaluation, relapse prevention, and individual, group, family, and other counseling techniques.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

Drug Free Residential Transition Program

410-010-0160

Treatment Services and Staffing

(1) Counseling and Education: A transition program is structured primarily for residents needing a drug-free environment and who have received treatment in a more intensive service (CIRT or Residential Treatment) and are now transitioning into the community. A transition program resident shall receive at least five hours of structured, therapeutic/counseling and alcohol and drug specific education services every seven-day week. The services shall include:

(a) Motivational counseling;

(b) Individual counseling;

(c) Group counseling;

(d) Family and/or marriage counseling; and

(e) Alcohol and other drug educational materials.

(2) Recreation/Fitness: A transition program resident shall receive, when appropriate, at least four hours of planned, structured recreational/ physical fitness activities every seven-day week. The program shall make such services available either through its own resources or those within the community.

(3) Additional Services: To the extent of community resources available and when appropriate, a transition program resident shall receive information and referral to the following services:

(a) Educational services;

(b) Pre-vocational, occupational, and vocational rehabilitation services; and

(c) Life skills training such as money management and nutrition.

(4) Staffing: A transition program shall employ a sufficient number of qualified treatment staff to ensure a ratio of at least one treatment staff per 25 residents.

(5) During hours when there is no on-site treatment staff coverage, coverage will be provided by at least one resident designated by the Administrator, upon recommendation by the treatment staff, as being capable of managing emergencies and other situations that require immediate attention.

(6) Administrator Qualifications: A transition program shall be directed by a person with the following qualifications at the time of hire:

(a) For an individual recovering from the disease of alcoholism and/or drug addiction, continuous sobriety under non-residential, independent living conditions for at least the immediate past three years; and

(b) One of the following combinations of education/experience:

(A) Three years of paid, full-time experience in the treatment of alcoholism and/or drug addiction, with at least one year in a paid administrative capacity; or

(B) A Bachelor's Degree in a relevant field and two years of paid full-time experience in the field of alcoholism or drug addiction treatment, with at least one year in a paid administrative capacity; or

(C) A Master's Degree in a relevant field and one year of paid full-time experience in the field of alcoholism or drug addiction treatment, with at least one year in a paid administrative capacity.

(c) The administrator of a transition program shall have knowledge and experience demonstrating competence in planning and budgeting, fiscal management, supervision, personnel management, employee performance assessment, data collection, and reporting.

(7) Treatment Staff Qualification: Care program treatment staff shall:

(a) For individuals recovering from the disease of alcoholism and/or drug addiction, have maintained continuous sobriety under non-residential, independent living conditions for at least the immediate past two years at the time of hire; and

(b) Have training, knowledge and experience demonstrating competence in the treatment of the disease of alcoholism and other drug addiction, including client evaluation; relapse prevention; individual, group, family, and other counseling techniques; and habilitation and rehabilitation skills.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

410-010-0170

Exception and Variance

(1) Exceptions: The Department may grant exceptions to OAR 410-010-0000 through 410-010-0160; however:

(a) Exceptions shall not be granted which are judged to be detrimental to the health or safety of residents in the residential program; and

(b) The residential program seeking an exception shall submit, in writing, reasons the requirement cannot be met and a plan to achieve compliance with the rule.

(2) Variances: The Department may also approve a variance to these rules based on demonstrated increases in program effectiveness. The residential program seeking a variance shall submit, in writing, the plan for increasing program effectiveness.

Stat. Auth.: ORS Ch. 183 & 430

Hist.: HR 2-1988, f. & cert. ef. 5-10-88

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 20

DISPLACED HOMEMAKER PROGRAMS

410-020-0000

Definitions

(1) "Administering Agency" means State Community Services Program, Department of Human Resources.

(2) "Audit Requirement" means an audit review on contract expenditures by a Certified Public Accountant of other qualified auditors within ninety (90) days of expiration of the contract from the Department of Human Resources.

(3) "Displaced Homemaker" as defined in ORS 411.900 means one who:

(a) Has not worked in the labor force for a substantial number of years but has, during those year, worked in the house, providing unpaid household services for family members;

(b) Has been dependent on public assistance or on the income of another family member but is no longer supported by that income, or is receiving public assistance on account of dependent children in the home, especially where such assistance will be terminated within one year as a result of the youngest child reaching the age of 18; or

(c) Is currently unemployed and is experiencing difficulty in obtaining employment or is currently underemployed as defined in the most current Federal Regulations for Comprehensive Employment and Training Act, and is experiencing difficulty in upgrading employment.

(4) "DHR" means the Department of Human Resources.

(5) "Director" means the Director of the Department of Human Resources.

(6) "DHR Displaced Homemakers Advisory Committee" means a statewide advisory committee appointed by the program administrator.

(7) "Local Advisory Board" means a locally appointed advisory body established to advise local contractors on program operation, evaluation and planning.

(8) "Multi-Purpose Service Programs" as defined in ORS 411.905 means distinct programs staffed to the maximum extent feasible by displaced homemakers. The programs shall include but not be limited to job placement, counseling and development services, job training services, health education and counseling services, financial management services, coordination of program services and existing community services and information and referral services developed to assist displaced homemakers.

(9) "Program Administrator" means the administrator of the State Community Services program, Department of Human Resources.

(10) "Proposal Review Criteria" means criteria by which proposals will be reviewed by DHR Displaced Homemakers Advisory Committee, including: problem statement, coordination with other community resources, use of volunteers and outreach activities, plans to implement sliding fee schedule and waiver process client eligibility, project evaluation plan, continuation, follow-up and dissemination activities, project work plan and budget information.

(11) "Donated Resources" means resources either in cash or inkind contributed by other resources.

(12) "Administrative Costs" means a maximum of 10% of the total project costs charged to the grant for costs not directly related to the provision of client services.

(13) "Project Costs" means the charges for direct client services.

(14) "Contractor" means public or private nonprofit agencies selected to operate DHR Displaced Homemakers programs.

Stat. Auth.: ORS Ch. 184

Hist.: HR 18-1979, f. & ef. 11-19-79

410-020-0010

Establishment of DHR Displaced Homemakers Programs

(1) The State Community Services Program is authorized by the "director" to administer grants and contracts pursuant to ORS 411.900, 411.905, and 411.910.

(2) The State Community Services Program shall solicit proposals for contract consideration on a statewide basis.

(3) Public and private agencies shall be given a minimum of 60 days from issuance of grant packages to submit proposal packages.

(4) The State Community Services Program shall screen proposals to determine eligibility as established in the administrative rules.

(5) Proposals meeting eligibility screening shall be reviewed and prioritized by DHR Displaced Homemakers Advisory Committee.

(6) The program administrator shall select proposals for contract awards based on the recommendations from the DHR Displaced Homemakers Advisory Committee, geographic distribution, proposed use of volunteers and ability of the applicant agency to administer the program.

(7) Programs selected for funding shall be required to sign a written contract with the State Community Services Program, Department of Human Resources.

Stat. Auth.: ORS Ch. 184

Hist.: HR 18-1979, f. & ef. 11-19-79

410-020-0020

Program Requirements

(1) Contractors shall operate the program in compliance with a written and signed contract between the contractor and the State Community Services Program, Department of Human Resources.

(2) Services shall not be denied any person on the basis of race, color, creed, sex, national origin, or ability to pay.

(3) Contractors shall establish and maintain a project advisory council for the duration of the contract period.

(4) Authorized program income generated from services under this program shall be used to further the purposes of the program or accrued and deducted from second year funding.

(5) Contractors shall not be allowed to expend more than ten percent of the total "project costs" on administrative costs.

Stat. Auth.: ORS Ch. 184

Hist.: HR 18-1979, f. & ef. 11-19-79

410-020-0030

Administrative Requirements

(1) Contractors shall submit to the administering agency the following reports:

(a) Quarterly Financial Report;

(b) Quarterly Program Progress Report;

(c) Other reports as required by the administering agency.

(2) Contracts shall show proof of status as a nonprofit public or private agency or incorporation and maintain said status for the duration of the contract.

(3) Contract shall provide for the following:

(a) Authorized Contract Work Plan;

(b) Authorized Contract Budget;

(c) Collection of fees and disposition of revenues;

(d) Contract termination.

(4) Contractors shall be required to have on file written agency personnel policies and affirmative action plan.

(5) Contractors shall establish and maintain records and statistics as may be required by the administering agency.

Stat. Auth.: ORS Ch. 184

Hist.: HR 18-1979, f. & ef. 11-19-79

410-020-0040

Disbursement of Funds

(1) Upon approval of contracts, funds shall be disbursed by warrant for the contract period.

(2) Changes in budget line items which exceed 10% of the authorized line item must be approved in writing by the administering agency, prior to expenditure.

Stat. Auth.: ORS Ch. 184

Hist.: HR 18-1979, f. & ef. 11-19-79

410-020-0050

DHR Displaced Homemakers Advisory Committee

(1) The State Community Services Program shall establish and maintain a DHR Displaced Homemakers Advisory Committee made up of representatives of state, federal, local programs and community persons.

(2) The DHR Displaced Homemakers Advisory Committee shall:

(a) Meet not less than four times a year for the duration of the DHR Displaced Homemakers Program;

(b) Review major policies or the DHR Displaced Homemakers Program and make recommendations to the "program administrator";

(c) Review and prioritize proposals for DHR Displaced Homemakers Program Contracts and make recommendations to the "programadministrator".

Stat. Auth.: ORS Ch. 184

Hist.: HR 18-1979, f. & ef. 11-19-79

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 30

CLIENT CIVIL RIGHTS

410-030-0010

Purpose

This rule requires Divisions of the Department of Human Resources to insure federal civil rights regulations prohibiting discrimination on the basis of race, color, national origin and handicap. It provides authority enabling Divisions of the Department of Human Resources to conduct compliance reviews of certain of its grantees, contractors, or providers of services, as required by the United States Department of Health and Human Services (DHHS). Only those Divisions which receive DHHS funds will conduct reviews annually on ten of their grantees, contractors, or providers of services. The compliance reviews will insure that the following federal regulations are being followed:

(1) Title VI, Civil Rights Act of 1964. This act prohibits discrimination on the basis of race, color, and national origin by federal recipients.

(2) Section 504, Rehabilitation Act of 1973. This act prohibits discrimination on the basis of handicap by federal recipients.

Stat. Auth.: ORS Ch. 184

Hist.: HR 5-1979(Temp), f. & ef. 8-1-79; HR 16-1979, f. & ef. 11-19-79; HR 7-1982, f. & ef. 8-26-82

410-030-0020

Review Requirements

(1) The Assistant Director for each Division shall insure that all reviews for which their Division is responsible are conducted by or with state agency Title VI/504 coordinators or their designees.

(2) Each actual review shall be preceded by written notification to each provider, contractor, or grantee containing:

(a) A statement as to the purpose of the review;

(b) The approximate time of the review; and

(c) A copy of the review document to be used.

(3) Each review shall be conducted and documented by the use of a review form approved by the Department of Health and Human Services and provided by the Department of Human Resources.

Stat. Auth.: ORS Ch. 184

Hist.: HR 5-1979(Temp), f. & ef. 8-1-79; HR 16-1979, f. & ef. 11-19-79; HR 7-1982, f. & ef. 8-26-82

410-030-0030

Implementation

(1) The provider compliance reviews for which each Division is responsible shall be determined by the Department of Human Resources and will be issued as Department policy.

(2) The methods of internal administration and coordination shall be determined by Department of Human Resources and published as Department policy. The "methods of Administration" will specify the procedures for avoiding duplication of reviews among the divisions of the Department and will define a method for informing the Department of Human Resources if similar reviews are being conducted at the same facility by other agencies.

Stat. Auth.: ORS Ch. 184

Hist.: HR 5-1979(Temp), f. & ef. 8-1-79; HR 16-1979, f. & ef. 11-19-79; HR 7-1982, f. & ef. 8-26-82

410-030-0040

Penalties for Non-Compliance

Following a review, if a provider of services, contractor, or grantee is found not be to be in compliance with Title VI or Section 504 regulations, an agreement will be developed between the reviewing Division and the provider, contractor, or grantee to assure that compliance occurs. If an agreement with time frames has been reached, compliance has not occurred, and appeal processes have been exhausted, the following will occur:

(1) Providers of Services: The reviewing Division will purchase no further services from the provider and will notify other affected agencies of the action. Service providers may be reinstated after assurance of compliance has been reached.

(2) Contractors and Grantees: The reviewing Division will notify the contractor or grantee that a breach of contract exists or the conditions of the grant have been violated. The grant or contract will be terminated and other affected agencies will be notified. Contractors and grantees may be reinstated after assurance of compliance has been reached.

Stat. Auth.: ORS Ch. 184

Hist.: HR 7-1982, f. & ef. 8-26-82

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 120

MEDICAL ASSISTANCE PROGRAMS

410-120-0000

Definitions

(1) "Acupuncturist" -- A person licensed to practice accupuncture by the relevant State Licensing Board.

(2) "Acupuncture Services" -- Services provided by a licensed Acupuncturist within the scope of practice as defined under state law.

(3) "Acute" -- A condition, diagnosis or illness with a sudden onset and which is of short duration.

(4) "AAA" -- Area Agency on Aging.

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

(6) "Administrative Medical Examinations and Reports" -- Examinations, evaluations, and reports, including copies of medical records, requested on the OMAP 729 form through the local AFS, SDSD, MHDDSD or CSD branch office or requested and/or approved by OMAP to establish client eligibility for a medical assistance program or for casework planning.

(7) "Adult and Family Services" (AFS) - A Division of the Oregon Department of Human Resources.

(8) "All Inclusive Rate" -- The nursing facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in 411-070-0085, and in the Pharmaceutical Services and the Home Enteral/Parenteral Nutrition and IV Services provider guides, except as specified in 410-120-1340, Payment.

(9) "Ambulance" -- A specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Health Division of the Department of Human Resources or the licensing standards of the state in which the provider is located.

(10) "Ambulatory Surgical Center" (ASC) -- A facility licensed as an ASC by the Oregon State Health Division.

(11) "Ancillary Services" -- Services supportive of or necessary to the provision of a primary service, e.g., anesthesiology is an ancillary service necessary for a surgical procedure.

(12) "Anesthesia Services" -- Administration of anesthetic agents to cause loss of sensation to the body or body part.

(13) "Audiologist" -- A person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(14) "Audiology" -- 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.

(15) "Automated Information System" (AIS) -- A computer system that provides information on clients' current eligibility status under the Medical Assistance Program.

(16) "Benefit Package" -- The "package" of covered medical services for which the client is eligible.

(17) "Billing Provider" (BP) -- A person, business, corporation, clinic, group, institution, or otherentity that submits claims to and/or receives payment from the Medical Assistance Program on behalf of a performing provider.

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

(19) "CDT (Current Dental Terminology)" -- A listing of descriptive terms identifying dental procedure codes used by the American Dental Association in the CDT-2.

(20) "Chiropractor" -- A person licensed to practice chiropractic by the relevant State Licensing Board.

(21) "Chiropractic Services" -- services provided by a licensed Chiropractor within the scope of practice, as defined under State law and Federal regulation.

(22) "Clinical Social Worker" -- A person licensed to practice clinical social work pursuant to State law.

(23) "Contiguous Area" -- The area up to 75 miles outside the border of the State of Oregon.

(24) "Contiguous Area Provider" -- A provider practicing in a contiguous area.

(25) "Cost Effective" -- The lowest cost health care service or item which, in the judgment of Medical Assistance Program staff, meets the medical needs of the client.

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

(27) "Date of Receipt of a Claim" -- The date on which OMAP 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 Internal Control Number (ICN).

(28) "Date of Service" -- The date on which the client receives medical services or items, unless otherwise specified in the appropriate provider guide. For items which 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.

(29) "Dental Services" -- Services provided within the scope of practice as defined under State law by or under the supervision of a dentist.

(30) "Dentist" -- A person licensed to practice dentistry pursuant to State law.

(31) "Denturist" -- A person licensed to practice denture technology pursuant to State law.

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

(33) "Department of Human Resources" (DHR) -- The Oregon Department of Human Resources or any of its divisions, programs, or offices.

(34) "Division" -- The Adult and Family Services Division, Children's Services Division, Mental Health and Developmental Disability Services Division, or Senior and Disabled Services Division of the Oregon Department of Human Resources.

(35) "DSO" -- Disabled Services Office.

(36) "Durable Medical Equipment and Supplies" -- Equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, 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, tubing.

(37) "Emergency Room" -- The part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(38) "Emergency Medical Services" -- The health care and services provided for diagnosis and treatment of an unexpected 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:

(a) Placing the health of the individual in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part; or

(d) With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or unborn child;

(e) Services that can be scheduled, prior authorized or that are ongoing or repetitive are not emergency services.

(39) "Emergency Transportation" -- Transportation necessary when a sudden, unexpected occurrence creates a medical crisis requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(40) "EOB" -- Explanation of Benefits.

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

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

(43) "Federally Qualified Health Center" (FQHC) -- A federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the "Public Health Service Act"; or a facility designated as a FQHC by the Health Care Financing Administration upon recommendation of the U.S. Public Health Service.

(44) "Fee-for-Service Provider" -- A medical provider who is not reimbursed under the terms of an OMAP contract with a Prepaid Health Plan. A medical provider participating in a Prepaid Health Plan may be considered a Fee-for-Service provider when treating clients who are not enrolled in a Prepaid Health Plan.

(45) "General Assistance" (GA) -- Medical Assistance administered and funded 100% with State of Oregon funds through the Oregon Health Plan.

(46) "HCPCS" -- Health Care Financing Administration's Common Procedure Coding System. HCPCS are composed of several types of codes: (1) CPT; (2) CDT; (3) National Medicaid Codes; and (4) Local Codes. The Medical Assistance Program does not accept the dental HCPCS codes.

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

(48) "Hearing Aid Dealer" -- A person certified by the Health Division 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.

(49) "Home Enteral Nutrition" -- 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 Guide.

(50) "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 Oregon State Health Division as a home health agency in Oregon.

(51) "Home Health Services" -- 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 patient's home.

(52) "Home IV (Intravenous) Services" -- 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 Guide.

(53) "Home Parenteral Nutrition" -- 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 Guide.

(54) "Hospital" -- A facility licensed by the Oregon Health Division as a general hospital which meets requirements for participation in the Medical Assistance Program under Title XVIII of the Social Security Act. Facilities licensed as Special Inpatient Care Facilities under the Oregon Health Division's definition of hospital are not considered hospitals by OMAP for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as an 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.

(55) "Hospital-Based Professional Services" -- 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" (OMAP 42) report for the Office of Medical Assistance Programs.

(56) "Hospital Laboratory" -- 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 the Medical Assistance Program.

(57) "ICD-9-CM" -- The Ninth revision of the International Classification of Diseases Clinical Modification, including volumes 1, 2, and 3, as revised annually.

(58) "Individual Adjustment Request" -- Form OMAP 1036 used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(59) "Inpatient Hospital Services" -- Services that are furnished in a hospital for the care and treatment of an inpatient. (See Hospital Services guide for definition of an inpatient).

(60) "Institution for Mental Diseases" (IMD) -- An institution whose overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases. The following guidelines are used to assist in determining whether an institution is an IMD. No single guideline is necessarily determinative:

(a) The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases and/or alcohol and/or drug abuse problems;

(b) The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases and/or alcohol and/or drug abuse problems;

(c) The facility is accredited as a psychiatric facility by the JCAHO or is licensed by the State Health Division as a facility for the treatment of alcohol and drug abuse problems;

(d) The facility specializes in providing psychiatric/psychological care and treatment and/or rehabilitative treatment for alcohol and/or drug abuse problems;

(e) The facility is under the jurisdiction of the State's Mental Health and Developmental Disability Services Division;

(f) More than 50 percent of all the patients in the facility are being treated for mental diseases and/or alcohol and/or drug abuse problems;

(g) A large proportion of the patients in the facility have been transferred from a State mental institution for continuing treatment of their mental disorders;

(h) Independent review teams report a preponderance of mental illness and/or drug and alcohol abuse diagnoses for the patients in the facility;

(i) Part or all of the facility consists of locked wards.

(61) "Institutional Level of Income Standards" (ILIS) -- Three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. (Example: If the SSI monthly payment amount were $434.00 the ILIS would be ($1,302.) This is the standard used to calculate eligibility for long-term nursing care in a Nursing Home or eligibility for services under SDSD's Home and Community Based Waiver.

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

(63) "Laboratory" -- A facility licensed under ORS 438 and certified by the Health Care Financing Administration, DHHS, as qualified to participate under Medicare, to provide laboratory services within or apart from a hospital.

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

(65) "Licensed Direct Entry Midwife" -- A practitioner licensed by the Oregon Health Division as a Licensed Direct Entry Midwife.

(66) "Liability Insurance" --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, 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.

(67) "Maternity Management" -- A program available to pregnant clients. The purpose of Maternity Management is to extend prenatal services to include non-medical services which address social, economic and nutritional factors. For more information refer to the Medical-Surgical Services guide.

(68) "Medicaid" -- A Federal and State funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Department of Human Resources (see Medical Assistance).

(69) "Medical Assistance" -- A program for payment of medical and remedial care provided to eligible Oregonians:

(a) The Medical Assistance Program is administered by identified Divisions, and the Office of Medical Assistance Programs (OMAP), of the Department of Human Resources;

(b) Coordination of the Medical Assistance Program is the responsibility of the Office of Medical Assistance Programs (OMAP).

(70) "Medical Assistance Eligibility Confirmation" -- Verification through AIS, AIS Hot-Line, an authorized DHR representative, or through presentation of a valid Medical Care Identification that a client has an open assistance case which includes medical benefits.

(71) "Medical Services" -- Care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

(72) "Medical Transportation" -- Transportation to or from covered medical services.

(73) "Medically Necessary Services and Items" -- Those services and items that are required for diagnosis or treatment of illness, or injury, and which, in the judgment of the Medical Assistance Program, are:

(a) Consistent with the diagnosis and treatment of the patient's condition; and

(b) Appropriate with regard to standards of good medical practice; and

(c) Not primarily for the convenience of the patient or a provider of services or supplies; and

(d) The least costly of the alternative supplies or levels of service which can be safely provided to the patient; and

(e) Will significantly improve the basic health status of the client;

(f) The fact that a licensed practitioner or other professional or provider prescribes, orders, recommends, or approves a service or item does not, in itself, make the service or item medically necessary.

(74) "Medicare" -- 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.

(75) "Medicheck for Children and Teens" -- See "EPSDT".

(76) "Mental Health and Developmental Disability Services Division" (MHDDSD) -- A Division of the Oregon Department of Human Resources.

(77) "Naturopath" -- A person licensed to practice naturopathy pursuant to State law.

(78) "Naturopathic Services" -- Services provided within the scope of practice as defined under State law.

(79) "Not Covered Services" -- Services or items for which the Medical Assistance Program is not responsible for payment. Not-covered services are identified in:

(a) OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations;

(b) The individual provider guides.

(80) "Nurse Anesthetist, C.R.N.A." -- A registered nurse licensed in the State of Oregon who is currently certified by the American Association of Nurse Anesthetists Council on Certification.

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

(82) "Nurse Practitioner Services" -- Services provided within the scope of practice of a nurse practitioner as defined under State law and by rules of the Board of Nursing.

(83) "Nursing Facility" -- A facility licensed and certified by the Senior and Disabled Services Division as defined in 411-070-0005.

(84) "Nursing Services" -- 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.

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

(86) "Occupational Therapist" -- A person licensed by the State Board of Examiners for Occupational Therapy.

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

(88) "Office of Drug and Alcohol Abuse Programs" -- An Office within the Department of Human Resources.

(89) "(The) Office of Medical Assistance Programs" (OMAP) - The Office of the Oregon Department of Human Resources responsible for coordinating the Medical Assistance Program within the State of Oregon.

(90) "Optometric Services" -- Services provided, within the scope of practice of optometrists as defined under State law.

(91) "Optometrist" -- A person licensed to practice optometry pursuant to State law.

(92) "Oregon Medical Professional Review Organization" (OMPRO) -- OMPRO is the Oregon Professional Review Organization for Medicare and contracts with OMAP to provide hospital utilization review and other services for the Medical Assistance Program. A Professional Review Organization is an organization established under federal law by the Department of Health and Human Services for the purpose of utilization review and quality assurance.

(93) "Oregon Youth Authority" -- 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.

(94) "Out-of-State Providers" -- Any provider located outside the borders of Oregon:

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

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

(95) "Outpatient Hospital Services" -- Services that are furnished in a hospital for the care and treatment of an outpatient. (See Hospital Services guide for definition of Outpatient).

(96) "Overdue Claim" -- A valid claim which is not paid within 45 days of the date it was received.

(97) "Overpayment" -- Payment(s) made by the Medical Assistance Program to a provider in excess of the correct Medical Assistance Program payment amount for a service. Overpayments are subject to repayment to the Medical Assistance Program.

(98) "Overuse" -- Use of medical goods or services at levels determined by Medical Assistance Program medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(99) "Payment Authorization" -- Authorization granted by the responsible agency, division, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate provider guides. See the individual provider guides for services requiring authorization.

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

(101) "Pharmacist" -- A person licensed to practice pharmacy pursuant to State law.

(102) "Physical Capacity Evaluation" -- 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.

(103) "Physical Therapist" -- A person licensed by the relevant State licensing authority to practice physical therapy.

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

(105) "Physician" -- A person licensed by the Oregon Board of Medical Examiners to practice medicine pursuant to State law.

(106) Physician Assistant -- A person who is registered 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.

(107) "Physician Services" -- Services provided, within the scope of practice as defined under State law, by or under the personal supervision of a physician.

(108) "Podiatric Services" -- Services provided within the scope of practice of podiatrists as defined under State law.

(109) "Podiatrist" -- A person licensed to practice podiatric medicine pursuant to State law.

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

(111) "Practitioner" -- A person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(112) "Primary Care Physician" -- A physician who has responsibility for supervising, coordinating and providing initial and primary care to patients, initiating referrals for consultations and specialist care, and maintaining the continuity of patient care.

(113) "Primary Care Provider" -- 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. Primary care providers initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically necessary client care.

(114) "Prior Authorization" (PA) -- Payment authorization for specified medical services or items given by Medical Assistance Program staff prior to provision of the service.

(115) "Private Duty Nursing Services" -- 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.

(116) "Provider" -- An individual, facility, institution, corporate entity, or other organization which supplies medical services or items or bills on behalf of a provider of services. The term "provider" refers to both Performing Providers and Billing Providers unless otherwise specified. Payment can only be made to enrolled providers, who have, by signature on the provider enrollment form, agreed to provide services and to bill in accordance with these General Rules and the rules in the appropriate provider guide(s).

(117)"Psychiatric Hospital" -- A hospital licensed by the relevant State licensing authority as a psychiatric hospital and certified as such under Title XVIII and XIX of the Social Security Act or any hospital which meets the federal definition of an Institution for Mental Disorders (IMD).

(118) "Public Health Clinic" -- A clinic operated by county government.

(119) "Public Rates" -- 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 Medical Assistance Program clients.

(120) "Qualified Medicare Beneficiary" (QMB) -- A Medicare beneficiary, as defined by the Social Security Act and its amendments.

(121) "Qualified Medicare and Medicaid Beneficiary" (QMM) -- A Medicare Beneficiary who is also eligible for Medical Assistance Program coverage.

(122) "Radiological Services" -- 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.

(123) "Recipient" -- A person who is currently eligible for Medical Assistance (same as "client").

(124) "Recoupment" -- An accounts receivable system that collects money owed by the provider to the Medical

Assistance Program by withholding all or a portion of a provider's future payments.

(125) "Referral" -- The transfer of total or specified care of a patient from one provider to another. As used by OMAP, the term "referral" also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of patients whose medical care is contracted through a prepaid health plan, or managed by a primary care physician, a referral is required before non-emergency care is covered by the health plan or the Medical Assistance Program.

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

(127) "Retroactive Medical Eligibility" -- Eligibility for Medical Assistance granted to a client retroactive to a date prior to the client's application for Medical Assistance.

(128) "Sanction" -- An action against providers taken by the Medical Assistance Program in cases of fraud, misuse or abuse of Medical Assistance Program rqirements.

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

(130) "Senior and Disabled Services Division" (SDSD) - A Division of the Oregon Department of Human Resources.

(131) "Service Agreement" -- An agreement between the Medical Assistance Program 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.

(132) "Sliding Fee Schedule" -- 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.

(133) "Social Worker" -- A person licensed by the Board of Clinical Social Workers to practice clinical social work.

(134) "Speech-Language Pathologist" -- A person licensed by the Oregon Board of Examiners for Speech Pathology.

(135) "Speech-Language Pathology Services" -- 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.

(136) "Spend-Down" -- The amount the client must pay for medical expenses each month before becoming eligible for Medical Assistance under the Medically Needy Program. The spend-down is equal to the difference between the client's total countable income and Medically Needy program income limits.

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

(138) "State Facility" -- A hospital or training center operated by the State of Oregon which provides long-term medical or psychiatric care.

(139) "State Office for Services to Children and Families (SOSCF)" -- A Division of the Oregon Department of Human Resources.

(140) "Surgical Assistant" -- A person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(141) "Suspension" -- A sanction prohibiting a provider's participation in the Medical Assistance Program by deactivation of the provider's 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.

(142) "Targeted Case Management" -- Activities which 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.

(143) "Termination" -- A sanction prohibiting a provider's participation in the Medical Assistance Program by cancelling the provider's 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 Medical Assistance Program at the time of termination.

(144) "Third Party Resource" (TPR) -- A medical or financial resource which, under law, is available and applicable to pay for medical services and items for a medical assistance client.

(145) "Transportation" -- see "Medical Transportation".

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

(147) "Type B AAA Unit" -- A Type B Area Agency on Aging funded by Oregon Project Independence (OPI), Title III - Older Americans Act, and Title XIX of the Social Security Act.

(148) "Type B Hospital" -- A hospital identified by the Office of Rural Health as a Type B hospital.

(149) "Usual Charge" (UC) -- The lesser of the following:

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

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

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

(150) "Utilization Review" (UR) -- 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.

(151) "Valid Claim" -- An invoice received by the appropriate Division or Office of the Medical Assistance Program for payment of covered health care services rendered to an eligible client which:

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

(b) Has been received within the time limitations prescribed in these General Rules; and

(c) Is on the billing form required by OMAP;

(d) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

(152) "Vision Services" -- Provision of corrective eyewear, including ophthalmological/optometric examinations for determination of visual acuity and vision therapy and devices.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-005; 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

410-120-0080

Verification of Eligibility

(1) The client's Medical Care Identification is confirmation of eligibility for medical services, subject to the limitations contained in these general rules and the appropriate individual provider guides.

(2) It is the responsibility of the provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service and for the service provided. The provider assumes full financial risk in serving a person not identified as eligible or not confirmed by the Medical Assistance Program as eligible for the service provided on the date(s) of service.

(3) A Medical Care Identification (Form OMAP 1417) or Temporary Medical Care Identification (Form OMAP 1086) is issued to the head of an eligible household or eligible individual. Both Medical Care Identifications include:

(a) The name(s) of the eligible individual(s), Social Security Number, and the eligible person(s) Recipient Identification Number;

(b) The client identification (ID) number;

(c) Dates of coverage;

(d) The benefit package for which the client is eligible;

(e) Optional program messages, for example, EPSDT (Medicheck) or third party resource (TPR) information;

(f) The dates of medical eligibility for the eligible person or persons;

(g) The name of the responsible branch, the worker's identification code and the phone number of the branch;

(h) The name and phone number of the managed care provider, if applicable;

(i) Medical Management restrictions, if applicable.

(4) The Medical Care Identification or Temporary Medical Care Identification is not transferable, and is valid only for the individual(s) listed on the card.

(5) Eligibility is verified either:

(a) From the Medical Care Identification or Temporary Medical Care Identification which shows the dates on which the client is eligible and indicates the client's benefit package; or

(b) If a patient identifies him/herself as eligible, but does not have a valid Medical Care Identification or Temporary Medical Care Identification, the provider may either:

(A) Contact AIS or the AIS hotline operators during normal business hours, to confirm eligibility; or

(B) Contact the local AFS or SDSD (DSO or AAA), or CSD branch office during regular working hours to confirm eligibility if the information is not available through AIS.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-040; Renumbered from 461-13-103 & 461-13-109; 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

410-120-1160

Medical Assistance Benefits and Provider Guides

(1) The following services are covered within the limitations established by the Medical Assistance Program and set forth in rules and procedures in the provider guides for each category of medical service:

(a) Acupuncture Services, as described in the Medical-Surgical Services Guide;

(b) Alcohol and Drug Abuse Treatment Services:

(A) Alcohol and Drug Detoxification inpatient services are covered by the Office of Medical Assistance Programs when provided in an acute care hospital and when hospitalization is considered medically necessary;

(B) Alcohol and Drug Abuse Treatment inpatient hospital services are not covered by the Office of Medical Assistance Programs;

(C) Non-hospital Alcohol and Drug Detoxification and Treatment services are available on a residential or outpatient basis through the Office of Medical Assistance Programs. Contact the client's managed care plan, local alcohol/drug treatment provider or local publicly-funded alcohol and drug abuse program for information.

(c) Ambulatory Surgical Center Services, as described in the Medical-Surgical Services Guide;

(d) Anesthesia Services, as described in the Medical-Surgical Services Guide;

(e) Audiology Services, as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Guide;

(f) Chiropractic Services, as described in the Chiropractic Services Guide;

(g) Dental Services, as described in the Dental/Denturist Services Guide;

(h) Early and Periodic Screening, Diagnosis and Treatment services (EPSDT, Medicheck for children and teens), are

covered for individuals under 21 years of age as set forth in the provider guides. OMAP may authorize services in excess of limitations established in the provider guides when medically necessary to treat a condition identified as the result of an EPSDT screening;

(i) Family Planning Services, as described in the Medical-Surgical Services provider guide. Family planning services are services and items provided to individuals of childbearing age including minors who can be considered to be sexually active who desire such services and which are intended to prevent pregnancy or otherwise limit family size. Services include annual exams, contraceptive education and counseling to address reproductive health issues, laboratory tests, radiological services, medical procedures, including birth control implants, tubal ligation, and vasectomy, and pharmaceutical supplies and devices;

(j) Federally Qualified Health Center Services, as described in the Federally Qualified Health Center Services Guide;

(k) Home and Community Based Waiver Services, as described in the rules of the Mental Health and Developmental Disability Services Division and Senior and Disabled Services Division;

(l) Home Enteral/Parenteral Nutrition and IV Services, as described in the Home Enteral/Parenteral Nutrition and IV Services Guide;

(m) Home Health Services, as described in the Home Health Services Guide;

(n) Indian Health Services, as described in The Indian Health Care Improvement Act and its Amendments (Public Law 102-573);

(o) Inpatient Hospital Services, as described in the Hospital Services Guide;

(p) Laboratory Services, as described in the Hospital Services Guide and the Medical-Surgical Services Guide;

(q) Licensed Direct Entry Midwife Services, as described in the Medical-Surgical Services Guide;

(r) Maternity Management, as described in the Medical-Surgical Services Guide;

(s) Medical Supplies, as described in the Hospital Services Guide, the Medical-Surgical Services Guide, the Durable Medical Equipment Guide, the Home Health Care Services Guide, and other guides;

(t) Medical Equipment, as described in the Hospital Services, Durable Medical Equipment, Home Enteral/Parenteral Nutrition and IV Services and other provider guides;

(u) Mental Health Rehabilitation Services for those clients whose OMAP Medical Care Identification has the notation "+XMH" (expanded mental health benefits) will be based on the Prioritized List of Health Services. Mental Health Rehabilitation Services for all other clients, including emotional, personality, and behavior disorder treatment, are covered by the Mental Health and Developmental Disabilities Services Division through the county mental health clinics, as described in Mental Health and Developmental Disabilities Services Division rules. Refer to the OMAP Hospital, Federally Qualified Health Centers and Rural Health Clinics provider guides for coverage of mental health services in those settings;

(v) Naturopathic Services, as described in the Medical-Surgical Services Guide;

(w) Nutritional Counseling is covered when provided by a registered dietician as part of the Maternity Management program or by a physician as part of the treatment of a specific medical condition, such as diabetes, hypercholesterolemia, phenylketonuria or morbid obesity. Nutritional counseling is not covered when the primary purpose of the counseling is to reduce weight in an individual who is not morbidly obese. (See 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations);

(x) Occupational Therapy, as described in the Physical and Occupational Therapy Services Guide;

(y) Organ Transplant Services, as described in the Transplant Services Guide;

(z) Outpatient Hospital Services, including clinic services, emergency room services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital, as described in the Hospital Services Guide;

(aa) Physician, Podiatrist, Nurse Practitioner and Physician Assistant Services, as described in the Medical-Surgical Services guide;

(bb) Physical Therapy, as described in the Physical and Occupational Therapy and the Hospital Services Guides;

(cc) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services, the Home Enteral/Parenteral Nutrition and IV Services and the Hospital Services provider guides;

(dd) Preventive Services, as described in the Medical-Surgical Services Guide and the Dental/Denturist Services Guide; children have coverage for preventive services under EPSDT;

(ee) Private Duty Nursing, as described in the Private Duty Nursing Guide;

(ff) Radiology and Imaging Services, as described in the Medical-Surgical Services, the Hospital Services, Dental and Denturist Services and Chiropractic Services provider guides;

(gg) Rural Health Clinic Services, as described in the Rural Health Clinic Services Guide;

(hh) School-Based Health Services, as described in the School-Based Health Services Guide;

(ii) Speech and Language Therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services and Hospital Services provider guides;

(jj) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation Guide;

(kk) Vision Services as described in the Vision Services Guide;

(ll) Hospice Services as described in the Hospice Services Guide.

(2) Other Divisions or Offices, including Vocational Rehabilitation, Mental Health and Developmental Disability Services Division, Office of Alcohol and Drug Abuse Programs, Children's Services Division, and Senior and Disabled Services Division may offer services to Medicaid eligible clients which are not reimbursed by or available through the Office of Medical Assistance Programs.

Stat. Auth.: ORS Ch. 409

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 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 461-13-000; 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 461-13-102; 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; HE 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-440; 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

410-120-1180

Medical Assistance Benefits: Out-of-state Services

(1) Out-of-state providers may enroll in the Medical Assistance Program as described in 410-120-1260, Provider Enrollment. Out-of-state providers must provide services and bill in compliance with all the rules in these General Rules and in the appropriate provider guides.

(2) Enrolled out-of-state providers are reimbursed in the same manner and at the same rates as in-state providers unless otherwise specified in the individual provider guides or by contract or Service Agreement with the individual provider.

(3) Enrolled non-contiguous out-of-state providers will be reimbursed for covered services under any of the following conditions:

(a) The service was emergent or 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 increases the risk that treatment will become more complex or hazardous, or that there will be a substantially increased risk of the development of chronic illness;

(b) Payment for the service was authorized by the Medical Assistance Program in advance of the provision of services or was otherwise authorized in accordance with payment authorization requirements in the individual provider guides or in the General Rules;

(c) The service was authorized by an FCHP or DCO and payment to the out-of-state provider is the responsibility of the FCHP or DCO.

(4) Non-emergency out-of-state services provided by a Non-contiguous enrolled provider, will be prior authorized under the following conditions:

(a) The service or item is covered by the Medical Assistance Program under the specific client's benefit package; and

(b) The service or item is not available in the State of Oregon and/or provision of the service or item by an out-of-state provider is cost effective, as determined by OMAP (or, for those covered by a managed care plan, the plan will make that determination); and

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

(d) If a client has FCHP coverage, the request for non-emergency services must be referred to the FCHP.

(5) Laboratory specimens sent to out-of-state independent or hospital-based laboratories are a covered service and do not require prior authorization. The laboratory must meet the same certification requirements as Oregon laboratories and must bill in accordance with Medical Assistance Program rules.

(6) No reimbursement is made for services provided to a client outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) Program.

(7) All services provided by enrolled providers to children placed in foster care by Oregon's State Office for Services to Children and Families (SOSCF), placed in a subsidized adoption by Oregon's SOSCF outside the state of Oregon or in the custody of Oregon's SOSCF and traveling with the consent of SOSCF will be reimbursed within the limits described in these General Rules and in the individual provider guides. Authorization of non-emergency services by OMAP is not

required except as specified in the individual provider guides.

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

Stat. Auth.: ORS Ch. 409

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 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 461-13-130; 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 461-13-045 & 461-13-046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-120, 410-120-140 & 410-120-160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1200

Medical Assistance Benefits: Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of eligible clients. If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client. No payment will be made for any expense incurred for any of the following services or items:

(a) That are not expected to significantly improve the basic health status of the client as determined by the Medical Assistance Program (e.g., OMAP's Medical Director, medical consultants or Peer Review Organization);

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

(c) That are determined not medically necessary by Medical Assistance Program staff or authorized representatives, including OMPRO or any contracted utilization review organization;

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

(e) That are 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 patient. Examples include exams for employment or insurance purposes;

(f) That are provided by friends or relatives of eligible clients or members of his/her household, except when the friend, relative or household member is a health professional, acting in a professional capacity, or when the friend, relative or household member is directly employed by the client under SDSD's Home and Community Based Waiver;

(g) That are 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;

(h) Where the need for purchase, repair or replacement of materials or equipment is caused by adverse actions of clients to personally owned goods or equipment or to items or equipment rented or purchased by the Medical Assistance Program;

(i) That are related to a non-covered service; some exceptions are identified in the individual provider guides. If the provision of a service related to a non-covered service is determined by OMAP to be cost-effective, the related medical service may, at OMAP's discretion and with OMAP's prior authorization, be covered;

(j) Which are considered experimental or investigational or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(k) That are identified in the provider guides, including the Hospital Guide, Revenue Codes Section, as not covered;

(l) That are requested by or for a client who has been determined by the Medical Assistance Program to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(m) That are for copying or preparing records or documents excepting those Administrative Medical Reports requested by the branch offices or OMAP for casework planning or eligibility determinations;

(n) Whose primary intent is to improve appearance, e.g., cosmetic or reconstructive surgery, except for the repair of an injury or as otherwise necessary to correct dysfunction;

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

(p) For the purpose of establishing or re-establishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence, except as specified by the Prioritized List of Health Services (OAR 410-141-0520);

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

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

(s) Educational or training classes which are not medically necessary (Lamaze classes, for example);

(t) Outpatient social services except Maternity Management services and other social services described in the individual provider guides as covered;

(u) Plasma infusions for treatment of Multiple Sclerosis;

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

(w) Radial keratotomies;

(x) Recreational therapy;

(y) Stop smoking services, except as described in the Medical-Surgical Services Guide;

(z) Telephone calls, including but not limited to telephone conferences between physicians or between a physician or other practitioner and a client or representative of the client;

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

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

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

(dd) Immunizations prescribed for foreign travel;

(ee) Pain center evaluation and treatment;

(ff) Services which are requested or ordered but not provided, i.e., an appointment which the client fails to keep or an

item of equipment which has not been provided to the client;

(gg) DUII-related services already covered by the Intoxicated Driver Program Fund as directed by OS 813.270(1) and (5);

(ii) For transportation to meet a client's personal choice of a provider.

(2) Medical Assistance Benefit Packages and the Medical Care Identification:

(a) Clients in some medical assistance program categories have limited benefits. These limitations or exclusions are in addition to those limitations or exclusions described in these General Rules and in the individual provider guides. The Benefit Package Messages on the Medical Care Identification describe the "package" of medical benefits. Benefit Packages are as follows:

(A) "Basic Health Care + Expanded Mental Health Package";

(B) "Limited Medicaid + Expanded Mental Health Package";

(C) "QMB - Qualified Medicare Beneficiary";

(D) "QMB - Qualified Medicare + Basic + Expanded Mental Health Package";

(E) "QMB - Qualified Medicare + Limited Medicaid + Expanded Mental Health".

(b) Additional limitations by Benefit Package Title and program category are as follows:

(A) Basic Health Care + Expanded Mental Health Package:

(i) Service coverage for clients with this Package is based on the Prioritized List of Health Services including those line items shown to be covered only for clients receiving services under the Expanded Mental Health Package;

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

(iii) Chemical dependency services provided through prepaid health plan or local alcohol/drug treatment providers.

(B) Limited Medicaid Plus Expanded Mental Health Package - These clients are Medically Needy clients. These clients receive:

(i) Prescription drugs provided through a retail pharmacy or state contracted mail order pharmacy;

(ii) Chemical dependency services through a local alcohol/drug treatment provider;

(iii) Medical Transportation to services covered by medical assistance;

(iv) Mental health services based on the Prioritized List of Health Services, to be provided through Community Mental Health Programs;

(v) Over-the-counter drugs.

(C) QMB - Qualified Medicare Beneficiary:

(i) QMB clients are Medicare beneficiaries who have limited income but do not meet the income standard for full Medical Assistance Program coverage. QMB clients have coverage through Medicare Part A and B for most covered services. The Medical Assistance Program provides coverage only for those services which are also covered by Medicare;

(ii) Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of the co-insurance and deductible, but no more than the Medicare allowable;

(iii) QMB clients may be billed by the provider for services which are not covered by Medicare. QMB clients may not be billed by the provider for the deductible and co-insurance amounts due for services which are covered by Medicare.

(D) QMB - Qualified Medicare + Basic + Expanded Mental Health Package: These clients are Medicare beneficiaries. They receive the same coverage as (F) QMB - Qualified Medicare + Basic clients, as well as mental health services based on the Prioritized List of Health Services;

(E) QMB - Qualified Medicare + Limited Medicaid + Expanded Mental Health: These are also Qualified Medicare clients who are in the Medically Needy Program. Their coverage includes:

(i) all services covered by Medicare;

(ii) prescription drugs through a retail pharmacy or state contracted mail order pharmacy;

(iii) chemical dependency services provided through a local alcohol/drug treatment provider;

(iv) medical transportation to services covered by medical assistance;

(v) Mental Health Services based on the Prioritized List of Health Services and provided through Community Mental Health Programs.

(F) Other Client Populations with Restricted or Limited Services:

(i) Citizen/alien-waived Emergency Medical Assistance (CAWEM):

(I) These clients generally do not receive a Medical Care Identification. Eligibility is generally established on a short-term basis to cover emergency medical needs or for labor and delivery services;

(II) Coverage is limited to emergency medical services for males and emergency medical services and labor and delivery services for pregnant women. Prenatal care is not covered. Transplant services are not covered. Emergency medical services are covered only when the alien has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunctions of any bodily organ or part. There may be other limitations depending on the eligibility category to which the client is assigned.

(ii) Fully Capitated Health Plans and Dental Care Organization Members: These clients are enrolled in a Prepaid Health Plan for their medical and ental care. Most non-emergency services are obtained from the Prepaid Health Plan or require a referral from the Prepaid Health Plan that is responsible for the provision and reimbursement for the medical or dental service. The name and phone number of the Plan appears on the Medical Care Identification;

(iii) Primary Care Case Managers - Most non-emergency services provided to clients enrolled with a Primary Care Case Manager (PCCM) require referral from the PCCM.

Stat. Auth.: ORS Ch. 409

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; Renumbered from 461-13-030; 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 461-13-055; 461-13-103, 461-13-109 & 461-13-112; 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 410-120-420, 410-120-460 & 410-120-480; 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

410-120-1260

Provider Enrollment

(1) Signing the provider application constitutes agreement by performing and billing providers to comply with all applicable rules of the Medical Assistance Program and federal and state laws and regulations.

(2) A performing provider is the provider of a service or item. A billing provider is a person or business entity who/which submits claims on behalf of a performing provider. All references to "provider" in this and other rules of the Medical Assistance Program include both performing and billing providers.

(3) An individual or organization must meet applicable licensing and/or regulatory requirements set forth by Federal and State statutes, regulations, and rules to be enrolled and to bill as a provider. 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.

(4) An individual or organization who is currently subject to sanction(s) by the Medical Assistance Program or Federal government is not eligible for enrollment (see Provider Sanctions).

(5) A performing provider number will be issued to an individual or organization providing covered health care services or items upon:

(a) Completion of the application and submission of the required documents;

(b) The signing of the provider application by the provider or a person authorized by the provider to bind the organization or individual to compliance with these rules;

(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) Approval of the application by OMAP or the Division responsible for enrolling the provider.

(6) Performing providers may be enrolled retroactive to the date services were provided to a Medical Assistance client if:

(a) The provider was appropriately licensed, certified and/or otherwise met all Medical Assistance Program requirements for providers 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.

(7) Issuance of a provider number establishes enrollment of an individual or organization as a provider for limited category(ies) of services for the Medical Assistance Program.

(8) If a provider changes address, business affiliation, licensure, ownership or certification, the Medical Assistance Program must be notified in writing within 30 days of the change. Payments made to providers who have not furnished such notification may be recovered.

(9) Providers of services outside the state of Oregon will be enrolled under the following conditions:

(a) The provider is appropriately licensed and/or certified and meets standards established within the provider's state for participation in the state's Medicaid program. Disenrollment from the other state's Medicaid program is a basis for disenrollment in the Oregon Medical Assistance Program;

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

(c) For non-continguous out-of-state providers the services provided must be for a specific Oregon Medicaid client who is temporarily outside Oregon or the contiguous area of Oregon;

(d) The services for which the provider bills are covered services under the Oregon Medical Assistance Program;

(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.

(10) Enrollment of Billing Providers:

(a) A billing provider (BP) number may be issued to a person or business entity who/which submits claims to the Medical Assistance Program and/or receives payments from the Medical Assistance Program on the behalf of a professional provider (e.g., physician, physical therapist, speech therapist);

(b) A billing provider number will be issued only to billing providers billing on behalf of providers who have signed the provider enrollment form, who have met the licensure or other standards for enrollment as a provider and who have been authorized by the provider to bill on behalf of the provider of service;

(c) A billing provider must maintain, and make available to the Medical Assistance Program, upon request, records indicating the billing provider's relationship with the provider of service;

(d) Effective with claims billed for services beginning on or after January 1, 1994, the Billing Provider must obtain signed confirmation from the performing provider that the Billing Provider has been authorized by the Performing Provider to submit claims. This authorization must be maintained in the Billing Provider's files for at least five years, following the submission of claims to OMAP.

(11) A provider's enrollment may be terminated if no claims have been submitted in an 18 month period. The provider must reapply for enrollment.

(12) The provision of health care services or items to clients of the Medical Assistance Program is a voluntary action on the part of the provider.

(13) 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 through 410-120-1840 to determine whether the provider's Medical Assistance Program number will be revoked.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-060; 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 461-13-063, 461-13-075 & 461-13-180; 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 410-120-020, 410-120-040 & 410-120-060; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1280

Billing

(1) Usual Charges. The provider must not bill the Medical Assistance Program more than the provider's Usual Charge (See Definitions).

(2) Provisions Regarding Billing of Clients. A provider must not seek payment from a Medical Assistance client or any financially responsible relative or representative of that individual for any service covered by Medicaid fee-for-service or through contracted managed care plans, including any co-insurance, co-pays, and deductibles, except under the circumstances described below:

(a) The health service or item is "Not Covered" by the Medical Assistance Program (see Medical Assistance Benefits: Excluded Services and Limitations). The client must be informed in advance of the receipt of the service that it is not covered and that the client or the client's family is or may be financially responsible for payment for the specified services;

(b) The client is not eligible for Medical Assistance at the time the service(s) or item(s) were provided, and is not made eligible retroactively;

(c) The client has no inpatient or outpatient hospital benefits. The provider may bill the client even though OMAP may request that a claim for services be submitted for rate setting purposes;

(d) The payment is the financial responsibility (spend-down) of a Medical Assistance Client under the Medically Needy Program;

(e) The client did not tell the provider that he/she had Medical Assistance Program coverage either at the time the service was provided or subsequent to the provision of the service and, as a result, the provider could not bill the Medical Assistance Program in accordance with the Timely Submission of Claims rule. The provider must document attempts to obtain information from the client on potential Medical Assistance Program coverage;

(f) The client did not tell the provider that he/she had Medical Assistance Program coverage prior to the delivery of the service, the service required authorization prior to the delivery of the service, and Medical Assistance Program staff will not retroactively authorize;

(g) The client did not tell the provider that he/she had other insurance coverage and the third party insurer will not make payment because of lack of timeliness or lack of prior authorization. The Medical Assistance Program will not make payment on a service which would have been covered by another insurer if the client had informed the provider in a timely manner of the other insurance;

(h) A third party resource makes payments directly to the client for medical services;

(i) The provider is not enrolled with the Oregon Medical Assistance Program and has advised the client prior to the delivery of services that the client may be responsible for payment;

(j) The client did not tell the provider that he/she currently had Medical Assistance Program coverage before or at the

time the service was provided and entered into a pay arrangement before or at the time service was provided. The provider must document the client's statement of no Medical Assistance Program coverage and acceptance of payment responsibility before the service is provided.

(3) All claims must be billed on the appropriate form as described in the individual provider guide.

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

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

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

(7) A claim may not be submitted prior to delivery of service. A claim may not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in OMAP's individual provider guides.

(8) 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 guide for specific instructions and requirements. Also, see "Valid Claim" in the Definitions Section of these rules.

(9) For claims requiring a procedure code the provider must bill as instructed in the appropriate Medical Assistance provider guide, and must use the appropriate CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, or OMAP Unique code which best describes the specific service or item provided. For claims which require the listing of a diagnosis and/or procedure code as a condition of payment, the code listed on the claim form must be the code which most accurately describes the patient's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual provider guide. Hospitals must follow national coding guidelines:

(a) Where there is no appropriate descriptive procedure code to bill the Medical Assistance Program the provider must use the code for "Unlisted Services". Instructions on the specific use of "unlisted services" are contained in the individual provider guides. A complete and accurate description of the specific care, item, or service must be documented on the claim;

(b) 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 Medical Assistance Program using that code rather than itemizing the services under multiple codes. Providers must not "unbundle" services in order to increase payment by the Medical Assistance Program.

(10) No person shall submit or cause to be submitted to the Medical Assistance Program:

(a) Any false claim for payment;

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

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

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

(11) The provider is required to submit an Individual Adjustment Request on any claim where the provider identifies an overpayment made by the Medical Assistance Program or to refund the amount of the overpayment.

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

(13) Billing and Payment from Other Resources and Potential Third Party Coverage:

(a) When the client has third party medical coverage indicated on the Medical Care Identification or through AIS, or other coverage which is known to the provider, the provider must bill the third party resource prior to billing the Medical Assistance Program, except under the following circumstances:

(A) When another party may be liable for an injury or illness (see definition of Liability Insurance), the provider may bill the insurer or liable party or place a lien against a settlement or the provider may bill the Medical Assistance Program. The provider may not both place a lien against a settlement and bill the Medical Assistance Program. The provider may withdraw the lien and bill the Medical Assistance Program within 12 months of the date of service. If the provider bills the Medical Assistance Program, the provider must accept payment made by the Medical Assistance Program as payment in full. The provider must not return the payment made by the Medical Assistance Program in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement;

(B) When the Motor Vehicle Accident Fund (MVAF) is the payer or anticipated payer, the provider may bill the Medical Assistance Program before receiving payment from the Motor Vehicle Accident Fund and indicate the expected payment from the MVAF in the prior payments field of the claim form. An adjustment request must be submitted if the MVAF fails to pay or pays a greater or lesser amount than the expected payment shown on the initial claim;

(C) The provider may bill the Medical Assistance Program for the following items and services and the Medical Assistance Program will bill the third party resource:

(i) Drugs other than home parenteral, home enteral and home intravenous therapy;

(ii) Intermediate Care Facility Services for the mentally retarded;

(iii) Institutional services for the mentally and emotionally disturbed;

(iv) Prenatal and preventive pediatric services;

(v) Services covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered. The provider must first bill the third party insurer. The provider may bill the Medical Assistance Program when payment by the insurer is not made within 30 days of the date of service (see TPR codes in the provider guides).

(D) The provider may bill the Medical Assistance Program directly for services which are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider guide. Documentation must be on file in the provider's records indicating this is a non-covered service. See the individual provider guides for further information on services which must be billed to Medicare first.

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

(c) Except as described in (13), any provider who accepts third party payment for furnishing a service or item to a Medical Assistance client shall:

(A) Submit an Individual Adjustment Request per instructions in the individual provider guides, indicating the amount of the third party payment; or

(B) Make direct payment of the amount of the third party payment to the Medical Assistance Program. When the provider chooses to directly repay the amount of the third party payment to the Medical Assistance program, the

provider must indicate the reason the payment is being made and must submit the check:

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

(ii) A copy of the Remittance Advice showing the original payment by the Medical Assistance Program.

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

(e) The Medical Assistance Program reserves the right to make a claim against any third party payer after making payment to the provider of service. The Medical Assistance Program may pursue alternate resources following payment if it deems this a more efficient approach.

(14) Full Use Of Alternate Resources:

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

(b) 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) Veterans Administration;

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

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

(iv) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or State funded Medical Assistance Program; or

(E) Through other reasonably available resources.

(15) Diagnosis Code Requirement:

(a) A primary diagnosis code is required on all claims, unless specifically excluded in an individual OMAP medical assistance programs' administrative rules;

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

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

Stat. Auth.: ORS Ch. 409

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 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-13-050, 461-13-060, 461-13-090 & 461-13-020; 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 461-13-140, 461-13-150, 461-13-175 & 461-13-180; 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 410-120-040, 410-120-260, 410-120-280, 410-120-300 & 410-120-320; 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

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 which was submitted within 12 months of the date of service, but which was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to OMAP. The provider must provide documentation acceptable to OMAP verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual provider guides. Acceptable documentation is:

(a) A remittance advice from OMAP which 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 OMAP.

(3) Exceptions to the 12-month requirement which may be submitted to OMAP are as follows:

(a) When the Office of Medical Assistance Programs or the client's branch office has made an error which caused the provider not to be able to bill within 12 months of the date of service. The error must be confirmed by the Medical Assistance Program;

(b) When a court or a Hearing Officer has ordered that the Medical Assistance Program make payment;

(c) When a client has been determined to be retroactively eligible for Medical Assistance Program coverage and more than 12 months have passed between the date of service and the determination of the client's eligibility.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-13-080; 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 461-13-145; 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 410-120-340; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1320

Authorization of Payment

(1) Some of the services or items covered by the Medical Assistance Program require authorization before payment will

be made. Some services require authorization before the service can be provided. See the appropriate provider guide for information on services requiring authorization and the process to be followed to obtain authorization. Services for clients identified by OMAP as "medically fragile children", shall be authorized by DHR's Medically Fragile Children's Unit.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one which contains all necessary documentation and meets any other requirements as described in the appropriate provider guides.

(3) The authorizing agency will authorize for the level of care or type of service which meets the client's medical need. Only services which are medically necessary 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 necessity or appropriateness of the service.

(4) The Department and it's authorizing agencies are not required to authorize services or to 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) Upon request by OMAP, the provider cannot produce appropriate documentation to support medical necessity, 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/or 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 and/or the services provided are determined retrospectively not to be medically necessary;

(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 guides.

(5) Payment made for services described in subsections (a) through (g) of this rule will be recovered (see also Basis for Mandatory Sanctions and Basis for Discretionary Sanctions).

(6) Retroactive Eligibility:

(a) In those instances where clients are made retroactively eligible, authorization for payment may be given if (A) through (C) of this rule are met;

(b) Services provided when a Title XIX client is retroactively disenrolled from a plan or services provided after the client was disenrolled from a plan may be authorized if (A) through (C) of this rule are met:

(A) The client was eligible on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules;

(C) The request for authorization is received by the appropriate DHR branch or OMAP within 90 days of the date of service.

(c) 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) Period of Authorization: Authorization of payment is valid for the time period specified on the authorization notice, but not to exceed 12 months.

(8) Payment Authorization for Clients with Other Insurance or for Medicare Beneficiaries:

(a) Medicare: When Medicare is the primary payer for a service, no payment authorization is required, unless specified in the appropriate provider guide;

(b) Private Insurance or Other Third Party Resources: For clients who have other third party resources (Blue Cross, Champus, etc.), payment authorization is required as specified above and in the appropriate provider guides when the other insurer or resource does not cover the service and/or when the other insurer reimburses less than the OMAP rate;

(c) Managed Care Providers: Authorization for some services for clients in SHMOS (Medicare's Social Health Maintenance Organization) is required by the managed care provider. Services which are covered under the Medical Assistance Program but which are not covered under the SHMO's require authorization as specified above and in the appropriate provider guides.

Stat. Auth.: ORS Ch. 409

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 461-13-060; AFS 13-1981, f. 2-27-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-13-041; 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 461-13-106 & 461-13-180; 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 410-120-180; 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

410-120-1340

Payment

(1) The Medical Assistance Program will make payment only to the enrolled provider who actually performs the service or the provider's enrolled billing provider for covered services rendered to eligible clients. Federal regulations prohibit OMAP from making payment to collection agencies. The Medical Assistance Program may require that payment for services be made only after review by the Medical Assistance Program.

(2) Fee-for-service payment rates are set by the Office of Medical Assistance Programs and/or the Division administering the program under which the billed services or items are provided.

(3) Payment rates will be the lesser of the amount allowed by the Medical Assistance Program or the provider's usual charge, except for reimbursement under the DRG methodology for inpatient hospital services. Reimbursement for services, including claims paid at DRG rates, will not exceed any Upper Limits established by Federal regulation.

(4) All out-of-state hospital services are reimbursed at Oregon DRG or fee-for-service rates as published in the Hospital Services Guide unless the hospital provides highly specialized services and has a contract or service agreement with the Office of Medical Assistance Programs for those services.

(5) Payment rates for in-home services provided through SDSD will not be greater than the current Medical Assistance rate for nursing facility payment category 5.

(6) Payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities will be set by Medical Assistance Program staff at a rate:

(a) That is consistent with similar services provided in the State of Oregon; and

(b) Is 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 Program in that state for that service; or

(c) Is the rate established by SDSD for out-of-state nursing facilities.

(7) The Medical Assistance Program will not make payment on claims which have been assigned, sold, or otherwise transferred or on which the billing provider receives a percentage of the amount billed 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.

(8) The Medical Assistance Program will not make a separate payment or co-payment 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 and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services and Home Enteral/Parenteral Nutrition and IV Services provider guides;

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the rules of the appropriate provider guide;

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment and Medical Supplies provider guide;

(d) Influenza immunization serum as described in the Pharmaceutical Services provider guide;

(e) Podiatry services provided under the rules in the Medical-Surgical Services provider guide;

(f) Medical services provided by physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services provider guide;

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies provider guide.

(9) Payment for clients with Medicare:

(a) Payment from the Medical Assistance Program is limited to the Medicare allowed amount less the Medicare payment up to the Medical Assistance Program allowable rate. The amount paid by the Medical Assistance Program cannot exceed the co-insurance and deductible amounts due;

(b) Payment from the Medical Assistance Program for services which are covered Medical Assistance services but are not covered by Medicare is made at the Medical Assistance Program allowable rate.

(10) Payment for clients with other third party resources. Payment is the Medical Assistance Program rate less the third party payment but not to exceed the billed amount.

(11) Payment in Full - Medical Assistance Program payments, including contracted managed care plan payments, unless in error, constitute payment in full. For the Medical Assistance Program this includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding the Medical Assistance Program's 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 provider guides.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; Renumbered from 461-13-061; PWC 833, f. 3-18-77, ef. 4-1-77; Renumbered from 461-13-061; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-13-060; 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 461-13-081, 461-13-085, 461-175 & 461-13-180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-040, 410-120-220, 410-120-200, 410-120-240 & 410-120-320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1360

Requirements for Financial, Clinical and Other Records

The Medical Assistance Program is responsible for analyzing and monitoring the operation of the Medical Assistance Program and for auditing and verifying the accuracy and appropriateness of payment, utilization of services, medical necessity, the quality of care, and access to care. The provider and/or the provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records, shall:

(1) Develop and maintain adequate financial and clinical records and other documentation which supports the specific care, items, or services for which payment has been requested. Payment will be made only for services which are adequately documented. Documentation must be completed before the service is billed to the Medical Assistance Program:

(a) All records must 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 was provided, and the individual who provided the service. Patient account and financial records must 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 is required to maintain adequate records 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;

(b) Clinical records, including records of all therapeutic services, must document the client's diagnosis and the medical need for the service. The client's record must be annotated each time a service is provided and signed or initialed by the individual who provided the service or must clearly indicate the individual(s) who provided the service. Information contained in the record must 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 guides and any pertinent contracts.

(2) Retain the financial, clinical, and other records described in subsections (A) and (B) of this rule for at least five years from the date(s) of service;

(3) Upon written request from the Medical Assistance Program, the Medicaid Fraud Unit, or the Department of Health and Human Services, or their authorized representatives, furnish requested documentation immediately or within the timeframe specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Medical Assistance Program, Medicaid Fraud Unit, or Department of Health and Human Services, 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

provision of such records if, in the opinion of the Program or Unit good cause for such 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 of such access is:

(a) To perform billing review activities; or

(b) To perform utilization review activities; or

(c) To review quality, quantity, medical necessity, and appropriateness of care, items, and services provided; or

(d) To facilitate payment authorization and related services; or

(e) To investigate a client's fair hearing request; or

(f) To facilitate investigation by the Medicaid Fraud Unit or the Department of Health and Human Services; or

(g) Where review of records is necessary to the operation of the program.

(5) Failure to comply with requests for documents and within the specified timeframes means that the records subject to the request may be deemed by the Medical Assistance Program not to exist for purposes of verifying appropriateness of payment, medical necessity, the quality of care, and the access to care in an audit or overpayment determination, and accordingly subjects the provider to possible denial or recovery of payments made by the Medical Assistance Program or to sanctions.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-060; 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 461-13-180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-040; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1380

Compliance with Federal and State Statutes

(1) Compliance with Federal and State Statutes. Submission of a claim for medical services or supplies provided to a Medical Assistance client shall be deemed 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) Title II and Title III of the Americans with Disabilities Act of 1991;

(c) Title VI of the Civil Rights Act of 1964.

(2) Hospitals, nursing facilities, home health care 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 and Medicaid regulations in their state. Submittal to the Office of Medical Assistance Programs (OMAP) of the appropriate billing form requesting payment for medical services provided to a Medicaid eligible client shall be deemed representation to OMAP of the medical provider's compliance with the above-listed laws.

(3) Child Abuse Reporting. Providers described in ORS Chapter 419 (Physicians,including Interns and Residents, Dentists, Licensed Practical Nurses and Registered Nurses, Psychologists, Social Workers, Optometrists, Chiropractors, Naturopaths, Health Department and Mental Health Clinic staff) are required to report suspected child abuse to their local office of the State Office for Services to Children and Families or police, in the manner described in ORS 419.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-060; 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 461-13-160 & 461-13-180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-040 & 410-120-400; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1400

Provider Sanctions

(1) There are two classes of provider sanctions, mandatory and discretionary, as outlined in OAR 410-120-1420, Basis for Mandatory Sanctions, and OAR 410-120-1440, Basis for Discretionary Sanctions.

(2) Except as otherwise noted, provider sanctions will be imposed at the discretion of the Administrator of the Division or Director of the Office whose budget includes payment for the services involved.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-600

410-120-1420

Basis for Mandatory Sanctions

(1) Basis for Sanction:

(a) Medical Assistance Program Sanctions: Mandatory sanctions will be imposed when a provider of medical services has been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act and/or related state laws (or entered a plea of nolo contendere);

(b) Medical Assistance Program Sanctions based on Medicare Sanctions:

(A) Mandatory sanction will be imposed when a provider of medical services is excluded from participation in the Medicare program (Title XVIII) of the Social Security Act, as determined by the Secretary of Health and Human Services;

(B) The provider will be suspended from participation in the Oregon Medical Assistance Program while suspended from participation in the Medicare program.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-620; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1440

Basis for Discretionary Sanctions

(1) Basis for Sanction: Sanction(s) may be imposed on a provider when one or more of the requirements governing provider participation in the Medical Assistance program are no longer met, as determined by the Medical Assistance Program.

(2) Conditions which may result in a 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/her health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrendered his/her license while a formal disciplinary proceeding is pending before such licensing authority.

(e) Been suspended or excluded from participation in a 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 patient'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 and/or contract with the Medical Assistance Program, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the patient;

(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 and/or to furnish as requested, records, or grant access to facilities upon request of the Medical Assistance Program 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 Medical Assistance Program, based on information supplied by the Professional Review Organization, to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Medical Assistance Program;

(m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education. The Medical Assistance program:

(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 which 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 which document the medical necessity, 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 which document charges incurred by a client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records which 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, rule, or regulation;

(s) Submitted claims or written orders contrary to generally accepted standards of medical practice;

(t) Submitted claims for services which exceed that requested or agreed to by the client or the responsible relative or guardian or requested by another medical practitioner;

(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 Medical Assistance client referral; or collected a portion of a service fee from the client, and billed the Medical Assistance Program for the same service;

(w) Submitted false or fraudulent information when applying for a provider number, or failed to disclose information requested on the enrollment application;

(x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from the Medical Assistance Program;

(y) Submitted any claim for payment for which payment has already been made by the Medical Assistance Program 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 Medical Assistance Program;

(aa) Failed to properly account for a Medicaid 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 which 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 Medical Assistance Program;

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

(ff) Collected or made repeated attempts to collect payment from clients for services covered by medical assistance, per OAR 410-120-1280, Billing.

(3) A provider who has been 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 provider or other provider, for any services or supplies provided under Medical Assistance, except those services or supplies provided prior to the date of suspension or termination.

(4) No provider shall submit claims for payment to the Medical Assistance Program for any services or supplies provided by a person or provider entity that has been 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 suspension or termination.

(5) When the provisions of subsections (3) or (4) are violated the Medical Assistance Program may suspend or terminate

the billing provider and/or any individual performing provider within said organization who is responsible for the violation(s).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-095; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-640; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1460

Type, Duration, and Determination of Sanction

(1) Mandatory sanctions:

(a) The provider will be either terminated or suspended from participation in Oregon's Medical Assistance Program (Medicaid and General Assistance);

(b) If suspended, the minimum duration of suspension will be determined by the Secretary of the Department of Health and Human Services, 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 Program longer than the minimum suspension determined by the Secretary of the Department of Health and Human Services.

(2) Discretionary sanctions. The following sanctions may be imposed on a provider by the agency:

(a) The provider may be terminated from participation in Oregon's Medical Assistance Program;

(b) The provider may be suspended from participation in Oregon's Medical Assistance Program for a specified length of time, and/or until specified conditions for reinstatement are met and approved by the state;

(c) The Medical Assistance Program may withhold payments to a provider;

(d) The provider may be required to attend provider education sessions. All costs shall be paid by the sanctioned provider;

(e) The Medical Assistance Program may require that payment for certain services be made only after documentation supporting the services has been reviewed by the Medical Assistance Program;

(f) Any other sanctions reasonably designed to remedy and/or compel future compliance with Federal, State and/or Agency regulations.

(3) The following factors shall be considered 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 peer review groups, licensing boards or a Peer Review Organization; and

(h) Adverse impact on the health of the Medical Assistance clients living in the provider's service area.

(4) When one or more of the requirements identified in this rule 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 through 410-120-1840 to determine whether the provider's Medical Assistance Program number will be revoked. Immediate suspension of a provider will occur to prevent public harm or inappropriate expenditure of public funds. A decision to immediately suspend a provider will be made at the sole discretion of OMAP.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-050; 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 461-13-095 & 461-13-140; 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 410-120-260 & 410-120-660; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1480

Notice of Immediate, Proposed and Final Sanctions

(1) If the Medical Assistance Program makes a decision to sanction a provider, the provider will be notified by certified mail or personal service of the intent to sanction. The provider may appeal this action within 30 days of the date of the notice. The provider must appeal this action separately from any appeal of audit findings and overpayments.

(2) The notice of immediate or proposed sanction shall 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 Medical Assistance Program intends to take;

(d) The provider's right to dispute the Medical Assistance Program's allegations, and submit evidence to support the provider's position; and

(e) The provider's right to appeal the Medical Assistance Program's proposed actions pursuant to OAR 410-120-1560, Provider Appeals through 410-120-1800, Provider Hearings - Postponement.

(3) If the Office of Medical Assistance Programs makes a final decision to sanction a provider the Office of Medical Assistance Programs will notify the provider in writing at least 15 calendar days before the effective date of action.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-680; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1500

Additional Remedy and Other Provisions

(1) The provider may appeal the Medical Assistant Program's proposed sanction(s), or other action the agency intends to take, including but not limited to termination or suspension from participation in the Medicaid funded Medical Assistance Program as well as the State funded portions of the program, pursuant to OAR 410-120-1580, Provider Appeals - Administrative Review. A written notice of appeal must be received by the agency within 30 days of the date sanction notice was mailed to the provider.

(2) Other Provisions:

(a) When a provider has been sanctioned, all other provider entities in which the provider has ownership (5 percent or greater) or control of, may also be sanctioned;

(b) When a provider has been sanctioned, the Medical Assistance Program may notify the applicable professional society, board of registration or licensure, Federal or State agencies, OHP Managed Care Plans and the National Practitioner Data Base of the findings and the sanctions imposed;

(c) At the discretion of the Medical Assistance Program, providers who have previously been terminated or suspended may not be re-enrolled as providers of Medicaid services;

(d) Nothing in this rule shall prevent the agency from simultaneously seeking monetary recovery and imposing sanctions against the provider;

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

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-700; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1520

Denial or Recovery of Reimbursement Resulting from Medical Review

(1) The Medical Assistance Program's medical staff or medical review contractor may review a claim before or after payment for assurance that the specific care, item or service was provided in accordance with the Medical Assistance Program's policy and rules and the generally accepted standards of a provider's field of practice or specialty.

(2) Payment may be denied or subject to recovery if medical review determines the service does not meet the criteria for medical necessity, quality of care, or appropriateness of the care or payment. Related practitioner and hospital billings will also be denied or subject to recovery.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: AFS 4-1984, f. & ef. 2-1-84; AFS 38-1986, f. 4-29-86, ef. 6-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-13-189; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-720; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1540

Recovery of Overpayments to Providers

(1) When the Medical Assistance Program determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery:

(a) To determine the overpayment amount, the Medical Assistance Program may use the random sampling method such as that detailed in the paper entitled "Development of a Sample Design for the Post-Payment Review of Medical Assistance Payments," written by Lyle Calvin, Ph.D., ("Calvin Paper"). The Medical Assistance Program hereby adopts by reference, but is not limited to, the method of random sampling described in the Calvin Paper;

(b) After the Medical Assistance Program determines an overpayment amount by the random sampling method set forth in subsection (a) of this rule, the provider may request a 100 percent audit of all billings submitted to the Medical Assistance Program for services provided during the period in question. If a 100 percent audit is requested:

(A) Payment and arrangement for a 100 percent audit is the responsibility of the provider requesting the audit; and

(B) The audit must be conducted by a certified public accountant who is knowledgeable with the Oregon Administrative Rules covering the payments in question, and must be conducted within 120 calendar days of the request to use such audit in lieu of the Medical Assistance Program's random sample.

(2) The amount of medical review overpayment to be recovered:

(a) Will be the entire amount determined or agreed to by the Medical Assistance Program; and

(b) Is not limited to amount(s) determined by criminal or civil proceedings;

(c) Will include interest to be charged at allowable State rates.

(3) The Medical Assistance Program will deliver to the provider by registered or certified mail or in person a request for repayment of the overpayment and the documentation to support the alleged amount.

(4) If the provider disagrees with the Medical Assistance Program's determination and/or the amount of overpayment the provider may appeal the decision by requesting a contested case hearing or administrative review:

(a) A written request for hearing or administrative review of the decision being appealed must be submitted to the Medical Assistance Program by the provider pursuant to OAR 410-120-1660, Provider Appeal - Hearing Request. The request must specify the area(s) of disagreement;

(b) Failure to request a hearing or administrative review in a timely manner constitutes acceptance by the provider of the amount of the overpayment.

(5) The overpayment is due and payable 30 calendar days from the date of the decision by the Medical Assistance Program:

(a) An additional 30 day grace period may be granted the provider upon request to the Medical Assistance Program;

(b) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due.

(6) The Medical Assistance Program may extend the reimbursement period or accept an offer of repayment terms. Any change in reimbursement period or terms must be made in writing by the Medical Assistance Program.

(7) If the provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Medical Assistance Program may:

(a) Recoup future provider payments up to the amount of the overpayment; and/or

(b) Pursue civil action to recover the overpayment.

(8) As the result of a hearing or review the amount of the overpayment may be reduced in part or in full.

(9) The Medical Assistance Program may, at any time, change the amount of the overpayment upon receipt of additional information. Any changes will be verified in writing by the Medical Assistance Program. Any monies paid to the Medical Assistance Program which exceed an overpayment will be refunded to the provider.

(10) If a provider is terminated or sanctioned for any reason the Medical Assistance Program may pursue civil action to recover any amounts due and payable to the Medical Assistance Program.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: AFS 87-1980, f. 12-8-80, ef. 1-1-81; Renumbered from 461-13-111; 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 52-1988, f. & cert. ef. 8-4-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-13-190; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-740; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1560

Provider Appeals

A provider may appeal certain decisions affecting the provider made by the Medical Assistance Program by requesting an administrative review, or a contested case hearing; as outlined in OAR 410-120-1580, Provider Appeals - Administrative Review, through 410-120-1840, Role of Hearing Officer.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-780; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1580

Provider Appeals - Administrative Review

(1) An administrative review allows an opportunity for the Director of the Medical Assistance Program or designee to reconsider a decision affecting the provider. The appeal may include the provision of new information or other actions that may result in the Medical Assistance Program, or prepaid health plan contractor, changing its decision. The provider must specify in the request for review the issues or decisions being appealed and the reason for the appeal on each issue or decision.

(2) The Director of OMAP or designee will decide which decisions may be reviewed under this rule. If the Director denies a request for an administrative review, the provider may within thirty days of the denial make a written request for a contested case hearing subject to OAR 410-120-1620, Provider Appeals - Appeal of Payment Decisions.

(3) A written request for an administrative review must be received by the Director of OMAP within 30 days of the date of the decision affecting the provider. If the Director decides that a meeting between the provider and Medical Assistance Program staff is required, the Director will notify the provider requesting the review of the date, time, and place the review meeting is scheduled.

(4) The review meeting will be conducted in the following manner:

(a) It will be conducted by the Director of the Office of Medical Assistance Programs, 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 and will be given ample opportunity to present relevant information;

(d) Medical Assistance Program staff will not be available for cross examination;

(e) The provider making the appeal may be requested by the Director of OMAP or designee, 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 all providers involved in the review, in writing, within 30 days of the Administrative Review decision.

(6) All administrative review decisions are subject to judicial review under ORS 183.484 in the Circuit Court.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-191 & 461-13-220; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-800; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1600

Provider Appeals -- Contested Case Hearings

(1) OAR 410-120-1620, Appeal of Payment Decisions, to OAR 410-120-1840, Role of the Hearing Officer, are the procedural rules applying to contested case hearings conducted by the Medical Assistance Program.

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

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-191 & 461-13-225; 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 410-120-820

410-120-1620

Provider Appeals - Appeal of Payment/Sanction Decisions

Providers may appeal:

(1) A denial of or limitation of payment allowed for services or items provided;

(2) A denial of provider's application for or continued participation in the Medical Assistance Program; or

(3) Sanctions imposed, or intended to be imposed, by the Medical Assistance Program on a provider or provider entity; and

(4) Overpayment determinations.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-840; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1640

Provider Appeals - Hearing Definitions

For purposes of hearings held under OAR 410-120-1620, Provider Appeals - Appeal of Payment Decisions, to 410-120-1840, Provider Appeals - Role of the Hearing Officer, the following terms have these meanings:

(1) "Provider": A person or business entity who/which has requested a hearing. The term provider may also refer to the provider's representative where appropriate.

(2) "Medical Assistance Program": Refers to the Division or Office within the Department of Human Resources whose administrative action is being contested.

(3) "Medical Assistance representative": The Assistant Attorney General who represents the Medical Assistance Program, or a person designated by the Medical Assistance Program to act as a representative at the hearing.

(4) "Party": The provider, prepaid health plan provider, or the Medical Assistance Program (even though the Medical Assistance Program is not legally a party in these proceedings).

(5) "Prepaid Health Plan Provider": A Managed Care Plan that contracts with the Medical Assistance Program to provide services to clients, whose action is being contested.

(6) "Request for a hearing": A clear, written expression from the provider expressing disagreement with a decision by the Medical Assistance Program. The provider must specify the issues or decisions being appealed and the reason for the appeal on each issue or decision.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-860; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1660

Provider Appeals -- Hearing Request

(1) A request for a hearing is considered filed when the written request is received by the Director of OMAP or by the person designated by the Director.

(2) To be timely, a hearing request must be postmarked not later than 30 days following the date of the notice of adverse action.

(3) An untimely hearing request will be denied after consideration by the Hearing Officer, unless it was untimely due to circumstances beyond the control of the provider.

(4) A hearing will be denied, by order, upon the determination by the Hearing Officer that the issue being protested is not subject to the hearing process.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: 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 461-13-195; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-880

410-120-1680

Client Appeals

(1) For all Medical Assistance Program clients: Medical Assistance clients have a right to a hearing under OAR 461-025-0305 through 461-025-0370, and 461-025-0380, to appeal denial of Medical Assistance service coverage and to appeal premium issues.

(2) A request for a hearing under Subsections (1) or (2) of this rule must be submitted, in writing, using the designated form, to the branch office responsible for the client's eligibility determination.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

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 461-13-053; 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 410-120-760; HR 7-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97

410-120-1700

Provider Appeals -- Hearing Issues

The Hearing Officer shall determine the issue(s) of the hearing raised by the notice of adverse action, pre-hearing summary, or request for hearing.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-920

410-120-1720

Provider Appeals -- Hearing Evidence

(1) All evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible. The parties may use witness testimony or other evidence to establish the facts of the case. No evidence will be used in the determination of the case other than that made a part of the record.

(2) Except as provided in section (3) of this rule, the parties must submit all documentary evidence and the names of all witnesses to the other party and the hearing officer not later than ten days before the hearing.

(3) The following evidence may be received after the hearing:

(a) Evidence which was identified but cannot be produced by the date of the hearing;

(b) Any rebuttal evidence;

(c) Any evidence which must be obtained and made part of the record in order to assure an accurate and complete hearing.

(4) The burden of presenting evidence to support a fact or position rests on the proponent of the fact or position. Per 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. The provider must submit a claim for payment that is true and accurate and otherwise meets rule requirements. Therefore, the burden of proof is on the provider to establish that a claim for payment meets all Medical Assistance Program requirements, including documentation requirements.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: 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 461-13-210 & 461-13-215; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-940

410-120-1740

Provider Appeals -- Hearing Subpoenas and Depositions

(1) Subpoenas will be issued for witnesses to the extent authorized by law according to the following rules:

(a) Before the hearing:

(A) The Hearing Officer will issue a witness subpoena upon request of any party if it appears that the testimony of the witness will be relevant and not unduly repetitious; the subpoena must be requested in time so that it can be served at least five days prior to the hearing;

(B) The party's attorney of record may issue a witness subpoena;

(C) The party who requests or issues a subpoena for a witness to appear at a hearing shall provide to the witness both a witness fee and mileage reimbursement as prescribed by law for witnesses in civil actions.

(b) After a hearing has begun, if it appears to the Hearing Officer that it is necessary to subpoena a witness in order to hold a fair and complete hearing, the Hearing Officer will issue a subpoena.

(2) Depositions to perpetuate testimony may be requested by a party:

(a) The Hearing Officer may order the testimony of a witness to be taken by deposition. The deposition will be taken in the manner prescribed by law for depositions in civil actions. Testimony taken at a deposition will be admitted only when there is good reason the witness cannot attend the hearing;

(b) A request for a deposition shall provide:

(A) The name and address of the witness whose testimony is desired;

(B) A statement of the need for the deposition;

(C) An explanation of why the witness will be unavailable;

(D) A showing that the expected testimony is material to the case;

(E) The name of the official who will take the testimony of the witness; and

(F) The date, time, and place set for the proposed deposition.

(c) The parties may agree to a deposition to perpetuate testimony of a witness.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: 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 461-13-210 & 461-13-215; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-960

410-120-1760

Provider Hearings -- Withdrawals

A provider may withdraw a hearing request at any time. The withdrawal is effective when received by the Medical Assistance Program. The Hearing Officer will issue an order dismissing the case following a withdrawal.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-980

410-120-1780

Provider Hearings -- Dismissals

(1) A hearing shall be dismissed by order when:

(a) The provider fails to appear for the scheduled hearing within 15 minutes of the scheduled time set for the hearing;

(b) The notice of hearing cannot be delivered by certified mail to the provider or the provider's representative at their last known addresses;

(c) Otherwise provided by rule.

(2) The hearing shall be rescheduled if:

(a) A written request is received by the Medical Assistance Program within ten work days after receiving the scheduled hearing date; and

(b) The reasons for missing the hearing and for not requesting a postponement from the hearing officer prior to the time of the scheduled hearing were beyond the control of both the party and the party's representative.

(3) Once a hearing is dismissed, any subsequent request is considered a new request, subject to the rules regarding timeliness of hearing requests.

(4) Once a hearing is dismissed, the action or proposed action which led to the hearing request may be taken as if a hearing had not been requested. An order of dismissal is the final agency decision in the case until amended by the Medical Assistance Program in an order on reconsideration or modified by a court of law.

(5) A dismissal may be rescinded if the dismissal was improper or caused by reasons beyond the control of the provider.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-1000

410-120-1800

Provider Hearings -- Postponement

Any party may request a postponement of the scheduled hearing. This shall not exceed 30 days unless stipulated to by all parties.

(1) The hearing officer will grant a postpone-ment of the hearing:

(a) Upon a showing by the party that for reasons beyond their control they:

(A) Cannot attend the scheduled hearing; or

(B) Cannot obtain necessary evidence; or

(b) If any party requests, and all agree, to a postponement.

(2) Reasons which are beyond the control of the parties include but are not limited to:

(a) A breakdown in transportation with no alternative;

(b) Inclement weather which prevents travel;

(c) Any other adverse circumstances which precludes the provider's or the Medical Assistance Program's representative from attending the hearing.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: 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 461-13-200; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-1020

410-120-1820

Provider Hearings -- Hearing Attendance and Notice

(1) Hearings will be held in Salem, unless otherwise stipulated to by all parties.

(2) The Hearing Officer may exclude from the hearing those persons whose presence is not considered essential to the proceedings depending upon all the circumstances of the case. The following persons are normally authorized to attend the hearing:

(a) The provider;

(b) Any person charged with recording the proceedings;

(c) Any witness while giving testimony;

(d) The attorney representing any party;

(e) Any Medical Assistance Program represen-tative;

(f) Any prepaid health plan representative, if a party to the proceedings;

(g) Any other person deemed necessary by the Hearing Officer.

(3) The hearing scheduling notice will be mailed by the Hearing Officer to the provider, the provider's attorney, and the Medical Assistance Program representative at least 20 days prior to the scheduled hearing date.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-1040

410-120-1840

Provider Hearings -- Role of the Hearing Officer

The hearing is conducted by an impartial person who has not been involved in the initial determination of the action in question. The Hearing Officer, in addition to statutory responsibilities, is responsible to:

(1) Administer oaths to all witnesses and record all testimony given at the hearing.

(2) Determine and explain the issues which are being contested.

(3) Explain the matters that the parties must either prove or disprove.

(4) Request, receive, and make part of the record all evidence determined by the Hearing Officer to be necessary to dispose fairly of the issues.

(5) Regulate the conduct of the hearing consistent with applicable rules.

(6) Question any testimony or other evidence and examine all witnesses as necessary.

(7) Write hearing orders.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-1060

410-120-1860

Client Appeals

(1) For all Medical Assistance Program clients:

(a) Medical Assistance clients have a right to a hearing under OAR 461-025-0305 through 461-025-0370, and 461-025-0380, to appeal denial of Medical Assistance service coverage and to appeal premium issues.

(2) For Medical Management Program clients appeals of an agency decision to be placed in or continued in the Medical Management Program shall be according to OAR 461-025-0305 through OAR 461-025-0385.

(3) A request for a hearing under Subsections (1) or (2) of this rule must be submitted, in writing, using the designated form, to the branch office responsible for the client's eligibility determination.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 409.010

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 461-13-053; 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 410-120-760; HR 7-1996, f. 5-31-96 & cert. ef. 6-1-96

410-120-1870

Client Premium Payments

Client premium arrearages will be carried forward for three years per OAR 461-135-1120. After three years, the amount due will be considered uncollectible. OMAP or SDSD Accounting may certify to the Secretary of State, according to procedures specified in ORS 293.235, 293.240 and 293.245, that certain premium debts are uncollectible.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 414.065

Hist.: HR 7-1996, f. 5-31-96, cert. ef. 6-1-96

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 agency in the following classes of hearings:

(a) Denial of Medical Assistance service coverage;

(b) Denial of prior authorization of payment.

(2) Legal argument as used in ORS 183.450(8) and this rule has the same meaning as defined in OAR 137-003-0008(1)(c) and (d).

(3) When an agency officer or employee represents the agency, the presiding officer shall 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 shall provide reasonable opportunity for the agency officer or employee 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 Chapter 409

Statutes Implemented: 414.065

Hist.: HR 8-1996, f. 5-31-96, cert. ef. 6-1-96

410-120-1880

Contracted Services

Contracts may be implemented for covered services in any program area(s) of the Medical Assistance Program in order to achieve one or more of the following purposes:

(1) To implement and maintain prepaid health plan services.

(2) To ensure access to necessary medical services which would otherwise not be available.

(3) To more fully specify the scope, quantity, and/or quality of the services to be provided and/or to specify

requirements of the provider or to specify requirements of the Medical Assistance Program in relation to the provider.

(4) To obtain services more cost effectively, i.e., to reduce the costs of program administration and/or to obtain comparable services at less cost than the fee-for-service rate.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.085, 414.135 & 414.725

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 461-13-172; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-580

410-120-1920

Institutional Reimbursement Changes

The Medical Assistance Program is required under federal regulations, **42 CFR 447**, to submit specific assurances and related information to the Health Care Financing Administration whenever it makes a material change in its methods and standards for setting payment rates for inpatient hospital services or long-term care facilities. Federal regulation also specifies that a public notice will be published in the newspaper of widest circulation in each city with a population of 50,000 or more when the change being made is a Significant Change. A "Significant Change" is defined as a change in payment rates which 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.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 409.010

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 461-13-006; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-380

410-120-1940

Interest Payments on Overdue Claims

(1) Upon request by the provider, the Medical Assistance Program will pay interest on an overdue claim:

(a) A claim is considered "overdue" if not paid by the Medical Assistance Program 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 the Medical Assistance Program 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 the Medical Assistance Program;

(f) Amount of billing on initial valid claim;

(g) Medical Assistance Program 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 Ch. 409

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 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-13-185; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-360

410-120-1960

Payment of Private Insurance Premiums

(1) Instead of paying providers directly, the Medical Assistance Program may pay insurance policy premiums or otherwise enter into agreements with other health insurance plans when it determines that payment of premiums and/or co-insurance and deductibles is likely to be cost effective, i.e., that the estimated net cost to the Medical Assistance Program will be less than the estimated cost of paying providers on a fee-for-service or other basis.

(2) The Medical Assistance Program will assure that all Medicaid covered services continue to be made available to eligible individuals for whom the Medical Assistance Program elects to purchase insurance.

(3) Payment of insurance policy premiums for Medicaid clients or eligible applicants will allow for the purchase of or continuation of a client or eligible applicant's coverage by another third party.

(4) Assessment of cost effectiveness will include:

(a) The past utilization experience of the client/eligible applicant as determined by past Medical Assistance and third party insurance utilization and claims data; and

(b) The current and probable future health status of the client/eligible applicant based upon existing medical conditions, previous medical history, age, number of dependents, and other relevant health status indicators; and

(c) The coverage of benefits, premium costs, copayments and coinsurance provisions, restrictions and other policies of the health insurance plans being considered.

(5) The Medical Assistance Program may purchase documents or records necessary to establish or maintain the client's eligibility for other insurance coverage.

(6) The Medical Assistance Program will not make payments for any benefits covered under the health insurance plan, except as follows:

(a) The Medical Assistance Program will calculate the Medical Assistance Program's allowable payment for a service.

The amount paid by the other insurer will be deducted from the OMAP allowable. If the OMAP allowable exceeds the third party payment, OMAP will pay the provider of service the difference;

(b) The payment made by OMAP will not exceed any co-insurance, co-payment or deductible due;

(c) OMAP will make payment only for covered services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.115

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 461-13-170; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-500 & 410-120-520

410-120-1980

Requests for Information and Public Records

(1) Non-exempt public records will be made available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) If copies of non-exempt public records are requested, a charge will be made to the requestor to cover actual costs. The charge must be paid before the requested copies are released. The charges will be based on the following:

(a) If the request for copies involves minimal staff time, the charge will be 20 cents a page;

(b) If the request is for ten pages or more and requires 15 minutes or more of staff time, the requestor will be charged for the actual cost of staff time taken to search, glean and edit the records, for computer costs if required, and for photocopying at 20 cents a page. The minimum hourly charge for staff time will be $8;

(c) When an Attorney General's review or consultation is required by OMAP, an additional charge will be made to cover the cost of that service.

(3) Part or all of the actual charges may be waived when the services provided will directly benefit OMAP or a client has need for copies of records and cannot afford the fee.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 192.410 - 192.500

Hist.: HR 32-1993, f. & cert. ef. 11-1-93

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 121

PHARMACEUTICAL SERVICES

410-121-0000

Foreword

(1) The **Pharmaceutical Services Guide** is a user's manual designed to assist providers in preparing claims for services provided to medical assistance clients. This **Guide** must be used in conjunction with the General Rules for Oregon Medical Assistance Programs.

(2) Instructions on completing claims forms, Administrative Rules and examples of some completed forms are included in this **Guide**. An **Appendices Section** listing NDC codes and their definitions, restrictions and limitations is also included.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

NOTE: Administrative rules and billing guidelines for Home Enteral/ Parenteral Nutrition and IV services have been removed from the **Pharmaceutical Services Provider Guide** and have been included in the newly published **Home Enteral/Parenteral Nutrition and IV Services Guide**. To request a copy of this guide, contact Provider Enrollment.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 409.010

Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90

410-121-0040

Prior Authorization is Required for the Following Drugs and Products

(1) Pharmacy providers are responsible for obtaining prior authorization for the following drugs and products:

(a) Isotretinoin (Accutane) and Retinoic Acid (Retin A);

(b) All legend laxatives: Cephulac and Chronulac and their generic equivalents;

(c) All over-the-counter medications except those listed in the Appendices;

(d) Growth hormone;

(e) Nutritional supplements.

(2) Prescribing practitioners are responsible for obtaining prior authorization for the following drugs and products:

(a) Acute anti-ulcer therapy;

(b) Antihistamines (non-sedating);

(c) Nasal Inhalers (selected);

(d) Antifungal(selected);

(e) Weight reduction drugs;

(f) Excessive daily doses.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

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 461-16-170; 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

410-121-0060

How to Get Prior Authorization for Drugs

(1) To request prior authorization of payment either the prescribing practitioner or pharmacy provider calls the Automated Information System. If the system is unavailable call the Technical Help Desk and a representative will take the request.

(2) The caller will be informed through the AIS if the request is approved, denied or if a previous request has already been approved. If there is already a current prior authorization, any pharmacist may dispense the product and bill for it.

(3) If the request is approved, it is the pharmacist'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 prior authorization. The pharmacy should also check for restriction to a different pharmacy or if the client is enrolled in a prepaid health plan. A restriction may have taken place after prior authorization was received.

(4) Prior authorization is given for a specific date of service and (other than anti-ulcer medication) specific NDC number or product.

(5) Emergency dispensings will be prior authorized for a ten-day supply.

(6) An emergency dispensing may be issued for clients who are not enrolled in a fully capitated health plan when:

(a) The pharmacist is unable to contact the prescribing practitioner for medical necessity; or

(b) The pharmacy the client is restricted to is closed or does not have the prescribed product.

Stat. Auth.: ORS Ch. 409

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 461-16-180; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95

410-121-0061

Durable Medical Equipment and Medical Supplies

(1) Follow the guidelines in the **Durable Medical Equipment and Medical Supplies (DME)** and **Home Enteral/Parenteral Nutrition and IV Services Guides** for prior authorization of these items and services.

(2) Medical supplies for home enteral/parenteral nutrition and IV services are listed in the **Home Enteral/Parenteral Nutrition and IV Services Guide**.

(3) You may bill for the above items and services using your pharmacy provider number.

(4) Bill Medicare first for qualified clients.

(5) Use the HCFA-1500 or OMAP 505 billing forms, as outlined in the above guides.

Stat. Auth.: ORS Ch. 409

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

410-121-0080

ProspectiveDrugTherapyReviewof Continuing Antiulcer Therapy - Effective for Services Provided on or after June , 1997

(1) A prior authorization is required after the initial eight weeks of acute antiulcer therapy when dosages exceed those shown below:

(2) Daily Dosages:

(a) Zantac (ranitidine) - less than 151 mg;

(b) Tagamet (cimetidine) - less than 401 mg;

(c) Pepcid (famotidine) - less than 21 mg;

(d) Axid (nizatidine) - less than 151 mg;

(e) Carafate (sucralfate) - less than 2 Gm;

(f) Prilosec (omeprazole) - less than 9 mg;

(g) Prevacid (lansoprazole) - less than 14 mg.

(3) How the Program functions:

(a) The prescribing practitioner selects the product of his/her choice to initiate acute or maintenance antiulcer therapy. The prescriber will request prior authorization for an acute dosage lasting longer than the initial eight weeks through the First Health Services PA Help Desk Pharmacist. Maintenance dosages listed in (2) do not require prior authorization;

(b) A claim for any acute dosage may be submitted against a prior authorization for any listed acute antiulcer drug.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; 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 16-1997, f. & cert. ef. 7-3-97

410-121-0100

Drug Use Review

(1) Drug Use Review (DUR) in Oregon Medicaid is a program designed to measure and assess the proper utilization, quality, therapy, medical necessity, 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, underutilization, 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 Drug Use Review program which identifies an individual is confidential and may not be disclosed by the Oregon State Medicaid Drug Use Review Board or the Retrospective Drug Use Review Council to any person other than health care providers appearing on a recipient's medication profile;

(b) Staff of the above-mentioned Board and Council may have access to identifying information to carry out intervention activities approved by OMAP, after signing an agreement to keep the information confidential. The identifying information may not be released to anyone other than DUR staff members of the Board or Council, or health care providers appearing on a recipient's medication profile. Identifying information is defined for the purposes of drug use review as names of prescribers, pharmacists and/or recipients.

(2) Prospective Drug Use Review:

(a) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is done at the point of sale by the dispensing pharmacist. Each dispensing pharmacist must offer to counsel each OMAP client receiving benefits (or the caregiver of such individual), who presents a prescription, unless the client refuses such counsel. Pharmacists must document these refusals. Counseling must be done in person, whenever practicable. 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 drug use review is not required for drugs dispensed to residents of nursing facilities or for drugs dispensed by HMOs;

(c) See Board of Pharmacy rule OAR 855-041-0100 for specific requirements relating to patient counseling,

recordkeeping and screening;

(d) Pharmacists should rely on criteria and standards provided through periodic electronic or provider letter notifications and the compendia shown in this rule for information in relation to prospective DUR screening.

(3) Retrospective Drug Use Review: Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. Through this program the Office of Medical Assistance Programs provides a professional drug therapy review for Medicaid clients. The criteria used in retrospective DUR are com-patible with those used in prospective DUR. The drug therapy review is carried out by a panel of Oregon licensed physicians and pharmacists appointed by the Director of the Office of Medical Assistance Programs. Members of this panel are referred to as council members. This service is called Drug Use Review of Ore-gon (DURO). If therapy problems are identified by the review council, a letter of notification is mailed to the prescribing provider, the dispensing provider, or both. Other forms of education are carried out under this program with OMAP approval.

(4) The Oregon State Medicaid Drug Use Review Board:

(a) The Oregon State Medicaid Drug Use Review Board is a group of individuals who comprise an advisory committee to the Office of Medical Assistance Programs (OMAP):

(A) The Oregon State Medicaid Drug Use Review Board is comprised of health care professionals with recognized knowledge and expertise in one or more of the following areas:

(i) Clinically appropriate prescribing of outpatient drugs covered by Medicaid;

(ii) Clinically appropriate dispensing and monitoring of outpatient drugs covered by Medicaid;

(iii) Drug use review, evaluation and intervention;

(iv) Medical quality assurance.

(B) The Board's membership is made up of at least 1/3 but not more than 51 percent licensed and actively practicing physicians and at least 1/3 licensed and actively practicing pharmacists. The Board is composed of not more than five practicing pharmacists, five practicing physicians, two persons who represent people on Medical Assistance and one person actively practicing dentistry. The retrospective DUR Coordinator will attend board meetings in an ex-officio capacity. Appointments to the Board are made by the OMAP Director. Nominations for Board membership may be sought from various professional associations and each member may serve a two-year term;

(C) When a vacancy occurs a new member is appointed to serve the remainder of the unexpired term;

(D) An individual appointed to the Board may be reappointed upon the completion of his/her term;

(E) Members of the Board receive no compensa-tion for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account.

(b) The Board is designed to develop policy recommendations in the areas specified below in relation to Drug Use Review (DUR);

(c) Appropriateness of criteria and standards for prospective and retrospective DUR and needs for modification of these areas. DUR standards are professionally developed expressions of the range of acceptable variation from a criterion. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medically necessity, and appropriateness of health care service may be compared. Criteria and standards will be consistent with the following compendia:

(A) American Hospital Formulary Services Drug Information;

(B) U.S. Pharmacopeia-Drug Information;

(C) American Medical Association Drug Evaluations;

(D) Peer-reviewed medical literature.

(d) Differences between source materials will be resolved through a consensus process;

(e) Recommendations for continued maintenance of patient confidentiality will be sought;

(f) The use of different types of education nd interventions to be carried out as part of retrospective DUR and the evaluation of the results of this portion of the program; and

(g) The preparation of an annual report on Oregon Medicaid DUR Program which describes:

(A) The nature and scope of the DUR program and its Board including a description of how pharmacies without computers comply with prospective DUR, detailed information on new criteria and standards in use and 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 physician visits and hospitalizations.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.355 - 414.380

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

410-121-0140

Definition of Terms

(1) Drug Order/Prescription:

(a) A written prescription, dated and signed by the prescribing practitioner, the elapsed time between the date of writing and date of filling of which is reasonable and appropriate to the drug and to the conditions for which it is ordinarily required; or

(b) An order on a nursing facility chart, dated and signed from the prescribing practitioner; or

(c) A telephone (verbal) order from the prescribing practitioner or his agent, to the pharmacist, which is documented by the pharmacist and filed in the pharmacist's place of business;

(d) All prescriptions and drug orders shall be filed with the pharmacist.

(2) Dispensing: Issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist. OMAP will not make payment for expired drug products.

(3) Estimated Acquisition Cost (EAC). The estimated cost at which the pharmacy can obtain the product. In the absence of actual cost data, OMAP will determine Estimated Acquisition Cost as the lesser of:

(a) Eighty-nine percent of Average Wholesale Price (AWP) of the drug;

(b) Health Care Financing Administration (HCFA) upper limits for drug payment. These prices will be the upper limit on EAC for the HCFA designated drugs as specified by OMAP;

(c) Oregon Maximum Allowable Cost (OMAC). These will be generic bioequivalent drugs which are available from at least two Pacific Northwest drug wholesale companies. When based upon AWP, the OMAC will be 89 percent of that AWP;

(d) Manufacturer's Direct Price (DEAC) for drugs supplied by the following companies:

(A) The Upjohn Company;

(B) Wyeth Laboratories;

(C) Ross Products;

(D) Abbott Laboratories;

(E) Merck, Sharp and Dohme;

(F) Pfizer Laboratories;

(G) Roerig.

(4) Actual Acquisition Cost: The net amount paid per invoice line item to a supplier. This net amount does not include separately identified discounts for early payment.

(5) 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 State Board of Pharmacy.

(6) 30-day Card:

(a) A 30-day blister pack, bingo or punch card containing multiple sealed single doses of medication. This is considered to be a variation of unit dose dispensing when the pharmacy has a system for dispensing and recovery of unused doses that has been approved by the Board of Pharmacy;

(b) If a 30-day card system does not meet the requirements of the Board of Pharmacy for the recovery of unused doses, or for other reasons does not qualify for payment, then that 30-day card system is considered to be a variation (modified unit dose) of bulk dispensing.

(7) Unit Dose Delivery Systems: OMAP currently recognizes two types of unit dose dispensing systems; True Unit Dose and Modified Unit Dose:

(a) The OMAP Pharmacy Program requires that:

(A) Each nursing facility patient's medication be delivered a minimum of five days weekly, or delivery of medical carts every other day with daily (seven days a week) service available;

(B) Only the actual number of drug units used by the recipient during the billing period can be billed. This requires a 30-day billing lag;

(C) Resumption of the same medication after a "stop order" or discontinuance ("DC") order constitutes a new prescription;

(D) The closing date for the monthly billing period shall remain the same for all recipients;

(E) Small quantity prescriptions are allowed only when the closing date for the monthly billing period is interrupted, e.g., hospitalization, new patient admit, etc..

(b) Modified Unit Dose Delivery System (also known as "blister packs", "bingo", "30 day cards", "punch cards"). The OMAP Pharmacy Program requires that:

(A) A pharmacy must deliver each nursing facility patient's medication in sealed single-or multi-dose packages;

(B) A pharmacy must dispense the greater of the quantity prescribed or a 30-day supply, except where short term therapy is specified by the prescriber;

(C) Only the actual number of drug units used by the recipient during the monthly billing period or during the prescribed medication period can be billed. This requires a 30-day billing lag;

(D) The closing date for the monthly billing period shall remain the same for all recipients;

(E) OMAP will be billed on the first day of the month or the first billing date after the closing date, whichever is applicable, for drugs dispensed during the monthly billing period;

(F) Except for controlled substances, all medications returned on or before the last day of the billing period must be credited (deducted from the total charge) to OMAP. Manufacturer's Unit Dose packaging of drugs is NOT reimbursable to Modified Unit Dose providers.

(c) True and Modified Unit Dose providers must:

(A) Supply OMAP with a list of the nursing facilities it will serve under this system;

(B) Sign an agreement to abide by the requirements of the program; and

(C) Keep a separate, detailed Medication Administration Record (MAR) of all medications dispensed for each nursing facility patient served.

(8) Prescription Volume Survey: The annual survey of pharmaceutical providers to determine dispensing rates. This survey documents for each pharmacy the total prescriptions dispensed, the total prescriptions dispensed to Medical Assistance Program clients, and, if used, the type of unit dose system.

(9) Bulk Dispensings: Multiple doses of medication packaged in one container labeled as required by pertinent Federal and State laws and rules.

(10) Prescription Splitting: Any one or a combination of the following actions:

(a) Reducing the quantity of a drug prescribed by a licensed practitioner. In situations where greater than a 34 day supply is prescribed, a pharmacist may dispense a 34 day supply (see OAR 410-121-0146);

(b) Billing the agency for more than one dispensing fee when the prescription called for one dispensing for the quantity dispensed;

(c) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients which, when combined together would represent the prescribed drug, with the exception of compounded medications, (see rule 410-121-0146);

(d) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.

(11) Nursing Facilities - The term Nursing Facility as used in the Pharmaceutical Services provider guide refers to an establishment which is licensed and certified by the Senior and Disabled Services Division as a Nursing Facility.

(12) Compounded Prescriptions - A prescription that is prepared at the time of dispensing and involves the weighing of at least one solid ingredient which must be a compensable item or a legend drug in a therapeutic amount. Compounded Prescription is further defined to include the Board of Pharmacy definition of Compounding.

(13) Automated Information System (AIS) - A computer system which provides on-line Medicaid eligibility information and automatic prior authorization, accessed through the provider's touch-tone telephone.

(14) Point-of-Sale (POS) - A computerized, claims submission process for retail pharmacies which provides an on-line, real-time environment for claims adjudication.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: 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 28-1982, f. 6-17-81, ef. 7-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82; AFS 54-1985(Temp), f. 9-23-85, 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 12-1984, f. 3-16-84, ef. 4-1-84; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 11-1987, f. 3-3-87, ef. 4-1-87; AFS 2-1989(Temp), f. 1-27-89, cert. ef. 2-1-89; AFS 17-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 42-1989, f. & cert. ef. 7-20-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-16-010; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-190; HR 52-1991(Temp), f. 11-29-91, cert. ef. 12-1-91; HR 6-1992, f. & cert. ef. 1-16-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 14-1993, f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 6-1996(Temp), f. & cert. ef. 8-1-96; HR 27-1996, f. 12-11-96, cert. ef. 12-15-96

410-121-0143

Client Confidentiality

Pharmacists are responsible for maintaining the confidentiality of client information. Facilities shall provide adequate privacy for patient consultations.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 16-1992, f. & cert. ef. 7-1-92

410-121-0145

Prescription Requirements -- Effective for Services Provided on or After May 1, 1994

(1) OMAP will make payment for covered drugs supplied on drug order or prescrip-tion of a licensed practitioner and furnished by a pharmacist. Dispensings include new prescriptions, refills of existing prescriptions, and over-the-counter (OTC) medications.

(2) Each drug order or prescription filled for an OMAP client must be retained in the pharmacy's file.

(3) For drugs which require prior authorization, the dispensing pharmacist must enter the diagnosis for which the product is being dispensed on the drug order or prescription and initial the order. The full name of the person who provided the diagnostic information must be shown on the prescription. Only diagnostic information obtained directly from the prescriber or the prescriber's agent is acceptable.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.325

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 461-16-020; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-200; HR 25-1994, f. & cert. ef. 7-1-94

410-121-0146

Dispensing Limitations - Effective for Services Provided On or After June 1, 1997

(1) The quantity indicated by the prescriber on the prescription may not be reduced except when in conflict with the limitations below. OMAP will consider any form of prescription splitting, except as required below in this rule, as a billing offense and will take appropriate action as described in the General Rules.

(2) The following dispensing limitations apply to OMAP reimbursement:

(a) Dispensing, except as otherwise noted in this rule, is limited to the amount prescribed by the physician but not to exceed a 34 day supply of the drug. Exceptions to the 34 days supply limitation are listed below. These drug classes are limited to the amount prescribed by the physician, but not to exceed a 100 day supply of the drug. Exceptions (codes are from First Data Bank's Standarad Therapeutic Classification Codes):

(A) Anticonvulsants, Code 48;

(B) Thyroid Preparation, Code 55;

(C) Rauwolfias, Code 70;

(D) Vasodilators, Coronary, Code 72;

(E) Vasodilators, Peripheral, Code 73;

(F) Digitalis preparations, Code 74;

(G) Xanthine derivatives, Code 75;

(H) Contraceptives, Topical, Code 36;

(I) Contraceptives, Oral, Code 63.

(b) After stabilization of a diabetic, a minimum of a one-month supply of Insulin should be provided per dispensing;

(c) For vaccines available in multiple dose packaging, a dispensing fee will be allowed for each multiple dose vial;

(d) For compounded prescriptions, components of the prescription shall be billed separately. A dispensing fee will be allowed for each component eligible for reimbursement and billed in this manner. Any reimbursement received from a third party for compounded prescriptions must be split and applied equally to each component.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: 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 461-16-090; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-210; 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

410-121-0147

Exclusions and Limitations

(1) Home pregnancy kits are not covered.

(2) Fluoride for individuals over 18 years of age is not covered.

Stat. Auth.: ORS Ch. 409

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

410-121-0148

Dispensing in a Nursing Facility

(1) A pharmacy serving OMAP clients in a nursing facility must dispense medication in a manner consistent with that facility's system of use, i.e., bulk, unit dose or 30-day card system as set forth in ORS Chapter 441.

(2) Pharmacies which do not dispense through a unit dose or 30-day card system may bill OMAP for a dispensing fee for each dispensing of legend drugs to eligible recipients in a nursing facility on a fee-for-service basis.

(3) The pharmacy must submit a written notification to OMAP of the agreement between the pharmacy and the nursing facility. The notice must be received in OMAP by the 15th of the month prior to the month the pharmacy initiates service to a facility. This notice must consist of the following:

(a) A completed Nursing Facility Dispensing Statement (OMAP 3063) signed by the pharmacist in charge, stating the dispensing method to be used for each facility;

(b) The name, address, and telephone number of each facility served by the pharmacy.

(4) Pharmacies dispensing through a unit dose or 30-day card system must bill OMAP only for the medications actually consumed. Only one dispensing fee will be reimbursed per medication dispensed in a 30-day period, for a medication ordered continuously for 30 days or more.

(5) The pharmacy must submit written notification to OMAP through a completed Nursing Facility Dispensing Statement (OMAP 3063) signed by the pharmacist in charge if at least one of the following situations occur:

(a) The percentage level of true or modified unit dose dispensings falls below the percentage level defined in OAR 410-121-160;

(b) The dispensing system changes from unit dose either true or modified, to bulk dispensing or vice versa;

(c) The pharmacy discontinues providing services to a specific nursing facility already on record as being served by the

pharmacy.

(6) Pharmacies may not bill OMAP for repackaging/handling fees. There may only be one billing for each dispensing.

[ED. NOTE: The Form OMAP 3063 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065 & Ch. 441

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 461-16-070; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-230; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94

410-121-0150

Billing Requirements

(1) When billing OMAP for pharmaceuticals, the provider must not bill in excess of the usual and customary charge to the general public.

(2) The National Drug Code (NDC) assigned to the dispensed product as it appears on the package from which the prescribed medications are dispensed must be indicated on the Prescription Drug Invoice OMAP 502 or OMAP 502N. When billing for drug products assigned an OMAP Unique NDC refer to OAR 410-121-0260 and 410-121-0400 for the specific NDCs to use.

(3) The provider must accurately furnish all information required on the OMAP 502 or 502N regardless of how the claim is submitted.

(4) When clients have private insurance, providers may either:

(a) Bill OMAP only, OMAP will bill the private insurance; or

(b) Bill the private insurance as primary and OMAP as secondary.

Stat. Auth.: ORS Ch. 409

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 461-16-093; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-240; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94

410-121-0155

Reimbursement

(1) Payment for legend pharmaceuticals will be the lesser of the amount billed or the Estimated Acquisition Cost (EAC) of the drug dispensed in the generic form, plus a professional dispensing fee.

(2) Pharmacies must make available to OMAP any information necessary to determine the pharmacist's actual

acquisition cost of pharmaceutical goods dispensed to OMAP clients.

(3) Payment may be made for trade name forms of multisource products at the lesser of the amount billed or the EAC of the trade name form of the product, plus a professional dispensing fee, except as outlined below. The prescribing practitioner must certify in his/her handwriting that the item is "brand medically necessary", "medically necessary" or "brand necessary" on the face of the prescription. Rubber stamp, initials, or a box to check to this effect are unacceptable. "Brand medically necessary certification", either on the prescription or on a separate sheet attached to the prescription, must be filed with the prescription by the pharmacist within 30 days of filling the prescription. A faxed copy of the certificate is acceptable.

(4) Payment for individual special admixtures, fluids or supplies shall be limited to the lesser of:

(a) Eighty percent of the usual and customary charges to the general public;

(b) The amount Medicare allows for the same product or service;

(c) The amount the agency negotiates with an individual provider, less any amount paid or payable by another third party; or

(d) The amount established or determined by OMAP.

(5) No professional dispensing fee is allowed for dispensing needles, syringes, condoms, contraceptive foams, suppositories, inserts, jellies and creams, medical supplies and equipment, or food supplements:

(a) Over the counter contraceptive drugs and devices, needles and syringes will be reimbursed at the lesser of billed amount or EAC, plus 50 percent of EAC;

(b) Food supplements will be reimbursed at the lesser of billed amount or EAC, plus 1/3 of EAC;

(c) Medical supplies that can be billed using NDC numbers will be reimbursed at a rate which does not exceed EAC, plus 50 percent of EAC.

(6) Other medical supplies and medical equipment will be reimbursed at a rate which does not exceed the rate at which the item is generally available or as defined in the **Durable Medical Equipment and Medical Supplies Guide**.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-16-100; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-250; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94

410-121-0157

Participation in Medicaid Prudent Pharmaceutical Purchasing Program

(1) The Oregon Medicaid Pharmaceutical Services Program is a participant in the Medicaid Prudent Pharmaceutical Purchasing Program. Pharmaceutical companies participating in this program have signed agreements with HCFA to provide rebates to OMAP on all their drug products. OMAP will reimburse providers only for outpatient drug products manufactured or labeled by companies participating in this program.

(2) A list identifying the pharmaceutical companies providing rebates to OMAP is shown in this guide beginning on page 95. This list is provided in two formats, alphabetically by company name and numerically by manufacturer's code number.

(3) OMAP contracts with First Health Services to manage the Medicaid Rebate Dispute Resolution program. Pharmacy providers must verify the accuracy of their Medicaid pharmacy claims with First Health Services 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. Table 1 [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-121-0160

Dispensing Fees

(1) Unless otherwise provided, the professional dispensing fee allowable for services provided on or after September 1, 1993 is as follows:

(a) $3.80 -- Pharmaceutical providers filling 30,000 or more total prescriptions annually;

(b) $3.93 -- Pharmaceutical providers filling over 15,000 but less than 30,000 total prescriptions annually;

(c) $4.05 -- Pharmaceutical providers filling 1 - 15,000 total prescriptions annually or pharmaceutical providers filling over 15,000 but less than 30,000 total prescriptions annually with greater than 20 percent Medicaid prescription volume annually;

(d) $4.16 -- Pharmaceutical providers filling 1 - 15,000 total prescriptions annually with greater than 20 percent Medicaid prescription volume annually or pharmaceutical providers operating with a True or Modified Unit Dose Delivery System as defined in this **Guide**. The True or Modified Unit Dose Delivery System applies to those providers who give this service to over 50 percent of their patient population base associated with a particular Medicaid provider number. For example, if a pharmacist provides prescription services to two nursing home patients but 200 other Medicaid clients outside of a nursing home the pharmacist will not be able to receive this rate unless he/she has a separate Board of Pharmacy license and applies for a second provider number for separate billing of the two nursing home clients prescription services at the True or Modified Unit Dose Delivery level.

(2) Pharmacy providers must apply for an OMAP review of their pharmacy dispensing fee level by completing a Pharmacy Prescription Volume Survey (OMAP 3062) when one of the following situations occurs:

(a) The pharmacy initiates dispensing medications to clients in Nursing Facility and the most recent two months worth of dispensing data is available. OMAP will only accept the most recent two months worth of data;

(b) The pharmacy discontinues dispensing medications to clients in a Nursing Facility. The pharmacy provider is required to notify OMAP within 60 days and complete a new Pharmacy Prescription Volume Survey with the most recent two months worth of dispensing data available. OMAP will only accept the most recent two months worth of data;

(c) A completed Pharmacy Prescription Volume Survey signed by the pharmacist in charge must be submitted to OMAP to initiate a review of dispensing fees;

(d) A significant change in the pharmacy total dispensing volume or Medicaid dispensing volume has occurred and the current dispensing fee level does not meet the criteria as defined in this rule.

[ED. NOTE: The publication(s) and Form OMAP 3062 referenced in this rule are not printed in the OAR Compilation. Copies are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-16-101; 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 461-16-260; 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

410-121-0180

Drug Cost Update

The Office of Medical Assistance Programs shall revise its estimated acquisition cost file twice monthly on the 1st and 16th of each month with the most recently received data tapes.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 37-1987(Temp), f. 8-12-87, ef. 9-1-87; AFS 48-1987, f. 10-16-87, ef. 11-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-16-115; HR 6-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 20-1990, f. & cert. ef. 7-9-90; Renumbered from 461-16-270; HR 30-1991(Temp), f. & cert. ef. 7-12-91; HR 40-1991, f. & cert. ef. 9-16-91

410-121-0190

Clozapine Therapy

(1) Clozapine is covered only for the treatment of chronic schizophrenic patients who have failed therapy with at least two anti-psychotic medications:

(a) Clozapine supervision:

(A) Only pharmacists or physicians may bill using the clozapine supervision code (200CM). Providers billing for

clozapine supervision must document all of the following:

(i) Exact date and results of weekly WBCs, including weekly WBCs for four weeks following discontinuation of clozapine therapy;

(ii) Date and result of WBC and differential count before initial clozapine therapy;

(iii) Notations of current dosage and change in dosage;

(iv) Evidence of an evaluation on a weekly basis of the current recommended dosage level based upon the current week's WBC;

(v) Dates provider sent required information to manufacturer.

(B) Clozapine supervision must be billed on a HCFA-1500. Also use an OMAP 505 if the client has Medicare coverage;

(C) Use OMAP Unique Code 200CM -- Clozapine Supervision -- Management and Recordkeeping of clozapine dispensings are required by the manufacturer or clozapine;

(D) Only one provider may bill per week per client;

(E) Limited to five units per 30 days per client;

(F) An **ICD-9** diagnosis for schizophrenia must be shown in Field 21 of the HCFA-1500. The diagnosis code must be shown to the 5th digit on the HCFA-1500 and OMAP 505.

(b) Drug Products: The information required on the OMAP 502 must be included in the billing. The actual drug product may be billed electronically or submitted on an OMAP 502/502N;

(c) Venipuncture: If the pharmacy performs venipuncture, bill for that procedure on a HCFA-1500 (and OMAP 505 if the client has Medicaid coverage). Use Type of Service "S" and Procedure Code G0001.

Stat. Auth.: ORS Ch. 409

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

410-121-0200

Billing Forms

(1) Prescription Drug Invoice OMAP 502/502N:

(a) This form is used to bill for all pharmacy services, except durable medical equipment and home enteral/parenteral nutrition and IV services identified with a five-digit HCPCS or OMAP Unique codes in the **Home Enteral/Parenteral Nutrition and IV Services Guide**;

(b) The provider may bill on the form when a valid Medical Care Identification has been presented. In the absence of a valid Medical Care Identification, the provider should call the Automated Information System or contact the local branch office where the client is being served;

(c) The provider should follow the usual procedures to order supplies of OMAP 502 and OMAP 502N forms from AFS. All completed OMAP 502s/OMAP 502Ns should be mailed to: Office of Medical Assistance Programs, Salem, OR

97309;

(d) A paper claim must be used when the billed amount exceeds $9,999;

(e) The information in OAR 410-121-0220 is required data on all claims, whether billing through Point-of-Sale, electronically, or on a paper claim.

(2) HCFA-1500 for Durable Medical Equipment:

(a) All durable medical equipment and certain enteral/parenteral nutrition and IV services must be billed on the HCFA-1500, using the billing instructions found in the **Durable Medical Equipment and Medical Supplies Guide**;

(b) All completed HCFA-1500 forms for durable medical equipment should be mailed to: Office of Medical Assistance Programs, Salem, OR 97309.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-121-0220

Instructions for Completion of the Prescription Drug Invoice

(1) The OMAP 502/OMAP 502N Prescription Drug Invoices are required billing forms for pharmacies billing on a paper claim. Fields designated with a (*) must be completed.

(2) Instructions for Completion of the Prescription Drug Invoice (Form OMAP 502/OMAP 502N):

*(a) Recipient Last Name: Enter the first two letters of the client's last name from the Medical Card;

*(b) First Initial: Enter the first letter of the client's first name as it appears on the Medical Card;

*(c) Recipient ID Number: Enter the client's eight-digit ID number from the Medical Card;

(d) Unit Dose Indicator: Enter the appropriate unit dose indicator from the choices below:

(A) U - Unit dose;

(B) C - Dose card;

(C) A - Ambulatory or leave blank.

*(e) Prescription Number: The number assigned by the pharmacy to the prescription. This may be a seven character, alpha, numeric or combination. Compound prescriptions must have a unique prescription number for each compound;

*(f) Prescribing Physician ID Number: Enter the OMAP provider number of the physician who prescribed the drug. Use the provider listing supplied by OMAP. If the number is unknown, enter 999999 and give the name of the prescribing physician in the Remarks area;

(g) Insurance Indicator: If the following situations do not apply, enter "N"in this column. If the pharmacist receives a third party insurance payment, put a "Y" in this column. In the REMARKS section, subtract the amount paid from the

provider's usual and customary charge, normally billed to OMAP. Document on the back of the prescription the amount received by the third party resource;

*(h) Date Dispensed: Enter the date the drug was dispensed in Month/Day/Year numeric format;

*(i) National Drug Code: Enter the NDC number assigned to the dispensed product as it appears on the package from which dispensed, with the hyphens in relation to the dotted vertical lines on the OMAP 502 billing form (example: 00000/0000/00);

(j) Bill the components of a compounded prescription separately. Each component must have a unique seven digit prescription number.A dispensing fee will be allowed for each component eligible for reimbursement and billed in this manner. Any reimbursement received from a third party for compounded prescriptions must be split and applied equally to each component;

(k) Use all 11 digits of the NDC Number;

(l) If it is impossible to find an NDC number for an item that is prescribed and eligible for reimbursement under this program, contact First Health Services;

*(m) Days Supply: Estimate in days the duration of this prescription supply. This field must be completed;

(n) TPR (Third Party Resources) Code: If no payment was received from the client's other insurance, enter one of the two-digit codes from the list of TPR codes following these billing instructions;

(o) Generic Override: Enter "Y" when a physician has specified no generic substitutions and the proper documentation is on file in the pharmacy. Prescriptions must have "medically necessary," "brand medically necessary" or "brand necessary" written upon it by the prescriber. Initials or checked boxes are not acceptable;

*(p) Metric Quantity: Exact decimal metric quantity must be billed, up to four decimal places. Enter the number of tablets or capsules, the number of grams of ointments or powders or the number of ml.'s of the liquids dispensed. When billing for food supplements make an exception to billing for ml.'s and bill according to the instructions in OAR 410-121-0400, Formulary for Food Supplement. If multiple dose vials are dispensed indicate the total number of ml.'s dispensed unless the vials have been assigned unique codes addressed in OAR 410-121-0260, Unique NDC Codes. The quantity cannot exceed 99,999.9999. Do not insert descriptive designations such as "ml." "gm.", or "each";

*(q) Charge: Enter your usual and customary charge for the prescription;

(r) Remarks: Use this field for:

(A) Other insurance amount paid;

(B) Non-participating and out-of-state prescribing physicians' names, etc;

(C) Any other information you wish to give relating to this billing. Always refer to the line number from field 1 to identify the prescription to which the information relates.

*(s) Total Amount Charged: Enter the sum of all charges on the claim;

*(t) Date: The billing date is required. Dates must be in six digit numeric format of month/ day/year;

(u) Return to: This is the mailing address on the form for pharmacy claims;

*(v) OMAP Provider Number: Enter the pharmacy's six-digit OMAP provider number;

*(w) Name and Address of Provider: Enter the name and address of the pharmacy, phone numbers also are appreciated;

(x) Exception Indicator: Enter an "X" in this column if the drug is for Home IV services; enter a "z" if the drug is for home enteral or parenteral nutrition.

(3) Third Party Resource Explanation Codes or "TPR" Codes. (Use in Field "13" on the OMAP 502/OMAP 502N). (Use a single insurance code when the client has only one insurance policy in addition to Medicaid):

(a) Single Insurance Coverage:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Cancelled/ Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

(I) NE -- Service Not Considered Emergency by Insurance;

(J) NP -- Service Not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/Condition;

(L) RI -- Requested Information Not Received by Insurance from Patient;

(M) RP -- Requested Information Not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(b) Multiple Insurance Coverage. (Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid):

(A) MP -- Primary Insurance Paid -- Secondary Paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Cancelled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(S) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: 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 461-16-280; 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

410-121-0240

Adjustments

(1) Overpayments and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be resubmitted using an OMAP 502 or 502N. Providers must submit an Adjustment Request Form if a claim is paid incorrectly. All overpayments must be reported. Overpayments will be recouped from later payments.

(2) Report any payment received from a third party resource as an overpayment if the amount received was not previously deducted from the OMAP payment. This includes a payment from other sources received after the claim was submitted to OMAP.

(3) Unused medications from 30-day card or unit dose dispensings which are returned to stock in accordance with OAR 410-121-0148 must be credited to OMAP if they were previously charged to OMAP. To credit (refund) OMAP, complete only Sections 4, 5, and 18 of the Individual Adjustment Request Form (OMAP 1036) and attach a refund check and a separate sheet listing the following information:

(a) The client identification number;

(b) The name of each client for whom a refund is submitted;

(c) Your provider number;

(d) The total amount of refund for each client. (The NDC codes or number of units for each medication are not required);

(e) The sum of all credits on this sheet.

(4) Much of the information required on the Adjustment Request Form is printed on the Remittance Advice (RA). Attach a copy of the claim and RA as well as any documentation to support your request. Adjustment Requests must be submitted in writing to Office of Medical Assistance Programs in Salem. Adjustment Requests will not be accepted by telephone.

(5) Instructions for Completion of the Adjustment Request (OMAP 1036):

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) This is a reminder to attach needed documentation;

(c) Mail your Adjustment Request to this address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**);

(e) Enter the client's recipient identification number in this space. This number can be found on the RA in Field 65, or on the client's Medical Card;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Card;

(g) Enter your six-digit provider number in this space;

(h) This space is for the provider name;

(i) Enter the date printed at the top of the RA;

(j) Description: This column contains possible areas which may need to be corrected. Check only the box(s) you want to change:

(A) Quantity/Unit: The number of services being billed. The Quantity/Unit information can be found in Field 12 of the Remittance Advice;

(B) NDC/Procedure Code: Enter the correct NDC/Procedure Code to the right of the incorrect NDC/Procedure code information. The NDC (National Drug Code) to the right of the incorrect NDC/Procedure code information;

(C) Insurance Payment/Patient Liability: For other resource payment, enter the amount paid by the other resource and give the name of the source. Enter the specific reason for this adjustment request and any pertinent information to assist OMAP in processing this adjustment. For Nursing Facility clients enter on the left the client's liability as shown on the Remittance Advice. Enter on the right the correct surplus amount;

(D) Drug Name (Pharmacy Only: List name(s) of the drug(s) referenced by the NDC listed above);

(E) Billed amount: The amount OMAP was billed (Field 14 on the RA);

(F) Other: Use this box if none of the above address your problems.

(k) Line #: List the line number from the original claim you are now adjusting;

(l) Service Date: Enter the date the service was performed;

(m) Wrong Information: Enter the incorrect information submitted on the original claim in this column;

(n) Right Information: Enter the correct information in this column;

(o) Remarks: This is the area to give additional information or explain the request;

(p) Provider's Signature: The signature of the provider or other authorized personnel must be in this space;

(q) Date: Enter the date this form was com-pleted.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-16-300; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94

410-121-0260

Unique NDC Codes

(1) Renacidin 10% 500 ml - 88888-3020-05.

(2) Renacidin 10% 1000 ml - 88888-3020-10.

(3) Acetic Acid for Irrigation 1/4%, 1/2%, (Non-sterile) - 88888-3030-00.

(4) Neosporin G.U. Irrigant in 0.9% Sod. Chloride Irr. 1-L - 88888-3040-00.

(5) Billing for Individual Doses of Vaccine:

(a) Influenza Vaccine:

(A) Wyeth Influenza Vaccine, 1 dose tubex - 88888-3100-01; 5 ml-10 dose/per dose - 88888-3100-02;

(B) Parke Davis - Fluogen, 5 ml-10 dose/per dose - 88888-3110-02; Fluogen, 1 dose Disposable Syringe - 88888-3110-03;

(C) Squibb - Fluzone, 5 ml-10 dose/per dose Whole Vir. - 88888-3130-02; Fluzone, Flu Vaccine Sub Vir. - 88888-3130-03.

(b) - Pneumonia Vaccine - Pneumovax:

(A) Merck-Sharp and Dohme - 5 dose vial/per dose - 88888-3150-01:

(i) 5 single dose 0.5 ml vials/per dose - 88888-3150-02;

(ii) 5 single dose syringes/per dose - 88888-3150-03.

(B) Lederle PNU-IMMUNE 23, 5 dose vial - 88888-3160-01;

(C) Lederle PNU-IMMUNE Lederject, disposable syringe - 88888-3160-03.

(6) Antihemophilic Unique Drug List:

(a) Bill quantity of "1" for every 10 units;

(b) AHF-M vial 308-1170U, manufactured by American Red Cross, NDC #88888-0460-01;

(c) Alphanine SD 350-1650U vial, manufactured by Alpha Therapeutic, NDC #88888-3800-01;

(d) Alphanine 350-1650U vial, manufactured by Alpha Therapeutic, NDC #88888-3900-01;

(e) Autoplex 180-1050U vial, manufactured by Baxter-Hyland, NDC #88888-0650-01;

(f) Bebulin VH Immuno 200-1200U, manufactured by Immuno-U.S., NDC #88888-0244-02;

(g) Feiba VH Immuno 400-800U vial, manufactured by Immuno-U.S., NDC #88888-0222-04;

(h) Hemofil-M 200-1500 AHFU vial, manufactured by Baxter-Hyland, NDC #88888-2935-01;

(i) Humate-P vial up to 1000U, manufactured by Armour Pharmaceutical, NDC #88888-7605-04;

(j) Hyate:C 400-700AHFU vial, manufactured by Porton Products, NDC #88888-0106-02;

(k) Koate-HP vial up to 1500AHFU, manufactured by Cutter Biological/Miles, NDC #88888-0664-60;

(l) Kogenate vial up to 1000RAHFU, manufactured by Cutter Biological/Miles, NDC #88888-0670-50;

(m) Konyne 80 vial up to 1000U, manufactured by Cutter Biological/Miles, NDC #88888-0626-50;

(n) Melate vial up to 1000AHFU, manufactured by New York Blood Center/Melville, NDC #88888-0321-56;

(o) Monoclate-P vial up to 1000AHFU, manufactured by Armour Pharmaceutical, NDC #88888-7656-04;

(p) Mononine vial up to 10O0U, manufactured by Armour Pharmaceutical, NDC #88888-7668-04;

(q) Nybcen 300-1200 IU vial, manufactured by New York Blood Center/Melville, NDC #88888-0321-53;

(r) Profilate OSD 0-20000IU vial, manufactured by Alpha Therapeutic, NDC #88888-4300-02;

(s) Profilate SD 0-20000IU vial, manufactured by Alpha Therapeutic, NDC #88888-4100-02;

(t) Profilnine 0-2000IU vial, manufactured by Alpha therapeutic, NDC #88888-3700-02;

(u) Proplex T 300-1200U vial, manufactured by Baxter-Hyland, NDC #88888-0581-01;

(v) Recombinate 220-1240AHFU vial, manufactured by Baxter-Hyland, NDC #88888-2938-03;

(w) Alphanate 950 AHFA by AlphaThera, NDC #88888-4500-01;

Stat. Auth.: ORS Ch. 409

Stats. Implemented: 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 461-16-310; HR 16-1992, f. & cert. ef. 7-1-92; HR 37-1993, f. & cert. ef. 12-15-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96

410-121-0280

Billing Quantities, Metric Quantities and Package Sizes

(1) Use the actual metric quantity dispensed when billing (up to three decimal places). The only exception to this requirement is in relation to unique code, see OAR 410-121-0400 if multiple dose vials are dispensed indicate the number of ml.'s dispensed unless the vials have been assigned unique codes as shown in OAR 410-121-0260.

(2) Use the following units when billing products (with the exception of products which have been assigned unique codes):

(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 filled 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) 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., Tes-tape, 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: Bill exact metric decimal quantities dispensed with the exception of unique coded items.

Stat. Auth.: ORS Ch. 409

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 461-16-320; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94

410-121-0300

HCFA Upper Limits for Drug Payments

The following listing of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and 1927(f)(2) of the Act. 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 which HCFA has determined to be equal to a 150 percent applied to the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of drugs. The FUL price list will be updated approximately every six months. Table 2 [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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 461-16-330; 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

410-121-0320

Oregon Maximum Allowable Cost (OMAC)

Effective July 1, 1990, the Office of Medical Assistance Programs will not use the OMAC limitations.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-29-89, cert. ef. 10-1-89; HR 3-1990(Temp), f. & cert. ef. 2-23-90; HR 13-1990, f. & cert. ef. 4-20-90; Renumbered from 461-16-340; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90

410-121-0340

Therapeutic Class Listing of Over-the-Counter Products

The following household remedies, medicine chest items, over-the-counter items, and non-legend pharmaceuticals and preparations do not require prior authorization:

(1) Gastro Intestinal:

(a) ALOH and Mag. Trisilicate -- Tablet or capsule;

(b) ALOH and Mg. OH -- Gel and tablet;

(c) ALOH Concentrate (Mylanta II, Gelusil II, Maalox Conc.) and/or with Simethicone;

(d) Aluminum Hydroxide -- Gel, liquid and tablet;

(e) Calcium Carbonate -- Liquid and tablet;

(f) Gaviscon -- Liquid and tablet up to 650 mg;

(g) Bismuth, Subsalicylate (Tums).

(2) Topical Products:

(a) Aluminum Acetate -- Tablet and powder (Domeboro);

(b) Artificial Tears;

(c) Artificial Tears Ointment;

(d) Bacitracin Ointment -- Polymixin B;

(e) Hydrocortisone -- Cream, lotion and ointment 0.5%, 1%;

(f) Hydrogen Peroxide;

(g) Iodochlorhydroxyquin -- Cream and ointment (vioform);

(h) Micatin;

(i) Neomycin Ointment;

(j) #Alcohol swabs and pads;

(k) #Scabicides/Pediculicides (Kwell, Rid, Nix, Lindane, R&C) liquid, shampoo, spray, aerosol;

(l) Neosporin Ointment;

(m) Povidone -- Iodine solution, scrub, skin cleanser ointment;

(n) Spectrocin Ointment;

(o) #Zinc Oxide Ointment;

(p) Antiminth;

(q) Debrisan;

(r) Duoderm;

(s) #Liban Spray;

(t) Tinactin, cream, liquid, spray;

(u) Uni-Solve Adhesive Wipes.

(3) Diabetic:

(a) #Autoclix;

(b) #Autolet;

(c) #Autolet Platforms;

(d) #Chemstrip bG, AC, 25's, 50's and 100's;

(e) #Clinistix;

(f) #Clinitest;

(g) #Dextrostix;

(h) #Diascan;

(i) #Diastix;

(j) Glucose Chew;

(k) Glutose Concentrate (gel and liquids);

(l) Insta-Glucose;

(m) Insulin;

(n) #Ketodiastix;

(o) #Ketostix;

(p) #Monojector;

(q) Monojel;

(r) #Needles;

(s) #Syringes;

(t) #Tes-Tape;

(u) #Lancets;

(v) #Acetest Tablets -- 100's;

(w) #Glucostix Reagent Strips;

(x) #Glucose, blood test strips;

(y) #Monolets.

(4) Contraceptive:

(a) Condoms;

(b) Encare;

(c) Foams;

(d) Intercept;

(e) Introducer;

(f) Jelly and Creams;

(g) Semecid.

(5) Vitamins, Minerals, Blood Modifiers, Protein Supplement:

(a) Calcium Acetate, 25% calcium (Phos-Ex);

(b) Calcium Carbonate with and without glycine -- Up to 650 mg;

(c) Ferrous Gluconate, Calcium Acetate -- Neo Calglucon (25% calcium), syrup (Phos-Ex);

(d) Ferrous Sulfate -- Tablet, liquid, drops, teaspoonful;

(e) Ferrous Fumarate (Ferro-Sequels);

(f) Multiple vitamins with or without multiple minerals and prenatal vitamins.

(6) Expectorants and Cough Syrups:

(a) Ammonium Chloride (tablet);

(b) Pseudoephedrine Hcl, Triprolidine Hcl 609 mg/2.5 mg tablets;

(c) Pseudoephedrine HCl 30 mg, dextromethor-phan HBr 15 mg, guaifenesin 100 mg (Ambenyl D);

(d) Dextromethorphan HBr syrup 10 mg/5 ml (Beylin DM);

(e) Dextromethorphan HBr 10 mg, Guaifenesin 100 mg liquid (Cheracol-D);

(f) Dextromethorphan HBr 30 mg/5 ml liquid (Delsym);

(g) Guaifenesin 100 mg/5 ml (Robitussin plain) phenylpropanolamine HCl 12.5 mg (Robitussin CF) dextromethorphan HBr 10 mg (Robitussin DM);

(h) Phenylpropanolamine HCl 12.5 mg, dextromethorphan HBr 10 mg (Triaminic DM liquid);

(i) Phenylpropanolamine HCl 12.5 mg, guaifenesin 100 mg (Triaminic Expectorant);

(j) Phenylpropanolamine HCl 12.5 mg, chlorpheneriramine maleate 2 mg (Triaminic Syrup);

(k) Diphenhydramine HCL Cough Syrup 12.5 mg/5 ml;

(l) Diphenhydramine 25 mg caps;

(m) Pseudoephedrine HCL, 30 mg dextromethorphan 15 mg, guaifenesin 100 mg;

(n) Terpin Hydrate Elix.

(7) Antiemetic/Antivertigo Agents:

(a) Dimenhydrinate 50 mg tablet;

(b) Meclizine 12.5 mg;

(c) Meclizine 25 mg;

(d) Phosphorated Carbohydrate Soln. (Emetrol).

(8) Anti-Asthmatic:

(a) Epinephrine Inhalant;

(b) Medihaler EPI, (combo and refill);

(c) Vapo-N-Iso;

(d) Vapo Nefrin.

(9) Anti-Diarrhea:

(a) Kaolin Mixture w/Pectin, with and without Paregoric;

(b) Loperamide HCl, A-D caps, tab, liquid (Imodium).

(10) Feminine Hygiene:

(a) Pavidone-Iodine Douche (Betadine);

(b) Vagisec Liquid;

(c) Clotrimazole, vag. tabs, cream 1% (Gyne-Lotrimin);

(d) Miconazole Nitrate (Monostate).

(11) Analgesics:

(a) #Acetaminophen 325 mg. and 500 mg.;

(b) #Acetylsalicylic Acid (E.C. Buffered and Suppositories);

(c) Sodium Salicylate EC 325 mg and 650 mg, tabs and caps;

(d) #Acetylsalicylic Acid, 81 mg chewables, Tabs and caps.

(12) Antihistamines:

(a) Chlorpheniramine 4, 8, 12 mg, tablet, capsule;

(b) Chlorpheniramine Syrup;

(c) Brompheniramine Maleate (Dimetane) -- Tablet and liquid;

(d) Diphenhydramine -- 25 mg caps/tablets;

(e) Phenylephrine HCl 5 mg and Chlorpheniramine Maleate 2 mg Elixir (Novahistine Elixir);

(f) Phenylpropanolamine HCl 12.5 mg and Chlorpheniramine maleate (Triaminic Syrup);

(g) Diphenhydramine -- Elixirs, syrups;

(h) Pseudoephedrine Sulfate 30 mg, Brom-pheniramine Maleate 2 mg (Drixoral).

(13) Decongestants:

(a) Oxymethazoline HCL solution: 0.05% (Afrin), spray, drops, menthol;

(b) Pseudoephedrine HCL 30 mg tab, 60 mg tab, 30 mg/5 ml syrup, time release 120 mg tabs.

(14) Nasal Spray and Drops: Xylametayoline HCl solution, .05% E 0.1% (Otrivin).

(15) Laxatives and Stool Softeners:

(a) #Bisacodyl Suppositories;

(b) #Docusate SOD 100 mg, 250 mg, syrup;

(c) #Docusate SOD with Casanthranol;

(d) #Konsyl;

(e) #Magnesium Hydroxide (Milk of Magnesia);

(f) #Siblin 16 oz;

(g) #Psyllium.

(16) Others:

(a) Aero Chamber;

(b) Infalyte;

(c) Inspirease;

(d) Nicotinic Acid 50, 100, 500 mg;

(e) Pedialyte;

(f) Quinine Sulfate 325 mg;

(g) Sodium Chloride (normal saline for inhalation);

(h) #TB Syringes, Insul and 3 ml syringes;

(i) Antiminth (antiparasitic);

(j) Charcoal, Activated;

(k) Ipecac syrup;

(l) Kaltostat;

(m) Magnesium citrate solution (citrate of magnesia);

(n) Ricelyte solution.

(17) Compounding: For the purpose of providing clients compounded prescriptions, the following products are available without prior authorization:

(a) Cocabutter;

(b) Methylcellulose powder;

(c) Vitamin C syrup.

NOTE: (#) Indicates item is the responsibility of the nursing facility.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 1-1-89; FWC 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-350; HR 20-1991, f. & cert. ef. 4-16-91; HR 26-1991, f. & cert. ef. 7-1-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; 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

410-121-0360

List of Minor Tranquilizers Subject to Control by OMAP - Effective for Services Provided in or After May 1, 1994

(1) All minor tranquilizers require prior authorization of payment except for those in the list entitled "Minor Tranquilizers That Do not Require Prior Authorization of Payment". Minor tranquilizers in the injectable (parenteral) dosage form do not require prior authorization.

(2) The following list of minor tranquilizers require prior authorization of payment prior to dispensing. Various trade names may not be included on the following list. Check products for generic equivalency against the list before dispensing to determine if prior authorization is required. Injectable minor tranquilizers do not require prior authorization:

(a) Alprazolam (Xanax);

(b) Meprobamate (Miltown 600)

(c) Oxazepam (Serax);

(d) Chlorazepate Dipotassium (Gen-Xene, Tranxene, Tranxene SD);

(e) Prazepam (Centrax);

(f) Chlormezanone (Trancopol);

(g) Diazepam (Valium, Valrelease, Zetran));

(h) Halazepam (Paxipam);

(i) Hydroxyzine (in excess of 50 mg) (Atarax, Atarax 100, Hydroxyzine Pamoate, Vistaril);

(j) Lorazepam (Ativan);

(3) The following minor tranquilizers may be dispensed without prior authorization:

(a) Chlordiazepoxide (Librium, Libritab, Mitran, Reposans-10);

(b) Hydroxyzine (up to 50 mg dosage per unit) (Atarax, Anxanil, Vistaril, Hydroxyzine Pamoate);

(c) Doxepin (HCL) (Adapin, Sinequan);

(d) Meprobamate (200 mg and 400 mg only, (Miltown, Equanil, Neuramate, Meprospan).

Stat. Auth.: ORS Ch. 409

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 461-16-360; HR 25-1994, f. & cert. ef. 7-1-94

410-121-0380

Amphetamines and Amphetamine Derivatives That Require Prior Authorization-- Effective for Services Provided on or After May 1, 1994

(1) The following list of amphetamines and amphetamine derivatives are subject to reimbursement restrictions by OMAP:

(a) Adipex;

(b) Amphalex;

(c) Amphetamine;

(d) Amphetamine Combined;

(e) Amphetamine Complex;

(f) Amphetamine salts;

(g) Apetinil;

(h) Benzedrine;

(i) Benzephetamin;

(j) Chlorphentermine;

(k) Chlortermine;

(l) Daro;

(m) Delcobese;

(n) Desoxyephedrine;

(o) Desoxyn;

(p) Dexamyl;

(q) Dexedrine;

(r) Dextroamphetamine;

(s) Dextroamphetamine salts;

(t) Didrex;

(u) Diethylpropion;

(v) Dimethylamphetamine;

(w) Diphetamine;

(x) Diphylets;

(y) Ethylamphetamine;

(z) Fastinl;

(aa) Fenfluramine;

(bb) Ferndex;

(cc) Fetamine;

(dd) Furfurlmethlamphetamine;

(ee) Furtenorex;

(ff) Ionamin;

(gg) Linyl;

(hh) Maxidol;

(ii) Mephentermine;

(jj) Methampex;

(kk) Methamphetamine;

(ll) Methedrine;

(mm) Obedrin;

(nn) Obetrol;

(oo) Obotan;

(pp) Obotan Forte;

(qq) Pervitin;

(rr) Oxydess;

(ss) Phendimetrazine;

(tt) Phenmetrazine;

(uu) Phentermine;

(vv) Ponderal;

(ww) Pondimin;

(xx) Plegine;

(yy) Preludin;

(zz) Presate;

(aaa) Statobex;

(bbb) Sanorex;

(y) Tenuate;

(z) Tepanil;

(aa) Voranil;

(bb) Wilpo;

(cc) Wyamine.

(2) Many brand and trade names are not listed above. Check products for generic equivalency against the above list before dispensing to deter-mine if prior authorization is required.

Stat. Auth.: ORS Ch. 409

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 461-16-370; HR 25-1994, f. & cert. ef. 7-1-94

410-121-0400

Formulary for Food Supplement

Due to the limitations of the metric quantities on the OMAP 502 billing form, the "Food Supplement" division has been revised and established as a specific formulary and all items are to be billed as 1 (one) per each unit, for example: 1 can, 1 packet, 1 bottle, etc. and using the unique codes as published in the formulary will circumvent the usual billing procedures and allow the latitude necessary to cover the prescribed quantities of food supplements. All items in this list as well as other nutritional supplements require prior authorization of payment. Pharmacy providers must bill for oral enteral nutritional products using OMAP's unique NDC numbers.

(1) Baxter:

(a) Travasorb HN Powder, 83.3 gm., 88338-9001-91;

(b) Travasorb STD Powder, 83.3 gm., 88338-9002-91;

(c) Travasorb MCT Powder, 89 gm., 88338-9004-91;

(d) Travasorb Hepatic Powder, 96 gm., All Flavors, 88338-9008-91;

(e) Travasorb Renal Powder, 112 gm., All Flavors, 88338-9010-91.

(2) Jackson, Mitchell Pharm. Inc.: Meyenberg Goat Milk, 420 ml., 82904-0000-20.

(3) Kendall-McGaw:

(a) Amin-Aid Instant Drink, Orange, 156 gm., 88264-6100-24;

(b) Hepatic-Aid II, Instant Drink, 93 gm., 88264-6521-24;

(c) Hepatic-Aid II, Instant Drink, All Flavors, 90 gm., 88264-6524-24.

(4) Mead Johnson:

(a) Casec Powder, can, 2.50 oz. ea., 240 gm., 88887-0390-47;

(b) Criticare HN, Liquid, 240 ml., 88887-0563-41;

(c) Enfamil Premature Formula, 24 Cal., 120 ml., 88887-0267-41;

(d) Enfamil Premature Formula, 24 Cal., 120 ml., 88887-2010-41;

(e) Hist 2 Powder, 500 gm., 88887-4081-41;

(f) Isocal II, Liquid, 1,000 ml., 88887-0496-01;

(g) Isocal HN Liquid, 240 ml., 88887-0446-42;

(h) Isocal HCN, Liquid, can 8 oz., 88887-0462-42;

(i) Isocal, Liquid, bottle 8 oz., 88887-0356-01;

(j) Isocal, Liquid, can 12 oz., 88887-0355-02;

(k) Isocal, Liquid, can 8 oz., 88887-0355-01;

(l) Isocal, Liquid, can 32 oz., 88887-0355-44;

(m) Kindercal, 8 oz., 88887-0694-46;

(n) LactoFree with Iron, 13 oz., 88887-0614-13;

(o) Lipisorb Powder 454 gm., 88887-0441-41;

(p) Lonalac, Powder 1#, 88887-0391-01;

(q) M-C-T Oil, 32 oz., 88887-0365-03;

(r) Moducal Powder, 368 gm., 88887-0480-41;

(s) Nutramigen, 1# can, 88887-0338-01;

(t) Nutramigen, 960 ml., 88887-0499-01;

(u) OS 2 Powder, 500 gm., 88887-4091-41;

(v) Portagen, Powder, can 1#, 88887-0387-01;

(w) Prosorbee Powder 420 gm., 88887-3101-21;

(x) Prosorbee Ready Use, 8 oz., 88887-0309-42;

(y) Prosorbee Ready Use, 32 oz., 88887-0309-01;

(z) Sustacal, Powder, All Flavors, 1.9 oz., 88887-0353-01;

(aa) Sustacal with Fiber, Liquid, Chocolate 240 ml., 88887-4205-42;

(bb) Sustacal, Powder, Vanilla 3.8#, 88887-0353-43;

(cc) Sustacal, Pudding, Vanilla 5 oz., 88887-0409-41;

(dd) Sustacal, Powder, Vanilla, 454 gm., 88887-0353-44;

(ee) Sustacal HC, Liquid, Any Flavor, can 8 oz., 88887-0460-42;

(ff) Sustacal HC, Liquid, 240 gm., 88887-0466-42;

(gg) Sustacal, Pudding, All Flavors, 5 oz., 88887-0415-41;

(hh) Sustacal, Liquid, All Flavors, 32 oz., 88887-0351-44;

(ii) Sustacal, Liquid, All Flavors, 8 oz., 88887-0465-42;

(jj) Sustacal with Fiber, Liquid, All Flavors, 8 oz., 88887-4204-42;

(kk) Sustacal, Liquid, All Flavors 12 oz., 88887-0351-01;

(ll) Sustagen, Powder, All Flavors, 1#, 88887-0393-01;

(mm) Sustagen, Powder, Vanilla 5#, 88887-0393-03;

(nn) Try 2 Powder, 500 gm., 88887-4086-41.

(5) Milani Foods: DiaFoods Thick-It Powder, 88400-0040-75.

(6) Norwich-Eaton:

(a) Tolorex Packet 6, 88149-0458-01;

(b) Vivonex, Delivery System-10, 10, 88149-0050-10;

(c) Vivonex, Acutrol Feeding System, 88149-0065-06.

(7) Organon/Sherwood:

(a) Comply Unflavored Liquid, 250 ml., 88884-3025-01;

(b) Comply All Flavors Liquid, 250 ml., 88884-3025-25;

(c) Comply Banana Flavored Liquid, 200 ml., 88884-3025-06;

(d) K.D.S. Pre-Attain Liquid, 1000 ml., 88884-3075-08;

(e) K.D.S. Attain Liquid, 1000 ml., 88884-3065-00;

(f) K.D.S. Vitaneed Liquid, 1000 ml., 88884-3085-06;

(g) K.D.S. Comply Unflavored Liquid, 1000 ml., 88884-3095-12;

(h) K.D.S. Pro-Fiber Liquid, 1000 ml., 88884-3055-02;

(i) Magnacal Liquid, 120 ml., 88884-3114-00;

(j) Magnacal Liquid cans, 250 ml., 88884-3118-00;

(k) Magnacal Liquid bottles, 250 ml., 88884-3108-00;

(l) Pre-Attain Liquid, 250 ml., 88884-3015-00;

(m) Pro-Fiber Liquid, 250 ml., 88884-3050-07;

(n) Sumacal Powder, 400 gm., 88884-3406-00.

(8) Ross Labs:

(a) Advera Liq, All Flavors, 8 oz. can, 88874-5117-10;

(b) Alimentum Liquid, 960 ml., 88874-6023-70;

(c) Enrich, Vanilla, 32 oz., 88874-0706-01;

(d) Enrich 8 oz., All Flavors, 88874-0759-08;

(e) Ensure Plus Liquid, 1000 ml. H-P/Ready-to-Hang, 8's, 88874-5034-00;

(f) Ensure w/Fiber Liq., All Flavors, 8 oz. 6's, 88874-4075-90;

(g) Ensure w/Fiber Liq., Van 32 oz., 88874-6070-60;

(h) Ensure Liq., Van Bot, 8 oz. 12's, 88874-0070-80;

(i) Ensure Liq., All Flavors, 8 oz. 6's, 88874-4071-10;

(j) Ensure Liq., All Flavors, 32 oz., 88874-6073-30;

(k) Ensure Vanilla Powder, 14 oz., 88874-6075-00;

(l) Ensure HN Liq., Any Flavor 8 oz. 6's, 88874-4071-90;

(m) Ensure HN Liq., Van, 32 oz., 88874-6073-20;

(n) Ensure Plus Liq., Van Bot, 8 oz. 6's, 88874-0074-10;

(o) Ensure Plus Liq., All Flavors 8 oz., 6's, 88874-4070-70;

(p) Ensure Plus Liq., All Flavors, 32 oz. Can, 88874-6068-80;

(q) Ensure Plus HN Liq., High Calorie/To-Hang, 88874-0068-10;

(r) Ensure Plus HN Liq., All Flavors, 8 oz. 6's, 88874-4072-10;

(s) Exceed Hi-Carbo Source Powd, All Flavors, 88874-5036-30;

(t) Exceed Hi-Carbo Source Liq, Golden Punch, 88874-5049-70;

(u) Forta Drink Pwd, All Flavors, 482 gm Can, 88874-4062-10;

(v) Forta Shake Pwd, All Flavors, 470 gm Can, 88874-4061-70;

(w) Glucerna Liq. 6's, 88874-5024-10;

(x) Introlite Liq., 88874-0066-90;

(y) Isomil DF 32 oz., 88874-5127-90;

(z) Isomil Liquid, Read/Feed Can 32 oz., 88874-6023-00;

(aa) Isomil Liq. Ready to Feed Bottles, 6's, 88874-5039-30;

(bb) Isomil Liq. Read/Feed Can 8 oz. 6's, 88874-4017-30;

(cc) Isomil Pow., 14 oz. Can, 88874-2010-70;

(dd) Isomil SF Liq. Conc., 13 oz. Can, 88874-4011-90;

(ee) Isomil SF Liq. Conc., 32 oz. Can, 88874-6012-80;

(ff) Jevity Liquid, Isotonic Nutrition, 4 x 6, 8 oz 24's, 88874-4014-30;

(gg) Jevity Liq. Ready-to-Hang 8's, 88874-0068-20;

(hh) Jevity Liq. 6's, 88874-5033-10;

(ii) Maxamaid XLEU Pow., Orange 7 oz. 10's, 88874-5038-80;

(jj) Maxamum XLVS, Tru Pow. 10's, 88874-5038-20;

(kk) Nepro Ready to Use Liq., 88874-5063-30;

(ll) Osmolite, 32 oz., 88874-0738-32;

(mm) Osmolite Liquid, 1000 ml. Ready-to-Hang, 88874-5035-00;

(nn) Osmolite Ready/Use Liq., 8 oz. Bot. 12's, 88874-0071-50;

(oo) Osmolite Ready/Use Liq., 8 oz. Can 6's, 88874-4070-90;

(pp) Osmolite Ready/Use Liq., 32 oz. Can, 88874-6073-80;

(qq) Osmolite HN Liq., Ready/Use 8 oz. Can 6's, 88874-4073-50;

(rr) Osmolite HN Liq., Ready/Use 32 oz. Can, 88874-6073-90;

(ss) Osmolite HN Liq., Ready/Use 8 oz. Bot 12's, 88874-0073-60;

(tt) Osmolite HN Liq., Nutrit, 88874-0066-80;

(uu) Pediasure Ready/Use Liq. Van 8 oz. 6's, 88874-4037-30;

(vv) Pediasure with Fiber Lactose - Free Food 8 oz., 6's, 88874-5065-30;

(ww) Polycose Powder, 12.3 oz. 6's, 88874-6074-60;

(xx) Polycose Liq., 4.2 oz. 48's, 88874-8043-10;

(yy) Promod Powder , 88874-0775-01;

(zz) Promod Powder, Protein Supp. 9.7 oz., 88874-6077-50;

(aaa) Pulmocare Liq., Strawberry 8 oz. 6's, 88874-5018-10;

(bbb) Pulmocare Liq., Van Ready/Use 8 oz. Can 6's, 88874-4069-90;

(ccc) Similac 60/40 Powder 454 gm., 88874-6085-00;

(ddd) Similac with Iron Liquid, 8 oz. 6's, 88874-4017-90;

(eee) Similac Special Care with Iron 4 oz., 6's, 88874-8021-40.

(9) Rugby Laboratories:

(a) Restore Liquid 8 oz., 88536-2750-59;

(b) Restore Plus Liquid 8 oz., 88536-2760-59.

(10) Sandoz Nutritional:

(a) Citrotein, Orange, 47.1 gm./pkt., 88212-1700-26;

(b) Citrotein, Punch, 14.16 oz. can, 88212-1701-08;

(c) Compleat Modified, 250 ml., 24 ea. cans, 88212-0200-51;

(d) Compleat-B Meat Base Form., Bottle 250 ml., 88212-0200-40;

(e) Compleat-B Modified, 250 ml. R.T.U., 88212-0202-51;

(f) Meritene, Powd., Plain or Flavored 4 1/2#, 88212-1200-03;

(g) Meritene, Ready-to-serve, Vanilla Supreme, 250 ml., 88212-0213-51;

(h) Meritene, Ready-to-serve, All Flavors, 250 ml., 88212-0210-51;

(i) Meritene, Powd., Plain and All Flavors 1#, 88212-1200-02;

(j) Precision High Nitrogen, Powd., Vanilla pkt., 88212-1801-23;

(k) Precision Diet Isotonic, Powd., Vanilla pkt., 88212-1910-22;

(l) Precision Lr. Diet, Powd., Orange pkt., 88212-1503-21;

(m) Resource Plus, Liquid, 240 ml., All Flavors, 88212-3383-62;

(n) Resource Liquid, 240 ml., 88212-3371-62;

(o) Resource, Lactose-free food, 8 oz. pkt., 88212-3232-25.

(11) Tyson & Associates: Complex-Cho Powder 454 gm., 83335-0016-25.

(12) Wyeth Labs:

(a) Nursoy Con. 390 ml., 88808-0481-05;

(b) Nursoy Con. 390 ml. (13 oz. - 12's), 88808-0481-06;

(c) Nursoy Powder, Soy Protein 1# 6's, 88808-0664-02.

(13) Electrolyte Solutions - No Prior Authorization Required: Infalyte Electrolyte Solution, 88887-1403-42.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: 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 461-16-380; HR 45-1990, f. & cert. ef. 12-28-90; HR 26-1991, f. & cert. ef. 7-1-91; HR 28-1992, f. & cert. ef. 9-1-92; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96

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 FederalDrugAdministrationNotice-of-Opportunity-for-Hearing stage.

(2) Since this ruling means the federal funding for these drugs will be terminated, payment for the following drugs will be terminated by OMAP. The "Active Ingredient" and "Route" of administration columns are the major controlling factors regarding the FDA's less-than-effective drug determinations and HCFA's reimbursement decisions regarding these drugs. The products' trade names, dosage forms and names of the producing firms are supplied for informational purposes. Thus, even though a drug's trade name, dosage form, or the name of the firm producing such a drug is not shown on this list, if by its generic make up and route of administration it is identical, similar, or related to a drug on this list, no Federal Financial Participation (FFP) is available for such a drug. Therefore, OMAP will not reimburse for DESI drugs or dispensings of products that are identical, related, or similar to the DESI drugs listed in **Table 2.**

(3) In accordance with current policy, federal financial participation will not be provided for any drug on the FUL listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the Drug Efficacy Study and Implementation (DESI) program and the drug has been found to be a less than effective or is identical, related or similar (IRS) to the DESI drug. The DESI drug listing is identified by the Food and Drug Administration or reported by the drug manufacturer for purposes of the Medicaid drug rebate program.

(4) The manufacturer has the responsibility of determining the DESI status of a drug product.

[ED. NOTE: Table 2 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-16-390; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94

410-121-0580

Oregon Medicaid and Pharmaceutical Manufacturers' Dispute Resolution Procedures

(1) Within 60 days after the end of each calendar quarter, the Office of Medical Assistance Programs (OMAP) shall report the number of units dispensed for each drug (NDC) for which payment was made to the manufacturer of said product. Utilization reports to manufacturers should 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) The Office of Medical Assistance Programs considers any failure to make timely payment in full of the amount due to be a dispute. Timely is defined by OMAP 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 Health Care Finance Administration (HCFA), 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 HCFA'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 OMAP 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 OMAP in letter form. Each letter will include an OMAP 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 HCFA of all disputing manufacturers in writing.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 21-1992, f. 7-31-92, cert. ef. 8-1-92

410-121-0600

Foreword

(1) **The Home Enteral/ Parenteral Nutrition -- IV Services Billing and Procedures Guide** is a user's manual designed to assist providers in preparing health claims for medical assistance clients. This **Guide** is used in conjunction with the General Rules for Oregon Medical Assistance Programs, the Oregon Health Plan Medicaid Demonstration Project Administrative Rules and the **Pharmaceutical Services Guide**.

(2) Instructions on completing claim forms, Administrative Rules and examples of some completed forms are included in this **Guide**. A section listing procedure codes and their defini-tions, restrictions and limitations is also included.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 3-1995, f. & cer.t ef. 2-1-95

410-121-0640

Home Enteral/Parenteral Nutrition and IV Services - Effective for Services Provided on or After January 1, 1995

(1)TheOfficeofMedical Assistance Programs will make payment for goods, suppliesandservices for home enteral/parenteral nutrition and IV therapy on verbal or written order or prescription by a licensed prescribing practitioner, and when considered to be medically necessary. An appropriately dated, legible prescription or physician order must be retained on file by the provider of service. A new prescription is required once a year for ongoing services. Also covered are services for subcutaneous, epidural and intrathecal injections requiring pump delivery.

(2) The Office of Medical Assistance Programs requires one nursing service visit to assess the home environment and appropriateness of enteral/parenteral nutrition or IV services in the home setting. This nursing service visit for assessment purposes does not require prior authorization and is not required when the only service provided is oral nutritional supplementation. Nursing service visits provided in the home will be reimbursed by OMAP only when performed by a person who is licensed by the Oregon State Board of Nursing to practice as a Registered Nurse. Payment for services identified in the **Home Enteral/Parenteral Nutrition and IV Services Provider Guide** will be made only when provided in the client's place of residence, i.e., home or nursing facility

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-16-290; 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

410-121-0660

Requirements for Home Enteral/Parenteral Nutrition and IV Services

(1) Home Enteral Nutrition:

(a) Enteral nutrition is considered medically necessary to maintain body mass and prevent nutritional depletion which occurs with some illnesses or pathologicalconditions. Home enteral therapy may be administered orally or by enteral tube feeding, i.e., nasogastric, jejunostomy or gastrostomy delivery systems;

(b) Home enteral nutrition services must include training and/or education of clientor support person on nutritional supplement and equipment operation. If enteral nutrition services are initiated in a hospital setting, reimbursement for training is included in the hospital reimbursement and will not be made separately. Reimbursement for enteral nutrition services training when done in the home is included in the payment for the nursing visit(s);

(c) All pharmacy administrative charges, admixture charges and compounding fees are incorporated in the enteral formulae paymentamount.

(2) Home Parenteral Nutrition:

(a) Parenteral nutrition is considered medically necessary 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. Initiation of home parenteral nutrition services must include client or support person education on catheter care, infusion technique, solution preparation, steriliza-tion technique, and equipment operation;

(b) If parenteral nutrition services are initiated in a hospital setting, reimbursement for training is included in the hospital reimbursement rate and will not be made separately. Reimbursement for parenteral nutrition services training when done in the home is included in the payment for the nursing visit(s);

(c) All pharmacy administrative charges, admixture charges and compounding fees are incorporated in the solution payment amount.

(3) Home Intravenous (IV) Services:

(a) Home IV services are covered by OMAP for the administration of antibiotics, analgesics, chemotherapy, hydrational fluids or other intravenous medications in a client's residence or nursing home. In addition, the provision of all goods andservices needed for maintaining venous or arterial access and required monitoring is covered;

(b) Home IV services must include training of client or support person(s).Reimbursement for IV services training when done in the home is included in the payment for the nursing visit. If IV services are initiated in a hospital setting, reimbursement for training is included in the Hospital reimbursement, and will not be made separately;

(c) All pharmacy administrative charges, admixture charges and dispensing/compounding fees are incorporated in diluent solution payment amount;

(e) Dispensing fees for intravenous medications are reimbursed as described in the **Pharmaceutical Services Guide** and are in addition to the payment amount for the diluent solution.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-121-0680

Authorization

(1) Authorization of payment is required for the following items or services:

(a) All enteral/parenteral or IV infusion pumps, the provider is required to submit documentation with each request 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/goods identified as requiring Prior Authorization in the **Pharmaceutical Services Guide**.

(2) Approval for payment for the above home enteral/parenteral nutrition and/or IV services entities will be made when considered to be a "medical necessity".

(3) Authorization of payment is not required forclients that have both Medicare and Medicaid coverage when Medicare covers the service. For clients that have insurance other than Medicare, authorization must still be obtained for any OMAP services that require authorization.

(4) For services requiring authorization, providers must contact OMAP forauthorization within five working days following initiation of services. Authorization will be given based on medical necessity and the appropriateness of level of care given.

(5) How to Obtain Prior Authorization:

(a) Authorization may be obtained by contacting either by phone or in writing to Office of Medical Assistance Programs;

(b) When authorization has been made, the requesting provider will receive an OMAP 1072C (Notice of Prior Authorization) or an OMAP 1072 (Notice of Prior Authorization of Payment for Medical Services). The notice will contain the nine-digit prior authorization number. This nine-digit number must be entered in Field 23 of the HCFA 1500, 23B of the OMAP 505, or in Field 14 of theOMAP 502 or 502N.

NOTE: Prior authorization does not guarantee reimbursement.

(A) Always check eligibility on the date of service by calling AIS or requesting a copy of the client's Medical Care Identification. This is especially important when services have been authorized beyond the current month of eligibility;

(B) For services provided to clients enrolled in a Prepaid Health Plan, contact the Plan for authorization information prior to service provision.

(C) Ensure the service to be provided is currently a medical service covered under the Title XIX program and the client benefit package;

(D) Ensure the claim is for the actual service(s) and/or number of services provided even though the authorization may be for a higher number of units or dollars;

(E) Services and/or dollars billed in excess of the number of units or dollars authorized will not be reimbursed.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-16-090; HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-16-220; 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

410-121-0700

Equipment Rental/Purchase/Repair

(1) The following equipment shall be authorized, if medically necessary on a rental basis only:

(a) IV infusion pumps;

(b) Enteral formulae pumps.

(2) Payment will not be made for pump rental beyond 15 consecutive months when the period of use extends beyond 15 consecutive months. (Consecutive months are defined as "any period of continuous use where no more than a 60-day break occurs"). OMAP considers that upon 15 consecutive months of pump rental, the purchase price has been met. Once the 15 consecutive months have been provided, the provider may bill OMAP for maintenance and servicing of the rental 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 rental of the pump. Payment for the maintenance service will only be made one time during every six-month period.

(3) All other equipment for home enteral/parenteral nutrition and IV services will be authorized on a purchase or rental basis to be determined at the time the authorization is given.

(4) For 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 OMAP.

(5) Repair of rental equipment is the responsibility of the provider.

(6) OMAP will not make payment for rental of pumps that are supplied by any manufacturer at no cost to the provider.

Stat. Auth.: ORS Ch. 409

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

410-121-0720

Reimbursement

(1) Drug ingredients (medications) shall be reimbursed as defined **i**n the **Pharmaceutical Services Guide**.

(2) The following service/goods will be reimbursed on a fee-for-service basis according to the Schedule of Maximum

Allowances:

(a) Enteral Formulae/Nutritional Supplements;

(b) Parenteral Nutrition Supplements and Solutions;

(c) Equipment;

(d) Supplies;

(e) Nursing Service Visits.

(3) Reimbursement for services covered by Medicare will be based on the lesser of Medicare's allowed amount or OMAP's maximum allowable rate.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90

410-121-0730

Reimbursement Limitations for Clients in a Nursing Facility

(1) The Office of Medical Assistance Programs (OMAP) will not reimburse for the following services/supplies for clients residing in a nursing facility:

(a) Nursing service visits (including assessment visit). Refer to Senior and Disabled Services Division (SDSD) rule covering All-Inclusive Rate;

(b) Certain supplies and items covered in the nursing facility All-Inclusive Rate. Refer to the Appendices of the **Home Enteral/Parenteral Nutrition and IV Services Provider Guide** for a listing of those supplies and items;

(c) Oral Nutritional Supplements that are in addition to consumption of food items or meals.

(2) OMAP will reimburse for the following:

(a) Oral Nutritional Supplements are covered by OMAP for Nursing Facility clients when medically necessary, i.e., the client cannot consume food items or meals;

(b) Tube fed enteral nutrition formula, when medically necessary.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-121-0740

Billing Information

(1) Prescription Drug Invoice OMAP 502/OMAP 502N:

(a) This form is used to bill for all medications and home IV drug ingredients;

(b) All completed OMAP 502s/OMAP 502Ns should be mailed to: Office of Medical Assistance Programs, Salem, OR 97309.

(2) HCFA-1500:

(a) Home Enteral/Parenteral Nutrition and IV services identified with a five-digit HCPCS or OMAP Unique Code must be billed on the HCFA-1500 using the billing instructions found in the **Home Enteral/Parenteral Nutrition and IV Services Guide**;

(b) Completed HCFA-1500s are mailed to: Office of Medical Assistance Programs, Salem, OR 97309.

(3) Third Party Resource Explanation Codes or "TPR" Codes. Use in Field "9" on the HCFA-1500 and OMAP 505. Use in Field "13" on the OMAP 502 or OMAP 502N:

(a) Single Insurance Coverage -- (Use a single insurance code when the client has only one insurance policy in addition to Medicaid.):

(A) UD -- Service Under Deductible;

(B) NC -- Services not Covered by Insurance Policy;

(C) PN -- Patient not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Cancelled/ Terminated;

(E) IL -- Insurance Lapsed or not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policy-holder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service not Authorized or Prior Authorized by Insurance;

(I) NE -- Service not Considered Emergency by Insurance;

(J) NP -- Service not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/Condition;

(L) RI -- Requested Information not Received by Insurance from Patient;

(M) RP -- Requested Information not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) TO -- Other (if above codes do not apply, include detailed informationof why no TPR payment was made);

(P) AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days.

(b) Multiple Insurance Coverage -- (Use a multiple insurance code when the client has more than one insurance policy

in addition to Medicaid.):

(A) MP -- Primary Insurance Paid -- Secondary Paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Cancelled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- ServicenotProvidedbyPrimaryCare Provider/ Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/ Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information not Received from Policy-holder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information not Received from Patient;

(Q) MC -- Service not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detaied information of why no TPR payment was made).

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

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

410-121-0750

Billing for Clients Who Have Both Medicare and Medicaid Coverage

(1) The Office of Medical Assistance Programs may be billed directly for services provided to a Medicare/Medicaid 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) Select the appropriate Third Party Resource Code from the list of codes printed in the **Home Enteral/Parenteral**

Nutrition and IV Services Guide. Enter the code in the appropriate box on the claim form OMAP 505 if billing for Enteral/Parenteral services and the HCFA-1500 for IV services, and bill OMAP directly.

(3) When the service qualifies for Medicare reimbursement, bill as follows:

(a) When billing for home enteral/parenteral nutrition services, bill in the usual manner to the local or designated Medicare Intermediary;

(b) After Medicare makes a payment determination, bill OMAP on the OMAP 505 form following the billing instructions and using the procedure codes listed in the **Guide**;

(c) When billing for home IV services, bill the local Medicare Intermediary in the usual manner;

(d) After Medicare makes payment determination, bill OMAP on the HCFA-1500 and/or OMAP 502(N) following the billing instructions and using the procedure codes listed in the **Home Enteral/Parenteral Nutrition and IV Services Provider Guide**.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-121-0760

Health Insurance Claim Form (HCFA-1500)

(1) Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another.

(2) The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight-digit number found on the OMAP Medical Care Identification;

(b) Patient's Name: The name as it appears on the OMAP Medical Care Identification;

(c) Date of Service: Must be numeric. If "From -- To" dates are used, a service must have been provided on each consecutive day and the claim must not be submitted prior to the "thru" date;

(d) Place of Service: Where service is provided:

(A) 4 = Patient's home;

(B) 5 = Day care facility;

(C) 6 = Night care facility;

(D) 7 = Intermediate care facility;

(E) 8 = Skilled nursing facility.

(e) Type of Service Codes (TOS): S = Home Enteral/Parenteral and IV Services;

(f) Procedures, Services or Supplies: Use only the HCPCS or OMAP Unique Codes listed in the **Home Enteral/Parenteral Nutrition and IV Services Provider Guide**;

(g) Charges: Enter a charge for each line item;

(h) Days or Units: Enter the number of services or units billed;

(i) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(j) Balance Due: Enter the balance (the information in the Total Charge Field minus the information in the Amount Paid Field);

(k) Provider Number: Enter the OMAP billing or provider number here.Only one number may be entered in this field;

(l) Diagnosis Code: Enter the single-digit line reference number from the "Diagnosis or Nature of the Illness or Injury" field;

(m) Diagnosis Dx: Enter primary diagnosis code first and subsequent diagnosis codes as needed. Use only ICD-9-CM diagnosis codes. Where a 4th and/or 5th digit is appropriate, summary diagnosis codes may not be entered.

(3) The following information fields are required, when applicable:

(a) Other Insured's Name: Third Party Resource information is listed on the Medical Care Identification. Use the Third Party Resource (TPR) Codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related To: Complete as appropriate when an injury is involved;

(c) Reserved for Local Use (Field 10d): Put a "Y" in this field if the service was an emergency;

(d) Prior Authorization Number: If required, enter the Prior Authorization Number here;

(e) Reserved for Local Use -- (Field 24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(f) Amount Paid: Enter the Total Amount Paid from Other Resources;

(g) Name of Referring Physician or Other Source: Enter the name of the referring provider, FCHP/PCO (if the client is in a prepaid health plan), or the primary care case manager;

(h) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, FCHP/PCO (if the client is in a prepaid health plan), or the primary care case manager.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95

410-121-0780

Instructions on How to Complete the OMAP 505

(1) The following information must be entered on the OMAP 505:

(a) Patient's Name: The name as it appears on the Medical Care Identification;

(b) Insured's Medicaid Number: The eight-digit number from the Medical Care Identification;

(c) Insured's Group Number: The Medicare number as it appears on the client's Medicare Card;

(d) Other Health Insurance Coverage: If no payment was received from Medicare, this space must be used to explain why no payment was made. Select a two-digit TPR code from the Third Party Resource (TPR) Codes that are found in the billing section of this **Guide**. Be sure that this TPR code is the first entry in Field 9, followed by the name of the Third Party Resource (Medicare);

(e) Date of Service: Must be numeric. If a "From -- To" date range is used, the claim must not be submitted to OMAP prior to the "thru" date;

(f) Place of Service: Where service was provided:

(A) 4 = Patient's home;

(B) 5 = Day care facility;

(C) 6 = Night care facility;

(D) 7 = Intermediate care facility;

(E) 8 = Skilled nursing facility.

(g) Procedure Code: Use only HCPCS or OMAP unique codes listed in the **Home Enteral/Parenteral Nutrition and IV Services Provider Guide**.;

(h) Days or Units: Enter the number of services or units billed;

(i) Type of Service Code (TOS): S = Home Enteral/Parenteral Nutrition and IV Services;

(j) Charges Billed Medicare: Enter the total dollar amount billed to Medicare foreach service;

(k) Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare foreach service;

(l) Provider Number: Enter the Medicaid provider number here unless it is used (or different than the provider number) in Field 34;

(m) Total Charge: Add the charges in Field 24G and enter the total dollar amount billed Medicare;

(n) Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services;

(o) Balance Due: Subtract the amounts in Fields 28 and 30 from Field 27 and enterthe balance in this field. An amount must be put in this field;

(p) Physician's or Supplier's Name, Address, Zip Code and Phone Number: Only theOMAP provider number is required;

(q) Diagnosis Dx: Enter primary diagnosis code first and subsequent diagnosis codes as needed. Use only ICD-9-CM diagnosis codes. Where a 4th and/or 5th digit is appropriate, summary diagnosis codes may not be submitted;

(r) Diagnosis Code: Enter the single-digit line reference number from the "Diagnosis or Nature of Illness or Injury"

field.

(2) The following information must be entered on the OMAP 505 when appropriate:

(a) Was Condition Related To: Complete if service is related to an injury/accident;

(b) If an Emergency Check Here: If the service was performed as an emergency;

(c) Name of Referring Physician or Other Source: If this service is the result of a referral, enter the OMAP provider number of the referring (requesting) practitioner. If this service is the result of an FCHP or PCO referral, the OMAP provider number of the FCHP or PCO Plan (not the practitioner) must be entered here;

(d) Prior Authorization: If prior authorization is required, enter the nine-digit code here. Services not covered by Medicare require prior authorization;

(e) Insurance Other Than Medicaid/Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance. If the amount is zero, put in a "0".

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-121-0800

Instructions for Completing the Prescription Drug Invoice (Form OMAP 502/OMAP 502N) - For Services Provided on or After January 1, 1995

(1) The following information must be entered on the OMAP 502/502N:

(a) Line: Preprinted line number;

(b) Recipient Last Name: Enter the first two letters of the client's last name from the Medical Care Identification;

(c) First Initial: Enter the first letter of the client's first name as it appears on the Medical Care Identification;

(d) Recipient ID Number: Enter the client's eight-digit ID number from the Medical Care Identification;

(e) Prescription Number: The number assigned by the pharmacy to the prescription. This may be a seven character, alpha, numeric or combination;

(f) Prescribing Physician ID Number: Enter the OMAP provider number of thephysician who prescribed the drug. Use the provider listing supplied by OMAP. If the number is unknown, enter 999999 and give the name of the prescribing physician in the Remarks area (Field 18);

(g) Date Dispensed: Enter the date the drug was dispensed in month/day/year (01/22/89) numeric format;

(h) National Drug Code: Enter the NDC number assigned to the dispensed product as it appears on the package from which dispensed, with the hyphens in relation to the dotted vertical lines in column #11 on the OMAP 502 billing form (Example: 00000/0000/00). If it is not possible to find an NDC number for a drug or item that is prescribed, code 99999-9999-99 (11 digits) must be used. Enter the product name, manufacturer, strength, quantity dispensed and any other pertinent data necessary for identification in Remarks (Field 18);

(i) Days Supply: Estimate in days the duration of this prescription supply. This field must be completed. If it is a PRN or you are unable to determine the estimated days or supply, use "99". The maximum allowed in this field is "100." A greater number of days must be indicated by Default code "99";

(j) Charge: Enter the usual and customary charge for the prescription;

(k) Total Amount Charged: Enter the sum of all charges on the claim;

(l) Date: The billing date is required. Dates must be in six digit numeric format of month/day/year;

(m) OMAP Provider Number: Enter the pharmacy's six-digit OMAP provider number;

(n) Name and Address of Provider: Enter the name and address of the pharmacy.

(2) The following information must be entered on the OMAP 502/502N when appropriate:

(a) Home Ent/IV: Enter an "X" in this column if drug is for home IVservices. Enter "Z" if drug is for home enteral or parenteral nutrition;

(b) Unit Dose Indicator: Enter the appropriate unit dose indicator from the choicesbelow:

(A) U -- Unit dose;

(B) C -- Dose card;

(C) A -- Ambulatory or leave blank.

(c) Insurance Indicator: If the pharmacist receives a third party insurance payment, put a "Y" in this column. In the Remarks Section (Field 18), indicate the line number and the payment amount received. If no other third party payment is received, enter an "N" in this field;

(d) TPR (Third Party Resources) Code: If no payment was received from theclient's other insurance, enter one of the two-digit TPR codes from the list of TPR codes found in the billing section of this **Guide**;

(e) Generic Override: Enter "Y" when a physician has specified no genericsubstitutions and the proper documentation is on file in the pharmacy.

NOTE: Prescriptions must have "medically necessary" or "brand medically necessary" or "brand necessary" written by the prescriber. Initials or checked boxes are not acceptable.

(f) Metric Quantity: Exact decimal metric quantity must be billed, up to three decimal places, if billing using the Point-of-Sale system. Use four decimal places for paper, electronic and modem billings. Enter the number of grams (if powders) or the number of ml's of the liquids dispensed. When billing for food supplements, bill according to instructions in OAR 410-121-0400. Formulary for Food Supplement (Pharmaceutical Services provider guide). If multiple dose vials are dispensed indicate the total number of ml's dispensed unless the vials have been assigned unique codes addressed in OAR 410-121-0260. The quantity cannot exceed 99.999.999;

(g) Remarks: Use this field for:

(A) Full descriptions of items for which an NDC number is not in evidence;

(B) Other insurance amount paid and recipient liability amount;

(C) Non-participating and out-of-state prescribing physicians names, etc.;

(D) Any other information you wish to give relating to this billing.

(h) Always refer to the line number from Field 1 to identify the prescription towhich the information relates;

(i) Return to: This is the mailing address for pharmacy claims. Please mail allpharmacy claims to OMAP

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95

410-121-0820

Individual Adjustment Request Form

(1) Overpayments, underpayments and payments from other sources received after OMAP has paid a claim can be resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be resubmitted using a HCFA-1500, OMAP 502 or OMAP 502N.

(2) Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation may be submitted to support your request. Adjustment Requests must be submitted in writing to the Office of Medical Assistance Programs.

(3) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) This is a reminder to attach needed docu-mentation;

(c) Mail your Adjustment Request to this address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**.);

(e) Enter the client's recipient identification number in this space. This number can be found on the RA in Field 6, or on the client's Medical Card;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Card;

(g) Enter the six-digit provider number in this space;

(h) This space is for the provider name;

(i) Enter the date printed at the top of your RA;

(j) Description-- This column contains possible areas to be corrected. Only check the box you want to change:

(A) Place of Service-- Enter place where service is provided:

(i) 4 = Patient's home;

(ii) 5 = Day care facility;

(iii) 6 = Night care facility;

(iv) 7 = Intermediate care facility;

(v) 8 = Skilled nursing facility.

(B) Type of Service -- Use Type of Service "S";

(C) Quantity/Unit-- The number of services being billed;

(D) Revenue Center Code (Hospital only) -- Do not check this box. This is for hospital billing only;

(E)Insurance Payment/Patient Liability -- The payments from other sources;

(F) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacybilling only;

(G) Billed Amount -- The amount you billed OMAP;

(H) Other -- Use this box if none of the above address your problems.

(k) Line # -- List the line number from the original claim (HCFA-1500 or OMAP 505) being adjusted;

(l) Service Date -- Enter the date the service was performed;

(m) Wrong Information -- Enter the incorrect information submitted on the original claim in this column;

(n) Right Information **--** Enter the corrected information in this column;

(o) Remarks-- This is the area to give additional information or explain the request;

(p) Provider's Signature-- The signature of the provider or other authorized personnel mustbe in this space;

(q) Date -- Enter the date this form was completed.

[ED NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

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

410-121-0840

Home Enteral Nutrition - For Services Provided on or After January 1, 1995

(1) The procedure codes which require prior authorization have the indicator following the code. Procedure codes that require a written report are marked with BR. Those codes marked NC are not covered by OMAP.

(2) Enteral Nutrition Formulae -- Use the following codes only when billing for tube-fed nutritional supplements. If the product dispensed is not shown in one of the listed categories, select a category equivalent when billing OMAP:

(a) B4150 -- Enteral Formulae; Category I: (semi-synthetic) Intact Protein/Protein Isolates (e.g., Enrich Ensure, Ensure

HN, Ensure Powder, Isocal, Lonalac Powder (Meritene, Meritene Powder, Osmolite, Osmolite HN, Portagen Power, Sustacal, Renu, Sustagen Powder, Travasorb, Gevity) 100 calories = 1 unit;

(b) B4151 -- Enteral Formulae; Category I: Natural Intact Protein/Protein Isolates (e.g., Compleat B, Vitaneed, Compleat B modified) 100 calories = 1 unit;

(c) B4152 -- Enteral Formulae; Category II: Intact Protein/Protein Isolates (calorically (e.g., Magnacal, Isocal HCN, Sustacal HC, Ensure Plus, Ensure Plus HN)) 100 calories = 1 unit;

(d) B4153 -- Enteral Formulae; Category III: Hydrolized Protein/Amino Acids (e.g., Criticare HN, Vivonex, T.E.N. (Total Enteral Nutrition), Vivonex HN, Vital (Vital HN), Travasorb HN, Isotein HN, Precision HN, Precision Isotonic) 100 calories = 1 unit;

(e) B4154 -- Enteral Formulae; Category IV: Defined Formula for Special Metabolic Need (e.g., Hepatic-aid, Travasorb Hepatic, Travasorb MCT, Travasorb Renal, Traum-Aid, Tramacal, Aminaid, Immun-Aid, Respalor, PulmoCare Advera, Lipisorb, Nepro, Reabolin HN, Replena (Supplena), Glucerna) 100 calories = 1 unit;

(f) B4155 -- Enteral Formulae; Category V: Modular Components (Protein, Carbohydrates, Fat) (e.g., Propac, Gerval Protein, Promix, Casec, Moducal, Controlyte, Polycose Liquid or Powder, Sumacal, Microlipids, MCT Oil, Nutri-Source) 100 calories = 1 unit;

(g) B4156 -- Enteral Formulae; Category VI: Standardized Nutrients (Vivonex Std., Travasorb Std., Precision LR and Tolerex) 100 calories = 1 unit;

(3) Oral Nutritional Supplements. Use the following codes only when billing for Oral Nutritional Supplements:

(a) 211EP -- Oral Formulae; Category I: Intact Protein/Protein Isolates (e.g., Enrich, Ensure, Ensure Powder, Osmolite, Isocal, Renu, Sustacal, Lonalac Powder, Travasorb, Travasorb MCT, Sustagen Powder, Meritene, Meritene Powder, Portagen, Portagen Powder, Gevity) 100 calories = 1 unit -- PA;

(b) 212EP -- Oral Formulae; Category II: Intact Protein/Proein Isolates (calorically dense) (e.g., Magnacal, Isocal HCN, Sustacal HC, Ensure Plus, Ensure Plus HN) 100 calories = 1 unit -- PA;

(c) 213EP -- Oral Formulae; Category III: Hydrolized Protein/Amino Acids (e.g., Vivonex HN Powder, Criticare HN, Vivonex Vital (Vital HN), Travasorb HN Powder Vipep, Isotein HN, Precision Isotonic Powder, Precision HN Powder, Osmolite HN, Ensure HN, Isotein HN) 100 calories = 1 unit -- PA;

(d) 214EP -- Oral Formulae; Category IV: Defined formula for special metabolic needs (e.g., Hepatic-Aid, Traum-Aid HBC, Travasorb Hepatic, Travasorb Renal, Amin-Aid, Immun-Aid, Respalor, Advera Lipisorb, Nepro, Reabolin HN, Replena (Supplena), Glucernia, Pulmocare) 100 calories = 1 unit -- PA;

(e) 215EP -- Oral Formulae; Category VI: Standardized (e.g., Vivonex STD Powder, Travasorb STD Powder, Precision LR Powder) 100 calories = 1 unit -- PA;

(f) 216EP -- Oral Formulae; not otherwise classified: Includes: Infant Foods, Infant Foods with Iron, Hypoallergenic Infant Food, Defined Formula Diet (e.g., Pulmocare for Pulmonary Patients) 100 calories = 1 unit -- PA;

(g) 219EP -- Oral Formulae; Category V: Modular Components (Protein, Carbohydrates, Fat) (e.g., Propac, Gerval Protein Promix, Casec, Moducal, Controlyte, Polycose Liquid or powder, Sumacal, Microlipids, MCT Oil, Nutri-Source) 100 calories = 1 unit -- PA.

(4) Enteral Supply Kits/Tubing:

(a) B4035 -- Enteral Feeding Supply Kit -- Pump Fed -- Monthly -- (1 kit = 1 unit);

(b) B4036 -- Enteral Feeding Kit -- Gravity Fed -- Monthly -- (1 kit = 1 unit);

(c) B4081 -- Nasogastric Tubing with Stylet, each;

(d) B4082 -- Without Stylet, each;

(e) B4083 -- Stomach Tube, Levine Type, each;

(f) B4084 -- Gastrostomy/Jejunostomy Tubing, each;

(g) B4034 -- Enteral Feeding Supply Kit -- Syringe -- Monthly - (1 Kit - 1 Unit) -- NC;

(h) Note: When billing for syringes, bill OMAP using the type of service and procedure codes listed in the **Durable Medical Equipment Guide**.

(5) Enteral Nutrition Equipment:

(a) 201EP -- Enteral Nutrition Infusion Pump -- Without Alarm -- Rental (1 month = 1 unit) -- PA;

(b) 203EP -- Enteral Nutrition Infusion Pump -- With Alarm -- Rental (1 month = 1 unit) -- PA;

(c) 208EP -- IV Pole -- Purchase;

(d) 209EP -- IV Pole -- Rental (1 month = 1 unit).

(6) Enteral Oral Electrolyte Mixtures: 210EP -- Electrolytes (e.g., Pedialyte, Rehydralyte Solution) 1,000 ml = 1 unit.

(7) Not Otherwise Classified (NOC): B9998 -- NOC for Enteral Supplies -- PA/BR.

(8) Home Nursing Visit:

(a) 217EP -- Home Nursing Visit (1 visit = 1 unit) -- PA;

(b) 218EP -- Home Nursing Visit for Assessment (1 visit = 1 unit) -- PA.

Stat. Auth.: ORS Ch. 409

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

410-121-0860

Home Parenteral Nutrition - For Services Provided on or After January 1, 1995

(1) Parenteral Nutrition Solutions: Reimbursement for compounding, admixture and administrative fees is included in the Unit Price of the solution.

(a) B4164 -- Parenteral Nutrition Solution: Carbohydrates (Dextrose), 50% or less; 500 ml = 1 unit -- Homemix;

(b) B4168 -- Parenteral Nutrition Solution: Amino Acid, 3.5%; 500 ml = 1 unit -- Homemix;

(c) B4172 -- Parenteral Nutrition Solution: Amino Acid, 5.5% through 7%; 500 ml = 1 unit -- Homemix;

(d) B4176 -- Parenteral Nutrition Solution; Amino Acid, 7% through 8.5%; 500 ml = 1 unit -- Homemix;

(e) B4178 -- Parenteral Nutrition Solution; Amino Acid, greater than 8.5%; 500 ml = 1 unit -- Homemix;

(f) B4180 -- Parenteral Nutrition Solution; Carbohydrates (Dextrose), greater than 50%; 500 ml = 1 unit -- Homemix;

(g) B4184 -- Parenteral Nutrition Solution; Lipids, 10% with Administration Set; 500 ml = 1 unit;

(h) B4186 -- Parenteral Nutrition Solution, Lipids, 20% with Administration Set; 500 ml = 1 unit;

(i) B4189 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength, 10 to 51 grams of protein -- Premix (10 to 51 grams = 1 unit);

(j) B4193 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength; 52 to 73 grams of protein -- Premix (52 to 73 grams = 1 unit);

(k) B4197 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength, 74 to 100 grams of protein -- Premix (74 to 100 grams = 1 unit);

(l) B4199 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength, over 100 grams of protein -- Premix;

(m) B4216 -- Parenteral Nutrition; Additives (Vitamins, Trace Elements, Heparin, Electrolytes) Homemix per day -- (1 day = 1 unit);

(n) B5000 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength, Renal -- Aminosyn RF, Nephramine, Renamine -- Premix -- (1 gram = 1 unit);

(o) B5100 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength, Hepatic -- Freamine HBC, Hepatamine -- Premix -- (1 gram = 1 unit);

(p) B5200 -- Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements and Vitamins, Including Preparation, any strength, Stress -- Branch Chain Amino Acids -- Premix -- (1 gram = 1 unit).

(2) Parenteral Supply Kits/Supplies: This is not an all inclusive list of supplies, but is included for illustration purposes only.

(a) B4220 -- Premix -- Parenteral Nutrition Supply Kit for One Month (1 kit = 1 unit)*:

(A) 180 Alcohol Wipes;

(B) 16 oz Isopropyl Alcohol;

(C) 30 Povidone Iodine -- Ointment 1.5 gm;

(D) 60 Povidone Swabs;

(E) 30 Povidone Sticks;

(F) 30 Gauze Sponges 2" x 2";

(G) 30 Heparin Lock -- Flush -- 100 u/ml;

(H) 4 Micropore Tape -- 2";

(I) 30 Syringe/Needle -- 3 cc, 20 gm, 1";

(J) 2 Plastic Tape -- 1/2";

(K) 30 Injection Caps;

(L) 1 Ketodiastix.

(b) B4222 -- Home-Mix -- Parenteral Nutrition Supply Kit for One Month (1 kit = 1 unit)*:

(A) 30 Gloves;

(B) 300 alcohol Wipes;

(C) 16 oz Isopropyl Alcohol;

(D) 30 Povidone Iodine -- Ointment -- 1.5 gm;

(E) 16 oz Acetone;

(F) 60 Povidone Swabs;

(G) 30 Povidone Sticks;

(H) 30 Gauze Sponges 2" x 2";

(I) 30 Heparin Lock -- Flush -- 100 u/ml;

(J) 30 Syringe/Needle -- 5 cc, 20 ga., 1";

(K) 30 Injection Caps;

(L) 4 Micropore Tape -- 2";

(M) 2 Plastic Tape -- 1/2";

(N) 240 Needles -- 20 ga. x 1";

(O) 180 Syringes -- 20 cc;

(P) 20 Syringe/Needles, 60 cc;

(Q) 1 Ketodiastix.

(c) B4224 -- Parenteral Nutrition Administration Kit for One Month (1 kit = 1 unit)* -- Administration Supplies, Including Bags and Tubing.

(3) Parenteral Nutrition Equipment:

(a) 206EP -- Parenteral Nutrition Infusion Pump -- Portable -- Rental (1 month = 1 unit) -- PA;

(b) 207EP -- Parenteral Nutrition Infusion Pump -- Stationary -- Rental (1 month = 1 unit) -- PA;

(c) 208EP -- IV Pole -- Purchase;

(d) 209EP -- IV Pole -- Rental -- (1 month = 1 unit).

(4) Not Otherwise Classified (NOC): B9999 -- NOC for Parenteral Supplies -- PA.

(5) Home Nursing Visit:

(a) 217EP -- Home Nursing Visit (1 visit = 1 unit) -- PA;

(b) 218EP -- Home Nursing Visit for Assessment (1 visit = 1 unit).

Stat. Auth.: ORS Ch. 409

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

410-121-0880

Home IV and Other Parenteral Administration Services

(1) The procedure codes which require prior authorization have the indicator PA following the code.

(2) Catheter Care Kits: All catheter care kit allowable amounts are determined on a per diem basis.

*This is not an all inclusive list of supplies, but is included for illustration purposes only.

(a) 226HV -- PICC Dressing Change Supplies Kit -- (1 day = 1 unit)*:

(A) Alcohol Wipes;

(B) Hydrogen Peroxide;

(C) Povidone Iodine;

(D) Swabsticks;

(E) Sterile Q-Tips;

(F) Antibacterial Ointment;

(G) Sterile Gauze;

(H) Transparent Dressing;

(I) Heparin Cap;

(J) T-Connector;

(K) Steristrips/Coverstrips;

(L) Kling;

(M) Surgiflex;

(N) Tape.

(b) 227HV -- Central Catheter Dressing Change Supplies Kit -- (1 day = 1 unit)*:

(A) Alcohol Wipes;

(B) Hydrogen Peroxide;

(C) Povidone Iodine;

(D) Swabsticks;

(E) Sterile Q-Tips;

(F) Antibacterial Ointment;

(G) Sterile Gauze 2" x 2";

(H) Transparent Dressing;

(I) Heparin Cap;

(J) Tape;

(K) Gloves.

(c) 228HV -- Peripheral Catheter Dressing Change Supplies Kit -- (1 day = 1 unit)*:

(A) Alcohol Wipes;

(B) Povidone Iodine;

(C) Swabsticks;

(D) Antibacterial Ointment;

(E) Sterile Gauze 2" x 2";

(F) Transparent Dressing;

(G) Tape.

(d) 229HV -- Implantable VAD (Venous Access Device) Dressing Change Supplies Kit -- (1 day = 1 unit)*:

(A) Sterile Gloves;

(B) Alcohol Swabsticks;

(C) Alcohol Wipes;

(D) Povidone Iodine;

(E) Swabsticks;

(F) Antibacterial Ointment;

(G) Steristrips/Coverstrips/Sterile;

(H) Tape;

(I) Heparin Cap;

(J) Sterile Gauze;

(K) Transparent Dressing;

(L) Sterile Drops;

(M) Sterile A-Tip;

(N) Tape.

(3) Medication Administration Supply Kits and Pumps. Medication Administration Supply Kits allowable amounts are determined on a per diem basis:

(a) 230HV -- Gravity Administration -- (1 day = 1 unit)*:

(A) Tubing;

(B) Needle;

(C) Filter;

(D) Tape;

(E) Alcohol Wipes;

(F) IV Pole;

(G) Flush.

(b) 231HV -- Small Volume Infusion Pump -- Rental -- (1 day = 1 unit)* -- PA:

(A) Pump;

(B) Microbore Tubing;

(C) Syringes;

(D) Needle;

(E) Alcohol Wipes;

(F) Tape;

(G) Flush;

(H) Batteries.

(c) 232HV -- Programmable Infusion Pump -- Rental (1 day = 1 unit)* -- PA:

(A) Pump;

(B) Tape;

(C) Alcohol Wipes;

(D) 9-Volt Batteries.

(d) 233HV -- Large Volume Infusion Pump -- Rental -- (1 day = 1 unit)* -- PA:

(A) Pump;

(B) IV Pole;

(C) Pump Tubing;

(D) Needle;

(E) Alcohol Swabs;

(F) Flush;

(G) Tape.

(e) 243HV -- Additional Pump for Simultaneous Administration -- Rental -- (1 day = 1 unit) -- PA;

(f) 244HV -- Pump not Otherwise Classified -- Rental -- (1 day = 1 unit) -- PA;

(g) 237HV -- IV Pole -- Purchase;

(h) 238HV -- IV Pole -- Rental -- (1 day = 1 unit)*;

(i) 239HV -- Medication Cassette (1 per unit);

(j) 204HV -- IV Medication -- Large Volume Diluent (1,000 ml = 1 unit).

(k) 242HV -- IV Piggy Back Diluent (100 ml = 1 unit).

(4) Venipuncture Supplies:

*This is not an all inclusive list of supplies, but is included for illustration purposes only.

(a) 234HV -- IV Starter Kit Supplies -- (1 day = 1 unit)*:

(A) Alcohol Wipes;

(B) Providone Iodine;

(C) Wipes;

(D) Sterile Gauze 2" x 2"; and/or

(E) Transparent Dressing;

(F) Tourniquet;

(G) Tape;

(H) Herparin Cap;

(I) T-Piece;

(J) Anesthetizing Agent Saline/Lidocaine;

(K) Flush -- Tubex or Syringe with Needle;

(L) Gloves;

(M) Optional -- Kling or Surgi-Flex for Securing Site;

(N) IV Catheter.

(b) 235HV -- VAD Starter Kit Supplies (Venous Access Device) -- (1 day = 1 unit)*:

(A) Sterile Gloves;

(B) 90° Huber Point;

(C) Needle with -- Extension Tubing;

(D) Sterile Drape;

(E) 5 cc Syringe with Needle;

(F) Bacteriostatic Sodium Chloride -- 30 cc vial;

(G) 20 cc Syringe with Needle;

(H) Heparin Flush;

(I) Sterile 2" x 2";

(J) Steristrips/Coverstrips/Sterile Tape;

(K) Transparent Dressing;

(L) Heparin Plug;

(M) Gloves.

(5) Nursing Service Visit:

(a) 236HV -- Home Nursing Visit (1 Visit = 1 unit) -- PA;

(b) 241HV -- Home Nursing Visit for Assessment (1 visit = 1 unit).

(6) Not Otherwise Classified (NOC): 999HV -- NOC for Home IV Supplies -- PA.

Stat. Auth.: ORS Ch. 409

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

410-121-0900

Billing Quantities, Metric Quantities and Package Sizes

(1) Use the following metric quantities when billing on the OMAP 402(N). When actual metric quantities are unknown, the following conversions are used:

(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., Tes-tape, 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 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90

410-121-0920

Items Covered in the All-Inclusive Rate for Nursing Facilities

The all-inclusive rate for nursing facilities includes but is not limited to the items listed below. Please bill the nursing facility for these items. See Over the Counter (OTC) drug list:

(1) Air mattresses, egg carton mattresses.

(2) Airway, oral.

(3) Alternating pressure pads and pumps.

(4) Applicators, cotton tipped.

(5) Aquamatic K pads (water-heated pad).

(6) Arm slings.

(7) Bandaids.

(8) Bandages, including elastic or cohesive.

(9) Basins.

(10) Bed frame equipment (for certain immobilized bed patients).

(11) Bedpan, regular and fracture.

(12) Bed rails.

(13) Bibs, including plastic.

(14) Canes.

(15) Catheter urinary (any size, including indwelling).

(16) Catheter bags, plugs and tray.

(17) Clinitest tablets.

(18) Colon tubes.

(19) Combs, brushes.

(20) Communication boards.

(21) Cotton and cotton balls.

(22) Creams (i.e., A and D, Eucerin, etc.).

(23) Crutches.

(24) Decubitus ulcer pads, preventive items.

(25) Deodorants, room.

(26) Diabetic urine testing (i.e., Clinitest, Diastic).

(27) Disposable underpads, diapers.

(28) Douche bags.

(29) Drainage bags, sets, tubes.

(30) Dressings (all, including surgical and dressing tray, pads, tape, sponges, swabs, etc.).

(31) Enemas and enema supplies, OTC.

(32) Eye pads.

(33) Feeding tubes and units, gastric, nasal (non-pumped).

(34) First aid supplies.

(35) Flotation mattress, pads and/or turning frames.

(36) Folding foot cradle.

(37) Food or food supplements provided between meals for nourishment.

(38) Footboards.

(39) Gauze and gauze sponges.

(40) Geriatric chairs.

(41) Gloves, unsterile and sterile, examination and surgical.

(42) Gowns, hospital.

(43) Heat cradle, heat pads.

(44) Hot pack machine.

(45) Hot water bottles.

(46) Ice bags.

(47) Incontinency care and supplies, pants, diapers.

(48) Infusion arm boards.

(49) Inhalation therapy supplies, Nebulizer and replacement kit, steam vaporizer.

(50) Intermittent positive pressure breathing apparatus (I.P.P.B).

(51) Invalid ring.

(52) Irrigation bulbs and trays.

(53) I.V. trays and tubing.

(54) Jelly, lubricating.

(55) Lamps, infrared and ultraviolet.

(56) Laxatives, OTC.

(57) Linens.

(58) Lotions, creams, and oils, over-the-counter (i.e., Keri, Lubriderm, etc.).

(59) Medicine dropper.

(60) Menstrual supplies.

(61) Nasal cannula.

(62) Nasal catheter.

(63) Needles (various sizes).

(64) Ointments (i.e., Neosporin, Vaseline).

(65) Ostomy bags and supplies.

(66) Overhead trapeze equipment.

(67) Oxygen.

(68) Oxygen tents, masks, etc.

(69) Padding for incontinent care.

(70) Pumps, aspiration and suction.

(71) Restraints.

(72) Rubber rings.

(73) Sand bags.

(74) Shampoo, including medicated shampoos, conditioners.

(75) Sheepskin.

(76) Soap, including medicated.

(77) Solutions for IV hydrational.

(78) Therapy.

(79) Specimen cups and bottles.

(80) Stomach tubes.

(81) Suction equipment and machines.

(82) Syringes (all sizes) reusable and disposable.

(83) Tes-Tapes.

(84) Thermometers.

(85) Tissues, bedside and toilet.

(86) Tongue depressors.

(87) Toothbrushes and paste.

(88) Traction equipment.

(89) Tuberculin tests.

(90) Urinals, male and female.

(91) Urological solutions.

(92) Walkers.

(93) Water bed.

(94) Water pitchers.

(95) Wheelchairs (non-customized).

(96) Bath/shower benches and chairs.

(97) Commode chairs.

(98) Glucose monitors.

Stat. Auth.: ORS Ch. 409

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

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 122

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

410-122-0000

Purpose

In conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Medicaid Demonstration Project Administrative Rules, these rules are established by the Office of Medical Assistance Programs (OMAP) for the purpose of supervising and controlling payments for durable medical equipment and medical supplies (DME) provided to those OMAP clients eligible to receive such services under the provisions of Oregon Revised Statutes.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 41-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 in the North Salem, Woodburn, Dallas, McMinnville, Lebanon, Albany and Corvallis branch offices, ef. 6-30-82 in the balance of the state; 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 461-24-000; HR 9-1993, f. & cert. ef. 4-1-93; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95

410-122-0020

Prescription Requirement - Effective for Services Provided On or After June 1, 1996

(1) The purchase or rental of durable medical equipment and supplies must have a proper written order signed by the physician or practitioner. (A practitioner means a person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitoner's license and certification.) A prescription is also required if modifications are made to original durable medical equipment. Repairs, parts needed for repairs and replacement parts (e.g., batteries do not require a prescription.

(2) The prescription must be dated, legible and specify the exact medical item or service required, the ICD-9-CM diagnosis codes and length of time needed. Medicare and Medicaid define a lifetime need as 99 months for the

following items:

(a) Nebulizers;

(b) Ventilators;

(c) Suction pumps;

(d) IPPB (intermittment positive pressure breathing device);

(e) CPAP (continuous positive pressure airway device);

(f) 15 month Medicare rentals.

(3) For all other items, a lifetime need for service is defined as one year. A new prescription is required once a year for ongoing equipment and supplies.

(4) The DME provider must obtain a prescription before providing the service. The prescription must be supported by documentation in the prescribing practitioner's records.

(5) Durable medical equipment providers are responsible for retaining a copy of the prescription in their records. The prescription does not have to be submitted to the appropriate authorizing agency.

Stat. Auth.: ORS Chapter 409

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 461-24-004; 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

410-122-0030

Pricing

(1) The Office of Medical Assistance Programs will reimburse for the lowest level of service which will meet the medical need.

(2) Rental fees include:

(a) Delivery;

(b) Pick-up;

(c) Routine service, maintenance and repair

(d) Training in the use of the equipment.

(3) Purchase price includes delivery; assembly; adjustments, if needed; and training in the use of the equipment.

(4) Repair of equipment includes pick-up and delivery. Travel time may not be billed to OMAP or the client.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 9-1993, f. & cert. ef. 4-1-93; HR 18-1993, f. & cert. ef. 8-9-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94

410-122-0040

Prior Authorization of Payment - Effective for Services Provided On or After June 1, 1996

(1) Prior authorization (PA) of payment is required for durable medical equipment and medical supplies indicated by PA(in the Procedure Code Section of the Durable Medical Equipment and Medical Supplies guide) even if private insurance or Medicare is billed first. Obtaining prior authorization is the responsibility of the DME provider.

(2) Contacts for prior authorization of payment or changes in prior authorization are as follows:

(a) Services for clients identified on the Medical Care Identification as Adult and Family Services (AFS) or State Office of Services for Children and Families (CSD) except for Medically Fragile Children (MFC) clients will be prior authorized by OMAP. All required documentation should be mailed to OMAP. Requests may also be FAXED. Indicate "Medical Group" on the cover page;

(b) Most services for clients identified on the Medical Care Identification as Senior and Disabled Services Division (SSD) clients will continue to be prior authorized through the local branch office designated on the Medical Care Identification. All required documentation should be submitted to that branch office. Those services authorized by OMAP are noted throughout the guide;

(c) If a client is enrolled in Managed Health Care, contact the health plan for authorization;

(d) Services for clients identified as Medically Fragile Children's Unit clients will be authorized by the DHR Medically Fragile Children's Unit.

(3) The following services are prior authorized by OMAP for all DHR clients not in a prepaid health plan (except for Medically Fragile Children):

(a) Ventilators;

(b) Apnea monitors;

(c) Pulse Oximeters;

(d) Pressure Reducing Support Surfaces;

(e) Uterine monitors.

(4) Requests for prior authorization must be submitted to the appropriate agency in writing. Documentation supporting medical necessity may be mailed or faxed. Postmark and fax dates will be used as the date of contact.

(5) For services needed after normal working hours, all requests must be received by the appropriate agency in writing within five working days from the initiation of service.

(6) Prior authorization does not guarantee eligibility - always check for the client's eligibility on the date of service.

(7) For clients determined eligible after services are provided, authorization may still be obtained, if it is determined the service was medically necessary and the prior authorization would have been granted had eligibility been determined prior to service.

(8) Information needed to request prior authorization:

(a) Client's name;

(b) Medicaid ID Number;

(c) Procedure codes;

(d) Provider Number;

(e) ICD-9-CM Diagnosis Code - obtained from the prescribing practitioner's office;

(f) Medical justification from the prescribing practitioner;

(g) Date of services;

(h) Usual and customary charge.

(9) Information needed to request a change in existing prior authorization:

(a) Client's name;

(b) The needed change;

(c) Medicaid ID Number;

(d) Reason for change;

(e) Prior Authorization Number.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

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 461-24-010; 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

410-122-0060

Medicare/Medicaid Services - Effective for Services Provided On or After June 1, 1996

(1) For services provided to clients with both Medicare and Medicaid coverage, bill Medicare first, except when using OMAP unique codes or if the items are not covered by Medicare.

(2) OMAP unique codes or services not covered by Medicare should be billed directly to OMAP on an OMAP 505 with the appropriate two-digit TPR code.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 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 13-1991, f. & cert. ef. 3-1-91; Renumbered from 461-24-050; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 17-1996, f. & cert. ef. 8-1-96

410-122-0080

Coverage and Exclusions

(1) Items will not be purchased by OMAP when less expensive alternatives are available which will substantially meet the need.

(2) Equipment which is primarily and customarily used for a non-medical purpose will not be approved for payment, although the item has some medically related use.

(3) OMAP does not cover items which primarily serve the following purpose (or similar or related equipment):

(a) Personal comfort;

(b) Convenience of client or caregiver;

(c) Education;

(d) Cosmetic;

(e) New equipment of unproven value;

(f) Equipment of questionable usefulness or questionable therapeutic value.

(4) Equipment and services not medically necessary are excluded from coverage by OMAP (see "medically necessary services and items" in General Rules), also:

(a) Criteria as listed with individual codes is considered the medical necessity for that item, and;

(b) If no criteria is listed or there are questions about the criteria, medical necessity is determined by OMAP.

(5) Equipment not covered for purchase, rental or repair by OMAP, includes, but is not limited to the following (or similar or related equipment):

(a) Air conditioners/air cleaners/air purifiers/room humidifiers/swamp coolers;

(b) Bathroom scales;

(c) Breast prostheses;

(d) Diet scales;

(e) Esophageal dilators;

(f) Exercise equipment;

(g) Hand controls for vehicles;

(h) Hot tubs/spas;

(i) Items of household furnishings;

(j) Lift chairs;

(k) Typewriters;

(l) Sports equipment;

(m) Vans, lifts and ramps for vans;

(n) Water beds;

(o) Bedwetting prevention devices;

(p) Medical alert bracelets or I.D. tags;

(q) Water piks;

(r) Overbed tables;

(s) Telephone alert systems;

(t) Telephones;

(u) Geriatric chairs (positioning chairs);

(v) Sharp 's containers;

(w) Household appliances;

(x) Hand-held showerheads;

(y) Special linens and bed coverings;

(z) Strollers;

(aa) Bladder stimulators (pacemakers);

(bb) Reachers;

(cc) Eating utensils;

(dd) ADL assistance devices;

(ee) Articles of clothing, except orthopedic shoes and support hose;

(ff) Passive motion machine;

(gg) Rubber or cloth draw sheets;

(hh) Barrier-free ceiling track lift;

(ii) Incubators/Isolettes;

(jj) Therapy balls;

(kk) Cribs, any type including hospital cribs;

(ll) Elevators;

(mm) Incontinent wipes, baby wipes, wipes, disposable wash cloths;

(nn) Wheelchair ramps;

(oo) Tie-downs for wheelchairs in vans;

(pp) Room deodorizer;

(qq) Stair lift;

(rr) Nipple shields;

(ss) Standard infant car seats;

(tt) Graphite Spiral AFOs;

(uu) Incontinent cleansor/perineal cleanser;

(vv) Supplemental Nutrition System;

(ww) Tocolytic Pumps;

(xx) Facial tissue;

(yy) Feminine hygiene products;

(zz) Toilet tissue;

(aaa) Medicine cups, paper or plastic.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-24-020; 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

410-122-0105

Billing Forms - Effective for Services Provided On or After June 1, 1996

(1) HCFA-1500:

(a) HCFA-1500 forms are not provided by the Office of Medical Assistance Programs (OMAP). A common source for getting these forms is a local forms supplier;

(b) The information listed is necessary for processing and must be on the form. This information is entered in the computer system without review. This means that any other information written on your claim will not be read. The computer will automatically deny any claim which does not contain necessary information;

(c) Send all completed HCFA-1500 Forms to: Office of Medical Assistance Programs, Salem, Oregon.

(2) Medicare/Medicaid Claims:

(a) DMERC invoices will not cross over to OMAP. Crossovers shall be billed in two ways:

(A) After an EOB is received from Medicare, complete an OMAP 505 billing form. Do not attach Medicare's EOB to the claim; or

(B) Bill electronically on the HCFA National Standard Format for electronic claims.

(b) OMAP payment will be based on either Medicare's maximum allowable rate, OMAP's maximum allowable rate or billed rate, whichever is the lesser;

(c) If Medicare changes a HCPCS code when they process a claim, bill the crossover to OMAP with the code originally billed to Medicare.

Stat. Auth.: ORS Chapter 409

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 17-1996, f. & cert. ef. 8-1-96

410-122-0120

Health Insurance Claim Form (HCFA-1500) - Effective for Services Provided On or After June 1, 1996

(1) Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another.

(2) The following fields are always required to be completed:

(a) Insured's Medicaid Number: The eight digit number found on the OMAP Medical Care Identification form;

(b) Patient's Name: The name as it appears on the OMAP Medical Care Identification;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider;

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider;

(e) Date of Service: Must be numeric. If "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day. When billing for rental equipment, use a single date of service. The date the item is delivered, shipped or picked up is considered the "Date of Service";

(f) Place of Service: Where service is provided:

(A) 2 - outpatient hospital/OP Dept.;

(B) 3 - practitioner's office;

(C) 4 - patient's home;

(D) 7 nursing facility;

(E) C - residential treatment center.

(g) Type of Service Codes (TOS):

(A) A - DME Purchase;

(B) B - DME Rental;

(C) C - DME Repair.

(h) Procedures, Services or Supplies: Use only the HCPCS or OMAP Unique Codes listed in the Durable Medical Equipment provider guide;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service field or the number of units of services provided. Note: Rental for one month equals one unit of service, unless otherwise specified;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge field minus the information in the Amount Paid field);

(m) Provider Number: Enter the OMAP billing or provider number here;

(n) Diagnosis or Nature of Illness or Injury: Enter primary diagnosis/condition of the patient by entering **ICD-9-CM** codes. Enter up to four codes in priority order. The codes should be carried out to their highest degree of specificity. Do not enter the decimal point or unnecessary characters;

(o) Diagnosis Code: Enter a single diagnosis reference number as shown in field 21.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Care Identification form. Use the Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related to: Complete as appropriate when an injury is involved;

(c) Reserved for Local Use (Field 10d): Put a "Y" in this field if the service was an emergency;

(d) Prior Authorization Number: If required, enter the Prior Authorization number here. Prior authorized and non-prior authorized services cannot be billed on the same HCFA-1500;

(e) Reserved for Local Use - (Field 24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(f) Amount Paid: Enter the total amount paid from other resources.

(4) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/ Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

(I) NE -- Service Not Considered Emergency by Insurance;

(J) NP -- Service Not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/Condition;

(L) RI -- Requested Information Not Received by Insurance from Patient;

(M) RP -- Requested Information Not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -not paid within 30 days;

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made);

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary paid;

(B) SU -- Primary Insurance Paid -- Secondary under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care -- Provider/Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why not TPR Payment was made);

(S) AP -- Insurance mandated under administrative/court order through an absent parent - not paid within 30 days.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 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 13-1991, f. & cert. ef. 3-1-91; Renumbered from 461-24-060; 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

410-122-0140

How to Complete the OMAP 505 -- Effective for Services Provided On or After January 1, 1994

(1) Patient Name: Enter the name as its appears on the Medical Care Identification Form*.

(2)Insured's Medicaid Number: Enter the eight-digit number from the Medical Care Identification Form*.

(3)*Insured's Group Number: The Medicare number as it appears on the client's Medicare Identification Card. (Example: 123456789A or 234567890C1).

(4)**Other Health Insurance Coverage: If no payment was received from Medicare, this space *must* be used to explain why no payment was made. Select a two-digit "Reason" code from the Third Party Resource (TPR) Codes that are found in the **Billing Section** of this **Guide**. Be sure that this "Reason" code is the *first* entry in Field 9, followed by the name of the Third Party Resource (Medicare). Example: Medicare paid nothing ("Reason" code NC, Not Covered). Enter: NC -- Medicare. Do not mail the Medicare EOB in with your claim.

(5)**Was Condition Related To: Complete if service is related to an injury accident.

(6)**If an Emergency Check Here: Check here if the service was performed as an emergency.

(7)*Referring Physician: Enter the OMAP provider number of the referring provider.

(8)**Prior-Authorization: If Prior Authoriza-tion is required enter the nine-digit number here.

(9)*Date of Service: Use a six-digit numeric date (03/01/91). If a "From -- To" date is used, all services must be on consecutive days. When billing for rental equipment, use a single date of service.

(10)*Place of Service: Where service is provided:

(a) 2= Outpatient hospital/OP department/ER;

(b) 3= Practitioner's office;

(c) 4= Patient's home;

(d) 7= Intermediate care facility;

(e) 8= Skilled nursing facility;

(f)C= Residential treatment center.

(11)*Procedure Code: Enter only the Health Care Financing Common Procedure Coding System (HCPCS) Codes or OMAP Unique Codes found in the **Provider Guide**.

(12)*Days or Units: Enter the number of services or units billed.

NOTE: One month rental equals one unit of service.

(13) *Type of Service Codes (TOS):

(a) A= DME Purchase;

(b) B= DME Rental;

(c) C= DME Repair;

(d)R= DME Installment.

(14)*Charges Billed Medicare: Enter the total dollar amount billed Medicare for the service.

(15)**Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare for this service.

(16)*Provider Number: Enter the OMAP provider number here unless it is used in Field 34.

(17)*Total Charge: Add the charges in Field 24G and enter the total dollar amount billed Medicare.

(18)*Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services provided.

(19)**Insurance Other Than Medicaid/Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "0".

(20)*Balance Due: Subtract the amounts in Fields 28 and 30 from Field 27 and enter the balance in this field. An amount *must* be put in this field.

(21)Your Patient's Account Number: If the patient account number is entered here, OMAP will print that number on the Remittance Advice.

(22)*Physician's or Supplier's Name, Address, Zip Code and Phone Number: Only the OMAP provider number is required in this field.

(23) *Diagnosis or Nature of Illness or Injury: Enter primary diagnosis/condition of the patient by entering ICD-9-CM codes. Enter up to four codes in priority order. The codes should be carried out to their highest degree of specificity. Do not enter the decimal point or unnecessary characters.

(24) *Diagnosis Code: Enter a single diagnosis reference number as shown in Field 23A.

* = Required Field

* * = Required When Applicable

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

Hist.: 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 461-24-070; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94

410-122-0160

How to Complete an Adjustment Request

(1) Overpayments, underpayments and payments received after the OMAP has paid a claim can be resolved through the adjustment process.

(2) Individual Adjustment Request Forms are obtained from the AFS Provider Forms Distribution Center.

NOTE: Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation may be submitted to support the request. Adjustment Requests must be submitted in writing to: Office of Medical Assistance Programs, Salem, OR 97309.

(3)Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much).

(4)This is a reminder to attach needed documentation.

(5)Mail the Adjustment Request to this address.

(6)Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**).

(7)Enter the client's identification number in this space. This number can be found on the RA in Field 6, or on the Medical Card.

(8)Enter the client's name in this area. Use the same name as is shown on the Medical Card.

(9)Enter the six-digit provider number in this space.

(10)This space is for the provider name.

(11)Enter the date printed at the top of the RA.

(12)Description -- This column contains possible areas that may need to be corrected. Only check the box to be changed:

(a)Place of Service -- Enter the place where service is provided. Use Place of Service indicator from HCFA-1500 or OMAP 505 instructions;

(b)Type of Service -- Use only OMAP type of service indicators. A listing of these indicators can be found in this **Guide** under HCFA-1500 billing instructions;

(c)Quantity/Unit -- The number of services being billed;

(d)NDC/Procedure -- Codes from this **Guide** must be used;

(e)Revenue Center Code (Hospital Only) -- Do not check this box. This is for hospital billing only;

(f)Insurance Payment/Patient Liability -- The payments from other sources;

(g)Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(h)Billed Amount -- The amount billed OMAP;

(i)Other -- Use this box if none of the above address the problem;

(j)Line # -- List the line number from the original claim (HCFA-1500 or OMAP 505) which is now being adjusted;

(k)Service Date -- Enter the date the service was performed;

(l)Wrong Information -- Enter the incorrect information submitted on the original claim here;

(m)Right Information -- Enter the corrected information in this column;

(n)Remarks -- This is the area to give additional information or explain the request;

(o)Provider's Signature -- The signature of the provider or other authorized personnel must be in this space;

(p)Date -- Enter the date this form was completed.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS

Hist.: 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 461-24-080; HR 10-1992, f. & cert. ef. 4-1-92

410-122-0180

Procedure Codes - Effective for Services Provided On or After June 1, 1996

(1) The Office of Medical Assistance Programs guide, **Durable Medical Equipment and Medical Supplies** (DME) is intended to be used in conjunction with the **HCFA Common Procedure Coding System (HCPCS)**. When billing for durable medical equipment and supplies, use the procedure codes listed in the **DME Guide**. When billing for orthotic and prosthetic equipment and supplies, use the **AOPA Publication**, prepared by the American Orthotic and Prosthetic Association.

(2) Any durable medical equipment needed during an inpatient hospital stay is paid as part of the inpatient reimbursement to the hospital and is therefore the responsibility of the hospital.

(3) To request prior authorization, follow the instructions outlined in OAR 410-122-0040.

(4) The term "Long-Term Care" in the Durable Medical Equipment and Medical Supplies guide refers to a nursing facility.

(5) Some items are considered to be paid after 16 months of rental payments are made by OMAP. When this happens, the client owns the equipment. Any needed repairs or maintenance after the 16th month is the responsibility of OMAP, based on client eligibility, unless the item is for a Medicare/Medicaid client and is in the Medicare Capped Rental Program, then continue to bill Medicare for maintenance, per their schedule. Before rental, purchase should be considered for long-term requirements.

(6) When prior authorization is required it must be obtained, even for clients with Medicare or other private insurance.

(7) Equipment purchased for the client through Medicaid becomes the property of the client.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 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 461-24-200; HR 13-1991, f. & cert. ef. 3-1-91; Renumbered from 410-122-100; 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

410-122-0190

Equipment and Services Not Otherwise Classified

(1) Documentation must support that the procedure code billed is accurate and is appropriate.

(2) Prior authorization is always required.

(3) Medical necessity and prescription requirements also apply.

(4) The level of reimbursement should not be considered as a factor in the use of these procedure codes.

(5) Each item requested must be itemized with description and amount.

(6) Procedure Codes:

(a) A4335, Incontinence supply; miscellaneous (not covered for clients under three years of age) -- Prior authorization required -- OMAP will purchase;

(b) A4421, Ostomy supply; miscellaneous -- Prior authorization required -- OMAP will purchase;

(c) A4649, Surgical supply; miscellaneous -- Prior authorization required -- OMAP will purchase;

(d) E1399, Durable medical equipment, miscellaneous -- Prior authorization required -- OMAP will purchase, rent, or repair -- This code may be covered for payment from OMAP when client is a resident of a long-term care facility, check when obtaining prior authorization -- This code shall be used for suction pump used with nasogastric tube, replacement wheelchair parts and modifications to existing wheelchair, walker gliders or for heavy duty walker without wheels because of patient's weight. Also used for heavy duty rigid frame tub transfer bench for client over 250 pounds; oxymiser cannula; hydraulic bath tub lift and heavy duty or extra wide rehab shower/commode chair. Used for eggcrate mattress without a durable waterproof cover. Also used for mucus clearance device. Not to be used for wheelchair base;

(e) A6261, Wound filler, not elsewhere classified, gel/paste (1 unit of service = 1 fluid ounce) -- Prior authorization required -- OMAP will purchase;

(f) K6262, Wound filler, not elsewhere classified, dry form (1 unit of service = 1 gram) -- Prior authorization required -- OMAP will purchase.

(7) Repairs:

(a) Repairs to equipment which a patient is purchasing or already owns are covered when necessary to make the equipment serviceable. 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 cam be made for the amount of the excess;

(b) Technicians are DME 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;

(c) A written description of the nature and medical necessity of the repair and an itemization of the parts and labor time involved need to be kept in the DME supplier's file;

(d) If equipment is sent to the manufacturer for repair or non-routine service, the manufacturer must itemize the invoice as to parts, labor time (documentation of start and stop time is not required), shipping and handling. Shipping and handling will not be reimbursed;

(e) E1340, Repair or non-routine service requiring the skill of a technician, labor component, per 15 minutes - OMAP will repair, covered for payment by OMAP for long-term resident if supplied for patient-owned equipment.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: 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; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97

410-122-0200

Respiratory Equipment

(1) Pulse Oximeter:

(a) All pulse oximeters are prior authorized by the OMAP Medical Group including those for SDSD clients;

(b) Rental of a pulse oximeter will be approved for the following:

(A) Continuous O_2 saturation readings in the home are the most appropriate setting;

(B) Unstable fluctuations of O_2 saturations (while on oxygen) with an identified intervention plan.

(c) DMA06, Pulse Oximeter, per month - Prior authorization required -- OMAP will rent - Item considered purchased after 16 months of rent. Effective for services provided on or after April 1, 1996.

(2) Oxygen Saturation Readings in the Home:

(a) In home oxygen saturation readings are reimbursable under the following conditions:

(A) Medical necessity has been established;

(B) The home setting is the most appropriate setting for the client;

(C) The service is being performed other than during a routine delivery of oxygen services;

(D) Other reasonable alternatives are not available.

(b) DMA07, Oxygen saturation readings - Prior authorization required - OMAP will purchase. Effective for services provided on or after April 1, 1996.

(3) CPAP:

(a) Indications and Coverage:

(A) Covered for moderate or severe obstructive sleep apnea (OSA) where surgery is a likely alternative;

(B) The diagnosis of OSA requires documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during 6 - 7 hours of recorded sleep.

(b) Documentation: Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(c) Other: A two month rental trial period is required of CPAP prior to purchase. Rental price applies to purchase;

(d) E0601, Continuous Airway Pressure Device (CPAP) -- Rental includes payment for the provision of all necessary accessories, i.e., mask, tubing or cannula. Do not bill E0601 and K0268 at the same time, use K0193 -- OMAP will purchase, rent and repair-- Also covered for payment by OMAP when client is a resident of a long-term care facility -- Item considered purchased after 16 months of rent;

(e) K0183, Nasal application device, used with CPAP device (mask) -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(f) K0184, Nasal pillows/seals, replacement for nasal application device, pair -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(g) K0185, Headgear, used with CPAP device -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(h) K0186, Chin strap, used with CPAP device -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(i) K0187, Tubing, used with CPAP device -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(j) K0188, Filter, disposable, used with CPAP device -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(k) K0189, Filter, non-disposable, used with CPAP device -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(l) K0268, Humidifier, used with CPAP device -- use if adding a humidifier to any existing CPAP. Do not bill E0601 and K0268 at the same time, use K0193. -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(m) K0193, Continuous Airway Pressure Device (CPAP) with humidifier. Use if billing for CPAP with humidifier, do not bill E0601 and K0268 at the same time. Rental includes payment for the provision of all necessary accessories, i.e., mask, tubing or cannula. OMAP will purchase, rent and repair. Also covered for payment by OMAP when client is a resident of a long-term care facility -- Item considered purchased after 16 month of rent;

(n) K0269, Aerosel compressor, adjustable pressure, light duty for intermittent use with CPAP device -- OMAP will purchase. Also covered for payment by OMAP when client is a resident of a long-term care facility.

(4) BiPAP S:

(a) Indications and Coverage:

(A) Covered for moderate or severe OSA intolerant of nasal CPAP where surgery is a likely alternative;

(B) The diagnosis of OSA requires documentation of at least 30 episodes of apnea, each lasting a minimum of 10

seconds, during 6 - 7 hours of recorded sleep.

(b) Documentation:

(A) Must be kept on file by the DME provider.

(B) Must show that CPAP was tried and not tolerated.

(c) E0452, Intermittent assist device with continuous positive airway pressure device (BiPAPS), per month -- OMAP will rent - Also covered for payment by OMAP when client is a resident of a long-term care facility;

(d) K0194, Intermittent assist device with continuous positive airway pressure, with humidifier -- OMAP will rent - Also covered for payment by OMAP when client is a resident of a long-term care facility.

(5) BiPAP S/T:

(a) Indications and Coverage:

(A) Covered for patients who:

(i) Are dependent on ventilation with some short duration time off the ventilator; or

(ii) Require ventilation assistance during the hours of sleep with possible periods of use during waking hours.

(B) Covered for patients with neuromuscular respiratory insufficiency, restrictive lung disease from thoracic wall deformity, or chronic respiratory failure consequent to chronic obstructive pulmonary disease;

(C) Coverage will be considered for the following diagnoses and other diagnoses as indicated by the documentation of medical necessity: COPD including emphysema, bronchitis, asthma; obesity hypo-ventilation syndrome; musculoskeletal disorders including kyphosis, scoliosis, kyphoscoliosis; osteogenesis imperfecta; phrenic nerve damage; amyotrophic lateral sclerosis; muscular dystrophy; spinal cord injury with respiratory involvement; diaphragmatic dysfunction (trauma or congenital); central alveolar hypo-ventilation syndrome; myasthenia gravis; multiple sclerosis; congestive heart failure; cystic fibrosis.

(b) Documentation:

(A) A sleep study is not required;

(B) Documentation showing medical necessity (for example, a Certificate of Medical Necessity (CMN)) kept on file by the DME provider.

(c) E0453, Therapeutic ventilator; suitable for use 12 hours or less per day (BiPAP S/T), per month -- OMAP will rent - Also covered for payment by OMAP when client is a resident of a long-term care facility.

(6) Oxygen Equipment - Children (Under age 21):

(a) Indications and Coverage: Prescribing practitioner must determine medical necessity;

(b) Documentation: DME providers must retain documentation of medical necessity from prescribing practitioners.

(7) Oxygen Equipment for Adults: Indications and Coverage:

(a) Home oxygen therapy is covered for patients with significant hypoxemia in the chronic stable state when:

(A) The attending physician has determined the patient suffers a lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy;

(B) The patient's blood gas levels indicate the need for oxygen therapy; and

(C) The patient has appropriately tried other alternative treatment measures without complete success.

(b) Coverage of oxygen therapy is not available for the following conditions:

(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. Although intermittent oxygen use is sometimes prescribed to relieve this condition, it is potentially harmful and psychologically addicting;

(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation;

(D) Terminal illnesses that do not affect the lungs.

(8) Covered Blood Gas Values:

(a) Group I - Coverage is provided for patients with significant hypoxemia evidenced by any of the following:

(A) An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken at rest. If the PO_2 is greater than 55 mm Hg., the service is not medically necessary unless "Group II" criteria are met; or

(B) An arterial PO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% taken during sleep for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake, or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen; or

(C) An arterial PO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken during exercise for a patient who demonstrates an arterial PO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% during the day while at rest. In this case, supplemental 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 patient was breathing room air.

(b) Group II - Coverage is available for patients whose arterial PO_2 is 56 to 59 mm Hg or whose arterial blood oxygen saturation is 89% if any of the following are documented:

(A) Dependent edema suggesting congestive heart failure;

(B) "P" pulmonale of EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or

(C) Erythrocythemia with a hematocrit greater than 56%.

(c) Group III - Home use of oxygen is presumed not medically necessary for patients with arterial PO_2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

(9) Portable Oxygen Systems: Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be covered if the patient is mobile within the home. The documentation must include a description of the activities or exercise routine (e.g., amount and frequency of ambulation) that the patient undertakes on a regular basis, and that the activities or exercises require the portable system.

(10) Standby Oxygen: Oxygen PRN or oxygen as needed is not covered.

(11) Topical Oxygen: Oxygen for topical use is not covered.

(12) Blood Gas Study:

(a) Initial documentation for oxygen therapy must include the results of a blood gas study that has been ordered and evaluated by the attending physician. This will usually be in the form of a measurement of the patient pressure of oxygen (PO_2) in arterial blood. A measurement of pulse arterial oxygen saturation may also be acceptable when ordered and evaluated by the attending physician;

(b) When a patient's initial certification for oxygen documents an arterial PO_2 of 56 mm Hg or greater or an oxygen saturation of 89% or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity;

(c) The condition under which the laboratory tests are performed must be documented. Examples of this documentation may include: At rest, while sleeping, while exercising, on room air, or, if while on oxygen, the amount, body position during testing, and similar information.

(13) Documentation:

(a) The Certificate of Medical Necessity (CMN) for home oxygen is HCFA form 484. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form or other documentation of medical necessity must be reviewed and signed by the ordering physician and kept on file by the DME provider. If the client is receiving oxygen above 4 liters per minute, the documentation should include:

(A) Blood gas testing on room air;

(B) Testing on 4L of oxygen;

(C) Testing on the ordered liters/min. of oxygen, i.e., testing on 5L/min. of oxygen. Improvement must be shown on the higher rate to be covered.

(b) Recertification is required three months after initial certification in patients whose arterial PO_2 was 56 mm Hg or greater or whose oxygen saturation 89% or greater on the initial certification or in whom the physician's initial estimate of length of need for oxygen was one to three months. For those patients for whom recertification at three months is not required, recertification will be required by 12 months after initial certification;

(c) Once one certification establishes the medical necessity for continued use of home oxygen, subsequent recertification will not be routinely required. However, a HCFA 484 or other documentation of medical necessity should be completed whenever there is a change in the oxygen prescription (e.g. increase or decrease in oxygen flow rate, different equipment, etc.) or if there is a change of the attending physician;

(d) Initial certification and three month recertifications required because of initial PO_2 of 56 mm Hg or greater or oxygen saturation of 89% or greater must include the results of a recently performed arterial blood gas (ABG) or oximetry test. For other recertification, retesting is not required but the results of the most recent ABG or oximetry test representing the patient's chronic stable state must be included on the form;

(e) Oxygen users before March 1, 1991 will continue to receive services and are not subject to the above criteria.

(14) Concentrators:

(a) E1400, Oxygen concentrator, manufacturer specified maximum flow rate does not exceed 2 liters per minute at 85% or greater concentration, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day;

(b) E1401, Oxygen concentrator, manufacturer specified maximum flow rate greater than 2 liters per minute, does not exceed 3 liters per minute, at 85% or greater concentration, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day;

(c) E1402, Oxygen concentrator, manufacturer specified maximum flow rate greater than 3 liters per minute, does not exceed 4 liters per minute, at 85% or greater concentration, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day;

(d) E1403, Oxygen concentrator, manufacturer specified maximum flow rate greater than 4 liters per minute, does not exceed 5 liters per minute, at 85% or greater concentration, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day;

(e) E1404, Oxygen concentrator, manufacturer specified maximum flow rate greater than 5 liters per minute, at 85% or greater concentration, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day;

(f) E1405, Oxygen and water vapor enriching system with heated delivery, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day;

(g) E1406, Oxygen and water vapor enriching system without heated delivery, per month -- OMAP will rent -- Covered for payment by OMAP if Long-Term Care resident uses more than 1000 liters per day.

(15) Compressed gas:

(a) E0425, Stationary compressed gaseous system purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing -- OMAP will purchase -- OMAP will repair;

(b) E0424, Stationary compressed gaseous oxygen system, rental, includes contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing, per month -- OMAP will rent;

(c) E0431, Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask, and tubing, per month -- OMAP will rent;

(d) E0430, Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing -- OMAP will purchase -- OMAP will repair;

(e) E0441, Oxygen contents, gaseous, (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned), per month -- OMAP will purchase;

(f) E0443, Portable oxygen contents, gaseous, for use only with portable gaseous systems when no stationary gas or liquid system is used, per month -- OMAP will purchase.

(16) Liquid oxygen:

(a) E0435, Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor -- OMAP will purchase -- OMAP will repair;

(b) E0442, Oxygen contents, liquid, for use with owned liquid stationary system or when both a stationary and portable liquid system are owned, per month-- OMAP will purchase;

(c) E0444, Portable oxygen contents, liquid, for use only with portable liquid systems when no stationary gas or liquid system is used, per month -- OMAP will purchase;

(d) E0439, Stationary liquid oxygen system, rental; includes use of reservoir, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing, per month -- OMAP will rent;

(e) E0434, Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing, per month -- OMAP will rent;

(f) E0440, Stationary liquid system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing -- OMAP will purchase -- OMAP will repair.

(17) Oxygen supplies:

(a) E0455, Oxygen tent, excluding croup or pediatric tents, per month -- OMAP will rent;

(b) E0555, Humidifier, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter, -- OMAP will purchase;

(c) E0565, Compressor, air power source for equipment which is not self-contained or cylinder driven -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(d) E0580, Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter -- OMAP will purchase;

(e) E1353, Regulator (yoke or other) -- OMAP will purchase -- OMAP will repair;

(f) E1355, Stand/rack for oxygen tank, -- OMAP will purchase.

(18) Nebulizer-Humidifier:

(a) E0550, Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery -- OMAP will purchase -- OMAP will rent -- Item considered purchased after 16 months of rent;

(b) E0560, Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery -- OMAP will purchase -- OMAP will rent -- Item considered purchased after 16 months of rent;

(c) E0570, Nebulizer, with compressor -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(d) E0585, Nebulizer, with compressor and heater -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(e) E0605, Vaporizer, room type -- OMAP will purchase;

(f) E1372, Immersion external heater for nebulizer -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(g) E1375, Nebulizer, portable with small compressor, with limited flow -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(h) DMA08, Nebulizer Supplies Disposable, per month -- OMAP will purchase; Effective for services provided on or after April 1, 1996;

(i) K0168, Administration Set, small volume nonfiltered pneumatic nebulizer, disposable -- OMAP will purchase;

(j) K0169, Small volume nonfiltered pneumatic nebulizer, disposable -- OMAP will purchase;

(k) K0170, Administration set, small volume nonfiltered pneumatic nebulizer, nondisposable -- OMAP will purchase;

(l) K0171, Administration set, small volume filtered pneumatic nebulizer -- OMAP will purchase;

(m) K0172, Large volume nebulizer, disposable, unfilled, used with aerosol compressor -- OMAP will purchase;

(n) K0173, Large volume nebulizer, disposable, prefilled, used with aerosol compressor -- OMAP will purchase;

(o) K0174, Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer -- OMAP will purchase;

(p) K0175, Corrugated tubing, disposable, used with large volume nebulizer, (1 unit of service = 100 feet) -- OMAP will purchase;

(q) K0176, Corrugated tubing, non-disposable, used with large volume nebulizer (1 unit of service = 100 feet) -- OMAP will purchase;

(r) K0177, Water Collection device, used with large volume nebulizer -- OMAP will purchase;

(s) K0178, Filter, disposable, used with aerosol compressor -- OMAP will purchase;

(t) K0179, Filter, disposable, used with aerosol compressor or ultrasonic generator -- OMAP will purchase;

(u) K0180, Aerosol mask, used with DME nebulizer -- OMAP will purchase;

(v) K0181, Dome and mouthpiece, used with small volume ultrasonic nebulizer -- OMAP will purchase;

(w) K0182, Water, distilled, used with large volume nebulizer (1 unit of service = 1000 ml) -- OMAP will purchase;

(x) K0270, Ultrasonic generator with small volume ultrasound nebulizer -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(y) K0501, Aerosol compressor, battery powered, for use with large volume nebulizer -- OMAP will purchase;

(z) K0529, Sterile water or sterile saline, 1,000 ml., used with large volume nebulizer -- OMAP will purchase;

(aa) K0530, Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen therapy -- OMAP will purchase.

(19) IPPB:

(a) E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source -- OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent. Covered if medically necessary for the following indications:

(A) Clients at risk of respiratory failure because of decreased respiratory function secondary to kyphoscoliosis or neuromuscular disorders;

(B) Clients with severe bronchospasm or exacerbated chronic obstructive pulmonary disease who fail to respond to standard therapy.

(b) The management of atelectasis that has not improved with simple therapy.

(20) Respiratory supplies:

(a) DMA10, Peak Flow Meter -- OMAP will purchase; Effective for services provided on or after April 1, 1996;

(b) E0480, Percussor, electric or pneumatic, home model -- Covered for mobilizing respiratory tract secretions when the client or the operator of the powered percussor has received appropriate training by a prescribing practitioner or therapist and no one competent to administer manual therapy is available -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(c) E0606, Postural drainage board -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(d) DMA09, Normal saline, per cc -- OMAP will purchase;

(e) A4615, Cannula, nasal -- OMAP will purchase;

(f) A4616, Tubing (oxygen), per foot -- OMAP will purchase;

(g) A4617, Mouthpiece -- OMAP will purchase;

(h) A4619, Face tent -- OMAP will purchase;

(i) A4620, Variable concentration mask -- OMAP will purchase;

(j) A4712, Water, sterile (1 unit of service = 1,000 ml) -- OMAP will purchase;

(k) A4627, Spacer, bag or reservoir, with/without mask, for use with metered dose inhaler -- OMAP will purchase;

(l) J7501, Sterile saline or water, up to 5 ml each -- OMAP will purchase;

(m) ZZ010, Transtracheal oxygen catheter for patient-owned equipment -- OMAP will purchase.

(21) Suction pumps:

(a) Indications and Coverage:

(A) Use of a home model suction machine is covered for patients who have difficulty raising and clearing secretions secondary to:

(i) Cancer or surgery of the throat; or

(ii) Dysfunction of the swallowing muscles; or

(iii) Unconsciousness or obtunded state; or

(iv) Tracheostomy; or

(v) Neuromuscular conditions.

(B) Suction catheters are disposable supplies and are covered with a medically necessary rented, purchased or owned suction pump. Sterile catheters are only covered for tracheostomy suctioning. Oropharyngeal and upper tracheal areas are not sterile and catheters can be reused if properly cleansed and/or disinfected;

(C) 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;

(D) When a suction pump is used for tracheal suctioning, other supplies (e.g., cups, basins, gloves, solutions, etc.) are included in the tracheal care kit code, A4625 - see that policy for details. When a suction pump is used for oropharyngeal suctioning, these other supplies are not medically necessary;

(E) Suction device will be purchased for individual use by a person in a Nursing Facility when the person is permanently on one of the following:

(i) A volume ventilator;

(ii) Chest shell;

(iii) Chest wrap;

(iv) Negative pressure ventilator.

(F) Use E1399 for suction pump used with a nasogastric tube.

(b) Documentation: Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(c) A4624, Tracheal suction catheter, any type, each -- OMAP will purchase;

(d) E0600, Suction pump, home model, portable -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility when the client is permanently on one of the following: A volume ventilator, chest shell, chest wrap or negative pressure ventilator -- Item considered purchased after 16 months of rent;

(e) A4628, Oropharyngeal suction catheter, each -- OMAP will purchase;

(f) K0190, Canister, disposable, used with suction pump -- OMAP will purchase;

(g) K0191, Canister, non-disposable, used with suction pump -- OMAP will purchase;

(h) K0192, Tubing, used with suction pump -- OMAP will purchase;

(i) A4323, sterile saline irrigation solution, 1000 ml -- OMAP will purchase.

(22) Tracheostomy care supplies:

(a) Indications and Coverage: For a patient following an open surgical tracheostomy which has been open or is expected to remain open for at least three months;

(b) Documentation: A prescription for tracheal equipment which is signed by the prescribing practitioner must be kept on file by the DME supplier. The prescribing practitioner's records must contain information which supports the medical necessity of the item ordered;

(c) A4625, Tracheostomy care kit for new tracheostomy contains 1 plastic tray, 1 basin, 1 pair of sterile gloves, tube brush, 3 pipe cleaners, 1 pre-cut tracheostomy dressing, 1 roll of gauze, 4 4x4 sponges, 2 cotton tip applicators, 30" twill tape -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility. One tracheostomy care kit per day is covered for two weeks following an open surgical tracheostomy;

(d) A4626, Tracheostomy cleaning brush, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(e) A4629 Tracheostomy care kit for established tracheostomy contains 1 tube brush, 2 pipe cleaners, 2 cotton tip applicators, 30" twill tape, 2 4x4 sponges -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility. One tracheostomy care kit per day is considered necessary for routine care of a tracheostomy, starting with post-operative day 15;

(f) A4621, Tracheotomy mask or collar -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(g) A4622, Tracheostomy or laryngectomy tube -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(h) A4623, Tracheostomy, inner cannula (replacement only) -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(i) DMA04 Trach ties, 1 unit = roll of any width x 72 yards -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility; Effective for services provided on or after April 1, 1996;

(j) A4481, Tracheostoma filter[(s)], any type, any size, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility.

Stat. Auth.: ORS Ch. 409

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

410-122-0210

Ventilators

(1) All ventilation, assistive equipment and associated services shown to require prior authorization are to be prior authorized by the Office of Medical Assistance Programs, Medical Group.

(2) The hospital discharge planner, case manager, or medical practitioner should call the DME provider directly. The DME provider will fax or mail the request for prior authorization.

(3) The DME provider is responsible for providing written medical justification within the first 30 days to continue authorization for further services.

(4) If written justification is not received, there will be no further authorization.

(5) The following criteria will be used to determine payment:

(a) Documentation of being unable to wean from ventilator or unable to wean from use at night; or

(b) Documentation that alternate means of ventilation were used without success; or

(c) Patient ready for discharge is currently on a ventilator and has been on the ventilator more than ten days.

(6) A back-up battery, generator, and ambu bag will be provided, if necessary.

(7) The allowable rental fee for the ventilator is to include all equipment, supplies, services and training necessary for the effective use of the ventilator.

(8) Routine maintenance is included in the rental fee.

(9) The ventilator provider must supply 24-hour emergency coverage.

(10) An emergency telephone number must be available 24 hours a day from the ventilator provider.

(11) The patient must have a telephone or reasonable access to one. OMAP will not be responsible for providing a telephone for the patient.

(12) All respiratory therapy services needed for the safe operation of the ventilator are included in the rental fee.

(13) The following criteria will be used to determine payment for a back-up ventilator:

(a) The patient is more than 60 minutes from the nearest hospital or back-up ventilator and has no documented spontaneous respirations; or

(b) Documentation supports medical necessity; or

(c) The patient needs to be transported frequently with portable ventilato; or

(d) The ventilator is used at maximum performance with high pressure and rate.

(14) A back-up ventilator will be reimbursed at half the allowable rate.

(15) Back-up ventilator users before April 1, 1992 will continue to receive services and are not subject to the above criteria. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0220

Pacemaker Monitor

E0615 -- Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems -- OMAP will purchase -- Also covered for payment by OMAP when client is resident in long-term care facility.

Stat. Auth.: ORS 184.750, 84.770, 409.010 & 409.110

Stats. Implemented: ORS

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993 f. & cert. ef. 4-1-93

410-122-0240

APNEA Monitor

(1) All apnea monitors and associated services are to be prior authorized by the OMAP Medical Group.

(2) All necessary training to utilize services is included in the rental fee.

(3) Indications and coverage:

(a) The following conditions will be considered for initial approval for a maximum of six months:

(A) A sibling has died from SIDS;

(B) Symptomatic apnea due to neurological impairment;

(C) Craniofacial malformation likely to cause symptomatic apnea.

(b) The following conditions will be considered for initial approval for a maximum of three months:

(A) Symptomatic apnea of prematurity;

(B) Observation of apparent life-threatening event (ALTE);

(C) Receiving home oxygen (not a universal requirement, full term infant usually does not require).

(c) The authorization may be extended if documentation is submitted to support one of the following conditions:

(A) Continues to have real alarms documented by memory monitor;

(B) Upper respiratory infection when monitoring was scheduled to be discontinued (will be extended for two weeks, no memory monitor required).

(4) Documentation: The following documentation must be submitted for initial authorization of an apnea monitor:

(a) Diagnosis and statement of medical necessity from the practitioner; and

(b) Copies of hospital records documenting medical necessity; and/or

(c) Copies of sleep studies of memory monitor reports; and/or

(d) Documentation of ALTE from log, nursing notes or doctor's progress records.

(5) Multi-Channel Sleep Study:

(a) Indications and coverage:

(A) Sleep study must be medically necessary;

(B) A sleep study is not required to discontinue use of an apnea monitor.

(b) Documentation: The following documentation must be submitted for initial authorization of a sleep study:

(A) Diagnosis and statement of medical necessity from the practitoner; and/or

(B) Copies of hospital records documenting medical necessity and diagnosis.

(6) Memory Monitor:

(a) Indications and coverage:

(A) May be substituted for up to three months of prolonged apnea monitoring;

(B) Needed to support continuation of apnea monitoring beyond initial limits;

(C) May be substituted for apnea monitoring to determine frequency of real alarms.

(b) Documentation: The following documentation must be submitted for initial authorization of a memory monitor:

(A) Diagnosis and statement of medical necessity from the practitioner; and

(B) Copies of hospital records documenting medical necessity; and/or

(C) Documentation of ALTE from log, nursing notes or doctor's progress records.

(7) Apnea Monitor Codes: [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0250

Electric Breast Pump - Effective for Services Provided On or After June 1, 1996

(1) Electric breast pumps will only be rented if documentation supports:

(a) The mother and infant are both eligible on the date of service;

(b) Local resources were explored, e.g., Health Department, Hospital, etc.;

(c) Medical necessity for Infant:

(A) Preterm; or

(B) Term and hospitalized beyond 5 days; or

(C) Cleft palate or cleft lip; or

(D) Rehospitalized for longer than 5 days; or

(E) Unable to suck adequately; or

(F) Crania-facial abnormalities; or

(G) Failure to thrive, or

(d) Medical Necessity for Mother:

(A) Has breast abscess; or

(B) Taking contraindicated medications (for short-term use to maintain lactation); or

(C) Mastitis; or

(D) Hospitalized due to illness or surgery (for short-term use to maintain lactation); and

(E) A hand pump or manual expression has been tried for one week without success in mothers with established milk supply.

(2) Other information:

(a) Documentation that transition to breast feeding started as soon as the infant was stable enough to begin breast feeding;

(b) A starter kit will be reimbursed separately from the pump rental;

(c) Pump rental will be per day;

(d) Rental will not exceed 60 days;

(e) Electronic pump is not for the comfort and convenience of the mother.

(3) Supplemental Nutrition System (SNS), is not covered.

(4) Electric Breast Pump codes:

(a) DMA15, Electric breast pump -- Prior Authorization Required -- OMAP will rent. Effective for services provided on or after April 1, 1996;

(b) DMA16, Electric breast pump starter kit for single or double pumping -- Prior Authorization Required -- OMAP will purchase. Effective for services provided on or after April 1, 1996;

Stat. Auth.: ORS Chapter 409

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

410-122-0260

Home Uterine Monitoring - Effective for Services Provided On or After June 1, 1996

(1) All home uterine monitoring services are to be prior authorized by the: Office of Medical Assistance Programs (OMAP), Medical Group, including those for SDSD clients.

(2) The medical practitioner or Durable Medical Equipment (DME) provider may fax or mail the prior authorization request.

(3) The DME provider is responsible for providing written medical justification within the first 30 days to continue authorization for further services. If written justification is not received, there will be no further authorization.

(4) The following criteria will be used to determine payment. Monitors will be approved for:

(a) Pre-term labor - current pregnancy:

(A) Incompetent cervix;

(B) Cervical cerclage;

(C) Polyhydramnios;

(D) Anomalies of the uterus;

(E) Cone biopsy;

(F) Cervical dilation or effacement;

(G) Unknown etiology.

(b) History of pre-term labor and/or delivery;

(c) Multiple gestation.

(5) Uterine monitoring will only be approved for the above conditions between the 24th and through the completion of the 36th week of pregnancy.

(6) 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 practitioner's professional services.

(7) The patient must have a telephone or reasonable access to one. OMAP will not be responsible for providing the telephone.

(8) DMA17, Uterine Home Monitoring -- Prior Authorization Required -- OMAP will rent. Effective for services provided on or after April 1, 1996.

Stat. Auth.: ORS Chapter 409

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

410-122-0280

Heating/cooling Accessories

Procedure Codes for Hearing/Cooling Accessories: [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0300

Light Therapy

(1) Kits are included in rental of equipment.

(2) Panel cover included in rental of equipment.

(3) Nursing visit is included in rental of equipment:

(a) E0202, Phototherapy Bilirubin light with photometer, per day -- Office of Medical Assistance Programs (OMAP) will rent;

(b) E0690, Ultraviolet cabinet appropriate for home use -- Prior Authorization Required for this procedure code --

OMAP will purchase -- OMAP will rent -- OMAP will repair. Item considered purchased after 16 months of rent.

Stat. Auth.: ORS Ch. 409

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

410-122-0320

Wheelchairs

(1) Manual wheelchair base:

(a) Indications and Coverage:

(A) A wheelchair is covered when the patient's condition is such that without the use of a wheelchair the patient would be bed-confined or confined to a non-mobile chair and the client is not ambulatory or not functionally ambulatory;

(B) OMAP will not pay for backup chairs;

(C) Reimbursement for wheelchair codes includes all labor charges involved in the assembly and delivery of the wheelchair and all adjustments for three months after date the client takes delivery. Reimbursement also includes emergency services, education and on-going assistance with use of the wheelchair for three months after the client takes delivery;

(D) Only one wheelchair will be rented or purchased for each recipient to meet the medical necessity, however, if a client's current wheelchair no longer meets the medical necessity, or repair to the wheelchair exceeds replacement cost, a new wheelchair can be authorized;

(E) If a client has a wheelchair that meets his/her medical needs regardless of who has obtained it, OMAP will not provide another chair;

(F) One month's rental of a wheelchair is covered if a patient-owned wheelchair is being repaired;

(G) Living quarters must be able to accommodate requested wheelchair. OMAP will not be responsible for adapting the living quarters to accommodate the wheelchair;

(H) Backpacks, accessory bags, clothing guards, additional positioning equipment if wheelchair meets the same need, and custom colors are not covered;

(I) Wheelchair "poundage" (lbs) represents the weight of the usual configuration of the wheelchair without front riggings;

(J) Do not use E1399 for manual wheelchair base.

(b) Documentation:

(A) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(B) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA);

(C) A copy of evaluation by a physical therapist, occupational therapist or registered nurse, with recommendations for

most appropriate equipment must be submitted when requesting a prior authorization. The evaluation must include client's functional ambulation status in their customary environment.

(c) K0001, Standard Wheelchair - Prior authorization required -- OMAP will purchase, rent and repair - Item considered purchased after 16 months of rent. Weight - >36 lbs; seat width - 16" (narrow), 18" (adult); seat depth - 16"; seat height - >19" and ¾21"; back height - non-adjustable 16" - 17"; arm style - fixed or detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable;

(d) K0002, Standard Hemi (low seat) Wheelchair - Prior authorization required -- OMAP will purchase, rent and repair - Item considered purchased after 16 months of rent:

(A) Weight - >36 lbs; seat width - 16" (narrow), 18" (adult); seat depth - 16"; seat height - 17" - 18"; back height - non-adjustable 16" - 17"; arm style - fixed or detachable; footplate extension - 14" - 17 1/2"; footrests - fixed or swingaway detachable;

(B) Covered when the patient requires a lower seat height (17" - 18") because of short stature or to enable the patient to place his/her feet on the ground for propulsion.

(e) K0003, Lightweight Wheelchair - Prior authorization required -- OMAP will purchase, rent and repair - Item considered purchased after 16 months of rent:

(A) Weight - ¾36 lbs; seat width - 16" or 18"; seat depth - 16"; seat height >=17" and ¾21"; back height - non-adjustable 16" - 17"; arm height - fixed height, detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable;

(B) Covered when a patient cannot functionally propel himself/herself in a standard wheelchair using arms and/or legs and the patient can and does propel himself in a lightweight wheelchair.

(f) K0004, High Strength, Lightweight Wheelchair - Prior authorization required -- OMAP will purchase, rent and repair - Item considered purchased after 16 months of rent:

(A) Lifetime warranty on side frames and cross braces; weight - < 34 lbs; seat width - 14", 16" or 18"; seat depth - 14" (child), 16" (adult); seat height >=17" and <21"; back height - sectional or adjustable 15" - 19"; arm style - fixed or detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable;

(B) Covered when a patient self-propels the wheelchair while engaging in frequent activities that cannot functionally be performed in a standard or lightweight wheelchair, or the activities may cause permanent damage to a standard or lightweight chair, or when a patient requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least 2 hours per day in the wheelchair.

(g) K0005, Ultralightweight Wheelchair -- Prior authorization required -- OMAP will purchase, rent and repair - Item considered purchased after 16 months of rent: Lifetime warranty on side frames and cross braces; weight - <30 lbs; adjustable rear axle position; seat width 14", 16", or 18"; seat depth - 14" (child), 16" (adult); seat height - >=17" and <21"; arm style - fixed or detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable;

(h) K0006, Heavy Duty Wheelchair -- Prior authorization required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent:

(A) Seat width - 18", seat depth - 16" or 17"; seat height >19" and <21"; back height - non-adjustable 16" - 17"; arm style - fixed height, detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable; reinforced back and seat upholstery; can support patient weighing >250 pounds or the patient has severe spasticity;

(B) Covered if the patient weighs more than 250 pounds, has severe spasticity, or has a mental/physical diagnosis that warrants a heavy duty chair (e.g., has a history of damaging equipment due to diagnosis).

(i) K0007, Extra Heavy Duty Wheelchair -- Prior authorization required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent:

(A) Seat width - 18"; seat depth - 16" or 17"; seat height >19" and <21"; Back height - non-adjustable 16" - 17"; arm style - fixed height, detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable; reinforced back and seat upholstery; can support patient weighing >300 pounds;

(B) Covered if the patient weighs more than 300 pounds, has severe spasticity or has a mental/physical diagnosis that warrants a heavy duty chair (e.g., has a history of damaging equipment due to diagnosis).

(j) K0008, Custom Manual Wheelchair/Base -- Prior authorization required -- OMAP will purchase and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility -- Item considered purchased after 16 months of rent:

(A) Uniquely constructed or substantially modified for a specific patient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. A custom wheelchair base is covered only if the feature needed is not available in an already manufactured base. The assembly of a wheelchair from modular components does not meet the requirements of a custom wheelchair base for payment purposes. The use of customized options or accessories does not result in the wheelchair base being considered as custom. There must be customization of the frame for the wheelchair base to be considered customized;

(B) Documentation must clearly describe what was customized;

(C) The custom manual wheelchair base outlined above may be used as the base for creating a unique, specially modified manual wheelchair for a specific person residing in a nursing home. The wheelchair is considered customized when the unique seating, arm rests, leg rests and/or head rests, in combination, make it virtually impossible to meet another persons positioning needs in the wheelchair. The frame for the wheelchair base does not have to be customized or changed to meet the definition of a customized wheelchair in a nursing facility;

(D) Documentation must clearly describe the unique modification to the wheelchair and the custom seating system.

(k) K0009, Other Manual Wheelchair/Base, use for tilt-in-space (inculdes base and tilt-in space feature). Use for pediatric manual wheelchair base -- Prior authorization required -- OMAP will purchase and repair -- Item considered purchased after 16 months of rent.

(2) Motorized/Power Wheelchair Base:

(a) Indications and Coverage:

(A) A power wheelchair is covered when all of the following criteria are met:

(i) The patient without the use of the wheelchair would be bed confined or confined to a non-mobile chair; and

(ii) The patient is not ambulatory or not functionally ambulatory; and

(iii) The patient has severe weakness of the upper extremities due to a neurological, respiratory or muscular disease/condition; and

(iv) The patient is unable to operate a manual wheelchair; and

(v) The patient is capable of safely operating the controls for the power wheelchair; and

(vi) The patient's condition is such that the requirement for a power wheelchair will be long-term (at least six months).

(B) OMAP will not pay for backup wheelchairs. Only one wheelchair will be rented, repaired, purchased or modified to meet the medical need;

(C) One month's rental of a wheelchair is covered if a patient-owned wheelchair is being repaired;

(D) Wheelchair "poundage" (lbs.) represents the weight of the usual configuration of the wheelchair without front riggings;

(E) Codes K0010 -- K0014 are not used for manual wheelchairs with add-on power packs;

(F) Living quarters must be able to accommodate requested wheelchair. OMAP will not be responsible for adapting the living quarters to accommodate the wheelchair;

(G) Do not use E1399 for motorized/power wheelchair base.

(b) Documentation:

(A) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(B) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA);

(C) A copy of evaluation by physical therapist, occupational therapist or registered nurse with recommendations for most appropriate equipment must be submitted when requesting a prior authorization. The evaluation must include client's functional ambulation status in their customary environment.

(c) K0010, Standard-weight frame motorized/power wheelchair -- Prior authorization required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent: Seat width - 14" - 18"; seat depth - 16"; seat height - >=19" and ¾21"; back height - sectional 16" or 18"; arm style - fixed height, detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable;

(d) K0011, Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking -- Prior authorization required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent: Seat width - 14" - 18"; seat depth - 16"; seat height - >=19" and ¾21"; back height - sectional 16" or 18"; arm style - fixed height, detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable;

(e) K0012, Lightweight portable motorized/power wheelchair -- Prior authorization required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent: Seat width - 14" - 18"; seat depth - 16"; seat height - >=19" and ¾21"; back height - sectional 16" or 18"; arm style - fixed height, detachable; footplate extension - 16" - 21"; footrests - fixed or swingaway detachable; weight - <80 lbs. without battery; folding back or collapsible frame;

(f) K0013, Custom motorized/power wheelchair base -- Prior authorization required -- OMAP will purchase and repair -- Item considered purchased after 16 months of rent: A custom power wheelchair base is one which has been uniquely constructed or substantially modified for a specific patient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. A custom wheelchair base is covered only if the feature needed is not available in an already manufactured base. The assembly of a wheelchair from modular components does not meet the requirement of a custom wheelchair base for payment purposes. The use of customized options or accessories does not result in the wheelchair base being considered as customized. There must be customization of the frame for the wheelchair base to be considered customized;

(g) K0014, Other motorized/power wheelchair base -- Prior authorization required -- OMAP will purchase and repair -- Item considered purchased after 16 months of rent. Use in addition to K0108 for power recline or tilt-in space. Use for pediatric motorized/power wheelchair base.

(3) Power operated vehicle:

(a) Indications and Coverage:

(A) A power operated vehicle (POV) is covered when all of the following criteria are met:

(i) A specialist in physical medicine, orthopedic surgery, neurology or rheumatology must provide an evalution of the patient's medical and physical condition and a prescription for the vehicle. A prescription from the client's physician is acceptable if it is determined that a specialist is not reasonably accessible (e.g., more than 1 day's round trip from the client's home) or the client's condition precludes such travel;

(ii) The patient, without the use of a wheelchair or POV would be bed confined or confined to a non-mobile chair;

(iii) The patient is unable to operate a manual wheelchair;

(iv) The patient is capable of safely operating the controls for the POV;

(v) The patient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and

(vi) The POV can be operated inside the home;

(vii) Living quarters must be able to accommodate requested POV. OMAP will not be responsible for adapting the living quarters to accommodate the POV;

(viii) OMAP will not pay for backup chairs. Only one wheelchair or POV will be rented or purchased to meet the medical need.

(b) Documentation:

(A) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(B) Submit list of all DME available or being used to meet the client's needs when requesting prior authorization (PA).

(c) E1230, Power operated vehicle (3 or 4 wheel non-highway) -- Prior authorization required -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Includes the cost of the initial batteries and battery charger.

Stat. Auth.: ORS Ch. 409

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. l2-30- 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

410-122-0340

Wheelchair Options/Accessories

(1) Indications and Coverage:

(a) Covered if patient meets the criteria for wheelchair;

(b)The options/accessories are necessary for the patient to perform one or more of the following actions:

(A) Function in the home;

(B) Perform instrumental activities of daily living;

(C) Use E1399 for replacement wheelchair parts if no other cost is appropriate.

(2) Documentation: Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider.

(3) Arm of Chair:

(a) K0015, Detachable, non-adjustable height armrest, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0016, Detachable, adjustable height armrest, complete assembly, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent: Covered if the patient requires an arm height that is different than that available using non-adjustable arms and the patient spends at least 2 hours per day in the wheelchair;

(c) K0017, Detachable, adjustable height armrest, base, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient requires an arm height that is different than that available using non-adjustable arms and the patient spends at least 2 hours per day in the wheelchair;

(d) K0018, Detachable, adjustable height armrest, upper portion, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient requires an arm height that is different than that available using non-adjustable arms and the patient spends at least 2 hours per day in the wheelchair;

(e) K0019, Arm pad, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0020, Fixed, adjustable height armrest, pair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient requires an arm height that is different than that available using non-adjustable arms and the patient spends at least 2 hours per day in the wheelchair.

(4) Back of Chair:

(a) K0021, Anti-tipping device, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0022, Reinforced back upholstery -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Included in the allowance for a heavy duty or extra heavy duty wheelchair. Not medically necessary if used in conjunction with other manual wheelchair bases. Covered if used with a power wheelchair base and the patient weighs more than 200 pounds;

(c) K0023, Solid back insert, planar back, single density foam, attached with straps -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0024, Solid back insert, planar back, single density foam, with adjustable hook-on hardware -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0025, Hook-on headrest extension -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patent has weak neck muscles and needs a headrest for support or meets the criteria for and has a reclining back on the wheelchair;

(f) K0026, Back upholstery for ultralightweight or high strength lightweight wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0027, Back upholstery for wheelchair type other than ultralightweight or high strength lightweight -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) K0028, Fully reclining back -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility -- Item considered purchased after 16 months of rent:

(A) Covered if the patient spends at least 2 hours per day in the wheelchair and has one or more of the following conditions/needs:

(i) Quadriplegia;

(ii) Fxed 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;

(v) Patient needs to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(B) Use for fully reclining back which is manually operated.

(5) Seat:

(a) K0029, Reinforced seat upholstery -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Included in the allowance for a heavy duty or extra heavy duty wheelchair. Not medically necessary if used in conjunction with other manual wheelchair bases. Covered if used with a power wheelchair base and the patient weighs more than 200 pounds;

(b) K0030, Solid seat insert, planar seat, single density foam -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Includes hardware. Covered when the patient spends at least 2 hours per day in the wheelchair;

(c) K0031, Safety belt/pelvic strap -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning;

(d) K0032, Seat upholstery for ultralightweight or high strength lightweight wheelchair -- OMAP will purchase, rent

and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0033, Seat upholstery for wheelchair type other than ultralightweight or high strength lightweight wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(6) Footrest/Legrest:

(a) K0034, Heel loop, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0035, Heel loop with ankle strap, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0036, Toe loop, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0037, High mount flip-up footrest, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0038, Leg strap, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0039, Leg strap, H style, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0040, Adjustable angle footplate, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) K0041, Large size footplate, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(i) K0042, Standard size footplate, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(j) K0043, Footrest, lower extension tube, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(k) K0044, Footrest, upper hangar bracket, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(l) K0045, Footrest, complete assembly -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered

purchased after 16 months of rent;

(m) K0046, Elevating legrest, lower extension tube, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee, or criteria for a reclining back option are met;

(n) K0047, Elevating legrest, upper hangar bracket, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee, or criteria for a reclining back option are met;

(o) K0048, Elevating legrest, complete assembly -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee, or criteria for a reclining back option are met. Use for the repair or replacement of an elevating legrest for a patient-owned wheelchair;

(p) K0049, Calf pad, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(q) K0050, Ratchet assembly -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(r) K0051, Cam release assembly, footrest or legrest, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(s) K0052, Swingaway, detachable footrests, each, replacement -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Included in allowance for the wheelchair base;

(t) K0195, elevating legrests, pair (for use with capped rental wheelchair base) -- OMAP will rent -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Covered if the patient has a musculoskeletal condition, or the presence of a cast or brace which prevents 90 degree flexion at the knee, or criteria for a reclining back option are met;

(u) K0053, elevating footrests, articulating (telescoping), each -- OMAP will purchase, rent and repair -- also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient has a musculoskeletal condition, or the presence of a cast or brace which prevents 90 degree flexion at the knee, or criteria for a reclining back option are met.

(7) Seat width, depth, height:

(a) K0054, Seat width of 10", 11", 12", 15", 17", or 20" for a high strength, lightweight or ultralightweight wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered only if the ordered item is at least 2" greater than or less than a standard option and the patient's dimensions justify the need;

(b) K0055, Seat depth of 15", 17" or 18" for a high strength, lightweight or ultra-lightweight wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered only if the ordered

item is at least 2" greater than or less than a standard option and the patient's dimensions justify the need;

(c) K0056, Seat height <17" or >= 21" for a high strength, lightweight or ultra-lightweight wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered only if the ordered item is at least 2" greater than or less than a standard option and the patient's dimensions justify the need;

(d) K0057, Seat width 19" or 20" for heavy duty or extra heavy duty chair -- OMAP will purchase, rent and repair - Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair - Item considered purchased after 16 months of rent. Covered only if the ordered item is at least 2" greater than or less than a standard option and the patient's dimensions justify the need;

(e) K0058, Seat depth 17" or 18" for motorized/power wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered only if the ordered item is at least 2" greater than or less than a standard option and the patient's dimensions justify the need.

(8) Handrims Without Projections:

(a) K0059, Plastic coated handrim, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0060, Steel handrim, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0061, Aluminum handrim, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(9) Handrims With Projections:

(a) K0062, Handrim with 8-10 vertical or oblique projections, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0063, Handrim with 12-16 vertical or oblique projections, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(10) Rear Wheels:

(a) K0064, Zero pressure tube (flat free inserts), any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0065, Spoke protectors -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0066, Solid tire, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0067, Pneumatic tire, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent -- If both a pneumatic tire and pneumatic tire tube are provided on the same date, bill both K0067 and K0068;

(e) K0068, Pneumatic tire tube, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent -- If both a pneumatic tire and pneumatic tire tube are provided on the same date, bill both K0067 and K0068;

(f) K0069, Rear wheel assembly, complete, with solid tire, spokes or molded, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0070, Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(11) Front Casters:

(a) K0071, Front caster assembly, complete, with pneumatic tire, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0072, Front caster assembly, complete, with semi-pneumatic tire, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0073, Caster pin lock, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0074, Pneumatic caster tire, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0075, Semi-pneumatic caster tire, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0076, Solid caster tire, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0077, Front caster assembly, complete, with solid tire, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) K0078, Pneumatic caster tire tube, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(12) Wheel Lock:

(a) K0079, Wheel lock extension, pair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP

when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0080, Anti-rollback device, pair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient propels himself/herself and needs the device because of ramps;

(c) K0081, Wheel lock assembly, complete, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(13) Batteries/Chargers for Motorized/Power Wheelchair:

(a) K0082, 22 NF deep cycle lead acid battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Separately payable from the purchased wheelchair base;

(b) K0083, 22 NF gel cell battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Separately payable from the purchased wheelchair base;

(c) K0084, Group 24 deep cycle lead acid battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Separately payable from the purchased wheelchair base;

(d) K0085, Group 24 gel cell battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Separately payable from the purchased wheelchair base;

(e) K0086, U-1 lead acid battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Separately payable from the purchased wheelchair base;

(f) K0087, U-1 gel cell battery, each -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair. Separately payable from the purchased wheelchair base;

(g) K0088, Battery charger, lead acid or gel cell -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if criteria for a power wheelchair are met. There will be no additional allowance if a dual mode charger is used. A battery charger is separately payable from a purchased power wheelchair base, if not included in the power base price.

(14) Motorized/Power Wheelchair Parts:

(a) K0090, Rear wheel tire for power wheelchair, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0091, Rear wheel tire tube other than zero pressure for power wheelchair, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(c) K0092, Rear wheel assembly for power wheelchair, complete, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned

wheelchair -- Item considered purchased after 16 months of rent;

(d) K0093, Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0094, Wheel tire for power base, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0095, Wheel tire tube other than zero pressure for each base, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(g) K0096, Wheel assembly for power base, complete, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) K0097, Wheel zero pressure tire tube (flat free insert) for power base, any size, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(i) K0098, Drive belt for power wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(j) K0099, Front caster for power wheelchair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent.

(15) Miscellaneous Accessories:

(a) K0100, Amputee adapter, pair -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(b) K0101, One-arm drive attachment -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent. Covered if the patient propels the chair himself/herself with only one hand and the need is expected to last at least six months;

(c) K0103, Transfer board, <25" -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(d) K0104, Cylinder tank carrier -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(e) K0105, IV hanger -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(f) K0106, Arm trough, each -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased

after 16 months of rent. Covered if patient has quadriplegia, hemiplegia, or uncontrolled arm movements;

(g) K0107, Wheelchair tray -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent;

(h) DMA18, Belt, custom safety -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent; Effective for services provided on or after April 1, 1996;

(i) K0108, Other wheelchair accessories -- Prior authorization required -- OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility if supplied for patient-owned wheelchair -- Item considered purchased after 16 months of rent:

(A) For option or accessories in which coverage rules have not been explicitly defined, the physician's order must include the item and a statement describing why that feature is medically necessary in the particular patient. Use for but not limited to:

(i) Nonstandard seat dimensions that do not fall under specific codes;

(ii) Power reclining back and power recline tilt as add-on to K0014;

(iii) Lateral thoracic supports;

(iv) Hip guides;

(v) Thigh abduction pommels;

(vi) Seat backs or cushions that do not fall under specific codes;

(vii) Non-joystick control devices;

(viii) Upgrade electronics;

(ix) Custom fabricated seat component when billing for a two piece seating system (use K0115 for the custom fabricated back component);

(x) Nonstandard seat height that does not fall under specific codes, e.g., 16" height;

(xi) Roho mini max for wheelchair back.

(B) Each item requested must be itemized with description and amount.

(j) K0452, Wheelchair bearings, any type -- OMAP will purchase -- also covered for payment by OMAP when client is a resident of a long-term care facility, if supplied for client-owned wheelchair.

(16) Pressure Pads:

(a) E0176, Air pressure pad or cushion, non-positioning -- Prior authorization required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(b) E0178, Gel pressure pad or cushion, non-positioning -- Prior authorization required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(c) E0179, Dry pressure pad or cushion, non-positioning -- OMAP will purchase;

(d) E0192, Low pressure and positioning equalization pad -- Prior authorization required -- OMAP will purchase and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility.

(17) Seating Systems:

(a) K0115, Seating systems, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(b) K0116, Seating systems, combined back and seat module, custom fabricated for attachment to wheelchair base. A one-piece system including both back and seat component -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(c) Item is individually made for a patient using:

(A) A plaster model of the patient;

(B) A computer-generated model of the patient (CAD-CAM) technology; or

(C) Detailed measurements of the patient used to create a curved foam custom fabricated component.

(d) Not used for seating components that are ready made but subsequently modified to fit an individual patient.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 14.065

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

410-122-0360

Walking Aids

(1) Walking aids are covered when prescribed by a practitioner for an individual whose condition impairs ambulation and there is a potential for ambulation.

(2) Documentation:

(a) An order for the cane or crutch which is signed by the prescribing practitioner must be kept on file by the supplier. The prescribing practitioner's records must contain information which supports the medical necessity of the item ordered;

(b) A white cane for a visually impaired person is considered to be a self-help item and is not covered by OMAP. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0380

Hospital Beds

(1) Fixed height hospital bed:

(a) Indications and Coverage:

(A) A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment;

(B) A fixed height hospital bed is covered if one or more of the following indications are met:

(i) A patient who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(ii) A patient who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(iii) A patient who 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 must have been tried and failed;

(iv) A patient who requires traction equipment which can only be attached to a hospital bed.

(b) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(c) E0250, Hospital Bed, fixed height, with any type side rails, with mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(d) E0251, Hospital Bed, fixed height, with any type side rails, without mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(e) E0290, Hospital Bed, fixed height, without side rails, with mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(f) E0291, Hospital Bed, fixed height, without side rails, without mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(2) Hospital beds -- variable height:

(a) Indications and Coverage:

(A) A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments;

(B) Covered if indications i and/or ii, iii, iv are met, and indication v is met:

(i) A patient who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(ii) A patient who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(iii) A patient who 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 must have been tried and failed;

(iv) A patient who requires traction equipment which can only be attached to a hospital bed;

(v) The patient requires a bed height different from that provided by a fixed height hospital bed in order to permit transfers to chair, wheelchair or standing position.

(b) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(c) E0255, Hospital bed, variable height (Hi-Lo), with any type side rails, with mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(d) E0256, Hospital bed, variable height (Hi-Lo), with any type side rails, without mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(e) E0292, Hospital bed, variable height (Hi-Lo), without side rails, with mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(f) E0293, Hospital bed, variable height (Hi-Lo), without side rails, without mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(3) Hospital beds -- semi-electric:

(a) Indications and Coverage:

(A) A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments;

(B) A semi-electric bed is covered if indications i and/or ii, iii, iv and indications v, vi are met:

(i) A patient who requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month;

(ii) A patient who requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(iii) A patient who 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 must have been tried and failed;

(iv) A patient who requires traction equipment which can only be attached to a hospital bed;

(v) The patient requires frequent changes in body position and/or has an immediate need for a change in body position;

(vi) The patient is capable of operating the controls.

(b) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(c) E0260, Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, with mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(d) E0261, Hospital Bed, semi-electric (head and foot adjustment), with any type side rails, without mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(e) E0294, Hospital Bed, semi-electric (head and foot adjustment) without side rails, with mattress -- OMAP will

purchase, rent and repair -- Item considered purchased after 16 months of rent;

(f) E0295, Hospital Bed, semi-electric (head and foot adjustment) without side rails, without mattress -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(4) Rails:

(a) E0305, Bedside rails, half length -- OMAP will purchase -- OMAP will rent -- Item considered purchased after 16 months of rent;

(b) E0310, Bedside rails, full length -- OMAP will purchase -- OMAP will rent -- Item considered purchased after 16 months of rent;

(c) DMA01, Bedside rails, half length, full length, any type, any material, customized or non-customized, for non-hospital bed. Use for client-owned non-hospital bed -- OMAP will purchase and rent -- Item considered purchased after 16 months of rent. Effective for services provided on or after April 1, 1996.

(5) Frames, Traction Devices, etc.:

(a) E0840, Traction frame, attached to headboard, cervical traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(b) E0850, Traction stand, free-standing, cervical traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(c) E0860, Traction equipment, overdoor, cervical -- OMAP will purchase;

(d) E0870, Traction frame, attached to footboard, extremity traction (e.g., Buck's) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(e) E0880, Traction stand, free-standing, extremity traction, (e.g., Buck's) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(f) E0890, Traction frame, attached to footboard, pelvic traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(g) E0900, Traction stand, free-standing, pelvic traction (e.g., Buck's) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(h) E0941, Gravity assisted traction device, any type -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(i) E0942, Cervical head harness/halter -- OMAP will purchase;

(j) E0943, Cervical pillow -- OMAP will purchase;

(k) E0944, Pelvic belt/harness/boot -- OMAP will purchase;

(l) E0920, Fracture frame, attached to bed, includes weights -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(m) E0930, Fracture frame, free-standing, includes weights -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(n) E0945, Extremity belt/harness -- OMAP will purchase;

(o) E0946, Fracture frame, dual with cross bars, attached to bed (e.g. Balken, 4-poster) -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(p) E0947, Fracture frame, attachments for complex pelvic traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent;

(q) E0948, Fracture frame, attachments for complex cervical traction -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent.

(6) Trapeze Bars:

(a) Indications and Coverage: Trapeze bars are indicated when patient 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) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(c) E0910, Trapeze bars, a/k/a patient helper, attached to bed, complete with grab bar -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent. Not covered when used on a non-hospital bed. Covered when it is either an integral part of or used on a hospital bed and both the hospital bed and the trapeze bar are medically necessary;

(d) E0940, Trapeze bar, free-standing, complete with grab bar -- OMAP will purchase, rent and repair -- Item considered purchased after 16 months of rent, When prescribed, it must meet the same criteria as the attached equipment and the patient must not be renting or own a hospital bed.

Stat. Auth.: ORS Ch. 409

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

410-122-0400

Pressure Reducing Support Surfaces

(1) All pressure reducing support surfaces are to be prior authorized by the OMAP Medical Group.

(2) Definitions:

(a) Mattress Overlay -- Device designed to be placed on top of a standard hospital or home mattress;

(b) Mattress Replacement -- Device that takes the place of the standard hospital or home mattress;

(c) Bottoming out -- the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the client'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 the head flat, in the supine position with the head slightly elevated (no more than 30 degrees) and in the sidelying position;

(d) The staging of pressure ulcers used in this policy is as follows:

(A) Stage 1 -- nonblanchable erythema of intact skin;

(B) Stage 2 -- partial thickness skin loss involving epidermis and/or dermis;

(C) Stage 3 -- full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia;

(D) Stage 4 -- full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures.

(3) Group 1 indications and coverage. Covered if the client meets:

(a) Criterion (A); or

(b) Criterion (B) or (C) and at least one of criteria (D) through (G):

(A) Completely immobile, i.e., client cannot make changes in body position without assistance;

(B) Limited mobility, i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(C) Any stage pressure ulcer on the trunk or pelvis;

(D) Impaired nutritional status;

(E) Fecal or urinary incontinence;

(F) Altered sensory perception;

(G) Compromised circulatory status.

(c) The client must also have a care plan established by the prescribing practitioner or other licensed health care practitioner directly involved in the client's care, which must include the following:

(A) Education of the client and caregiver on the prevention and/or management of pressure ulcers;

(B) Regular assessment by a nurse, physician or other licensed health care practitioner;

(C) Appropriate turning and positioning, including instruction and frequency intervals;

(D) Appropriate wound care (for stage II, III or IV ulcer);

(E) Appropriate management of moisture/incontinence;

(F) Nutritional assessment and intervention consistent with the overall plan of care.

(d) Client does not bottom out;

(e) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider and submitted with the prior authorization request;

(f) Procedure codes for Group 1. OMAP will purchase the following items:

(A) E0184, Dry pressure mattress. Nonpowered pressure reducing mattress. Foam height of 5" or greater, and foam with a density and other qualities that provide adequate pressure reduction, durable waterproof cover, can be placed directly on a hospital bed frame. Requires prior authorization;

(B) E0185, Gel or gel-like pressure pad for mattress. Gel layer with a height of 2" or greater. Nonpowered pressure reducing mattress overlay. Requires prior authorization;

(C) E0186, Air pressure mattress. Total height of 5" or greater, durable waterproof cover and can be placed directly on a hospital bed frame. Nonpowered pressure reducing mattress. Requires prior authorization;

(D) E0187, Water pressure mattress. Total height of 5" or greater, durable waterproof cover and can be placed directly on a hospital bed frame. Nonpowered pressure reducing mattress. Requires prior authorization;

(E) E0196, Gel pressure mattress. Total height of 5" or greater, durable waterproof cover and can be placed directly on a hospital bed frame. Nonpowered pressure reducing mattress. Requires prior authorization;

(F) E0197, Air pressure pad for mattress. Composed of interconnected air cell that is inflated with an air pump with cell height of 3" or greater. Requires prior authorization;

(G) E0198, Water pressure pad for mattress. Filled height of 3" or greater. Nonpowered pressure reducing mattress overlay. Requires prior authorization;

(H) E0199, Dry pressure pad for mattress. Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least 3" if it is a nonconvoluted overlay and foam with a density and other qualities that provide adequate pressure reduction and durable waterproof cover. Use E1399 for an eggcrate mattress without a durable waterproof cover also authorized by OMAP. Nonpowered pressure reducing mattress overlay;

(I) A4640, Replacement pad for use with medically necessary alternating pressure pad owned by client. An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5" or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out. OMAP will purchase and repair. Also covered for payment by OMAP when client is a resident of a long-term care facility;

(J) E0180, Pressure pad, alternating with pump. OMAP will purchase, rent and repair. Item considered. Item considered purchased after 16 months of rent:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay; and

(ii) Inflated cell height of the air cells through which air is being circulated is 2.5" 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.

(K) E0181, Pressure pad, alternating with pump, heavy duty. OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay; and

(ii) Inflated cell height of the air cells through which air is being circulated is 2.5" 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.

(L) E0182, Pump for alternating pressure pad. Must generate enough pressure to maintain at least 2.5" depth in chambers and has appropriate frequency of air cycling. OMAP will purchase, rent and repair. Item considered purchased after 16 months of rent.

(4) Group 2. Group 2 items are covered if the client meets:

(a) Criterion (A) and (B) and (C) and (G); or

(b) Criterion (D) and (G); or

(c) Criterion (E) and (F) and (G):

(A) Multiple stage II pressure ulcers located on the trunk or pelvis;

(B) Client has been on a comprehensive ulcer treatment program for at least 30 consecutive days which has included the use of an appropriate group 1 support surface;

(C) The ulcers have worsened or remained the same over the last 30 days;

(D) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis;

(E) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days);

(F) 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);

(G) Only covered for individuals in category (4) or (5) in a nursing facility.

(d) The comprehensive ulcer treatment described in (4)(c)(B) should generally include:

(A) Education of the client and caregiver on the prevention and/or management of pressure ulcers;

(B) Regular assessment by a nurse, physician, or other licensed health care practitioner (usually at least weekly for a client with a stage III or IV ulcer);

(C) Appropriate turning and positioning;

(D) Appropriate wound care (for a stage II, III or IV ulcer);

(E) Appropriate management of moisture/incontinence;

(F) Nutritional assessment and intervention consistent with the overall plan of care.

(e) Other Coverage Issues:

(A) Not covered for prevention of pressure sores or pain control;

(B) The allowable rental fee includes all equipment, supplies and services necessary for the effective use of the support surface;

(C) Coverage following a myocutaneous flap or skin graft is limited to 14 days immediately following hospital discharge. All other criteria is waived for this condition.

(f) Documentation: The following information and criteria must be submitted with the initial written request:

(A) A prescribing practitioner's prescription;

(B) The resident care manager evaluation describing the underlying condition (diagnosis, prognosis, rehabilitation potential and nutritional status) as well as a comprehensive assessment and evaluation of the individual after conservative treatment has been tried without success. A statement of goals for stepping down the intensity of support therapy is required;

(C) Documentation of other pressure reducing products or methods used but not proven adequate;

(D) A summary of a nutritional assessment by a registered dietician within the last 90 days including the client's height and weight;

(E) Serum total protein and albumin values within the last 30 days;

(F) Written description of decubitus. This should include numbers, locations, sizes and stages;

(G) Dated photographs of pressure sores;

(H) Pressure sores on extremities must have documentation of change in sensorium and/or reason why pressure cannot be relieved be other methods. This means that the medical necessity for special pressure reducing products must be proven and documented.

(g) Prior authorization will be given for ten weeks of pressure reducing therapy. To continue coverage there must be documented progress from the nursing facility, product provider or prescribing practitioner. If no progress is reported, further authorization for services will be denied;

(h) At review, submit:

(A) Dated photographs of pressure sores;

(B) Copies of skin flow sheets;

(C) Copies of any pertinent notes in the progress records;

(D) Copies or records supporting changes in laboratory values or nutritional status;

(E) Written description of pressure sores by resident care manager including numbers, locations, sizes and stages.

(i) Procedure Codes for Group 2. OMAP will rent the following items. Items require prior authorization. Items are also covered if the client is a resident in a long-term care facility:

(A) E0193, Powered air flotation bed (low air loss therapy) per day. A semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress 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 mattress; and

(ii) Inflated cell height of the air cells through which air is being circulated is five 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 mattresses), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear; and

(v) Can be placed directly on a hospital bed frame;

(vi) Use also for 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; and

(II) Inflated cell height of the air cells through which air is being circulated is 3.5" 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; and

(IV) A surface designed to reduce friction and shear.

(B) E0277, Alternating pressure mattress per month. 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:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress; and

(ii) Inflated cell height of the air cells through which air is being circulated is five 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 mattresses), and air pressure provide adequate client lift, reduce pressure, and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear; and

(v) Can be placed directly on a hospital bed frame;

(vi) Use also for 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; and

(II) Inflated cell height of the air cells through which air is being circulated is 3.5 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; and

(IV) A surface designed to reduce friction and shear.

(C) K0413, Nonpowered adjustable zone pressure-reducing air mattress overlay. A nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

(i) At least three independent sections in which the air pressure is custom adjusted for each patient;

(ii) Each section contains numerous air cells connected by restrictive manifolding that provides constant force equalization;

(iii) Each cell is displaceable and low surface tension over the entire body is continually maintained;

(iv) A surface which reduces friction and shear;

(v) Cell height of 3 inches or greater.

(D) K0414, powered air overlay for mattress. 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 3.5 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 client lift, reduce pressure and prevent bottoming out; and,

(iv) A surface designed to reduce friction and shear.

(5) Group 3 -- Air-fluidized beds are not covered.

(6) Other codes:

(a) E0188, synthetic sheepskin pad -- OMAP will purchase;

(b) E0189, Lambs wool sheepskin pad -- OMAP will purchase.

Stat. Auth.: ORS Ch. 409

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

410-122-0420

Replacement Mattresses - Effective for Services Provided On or After June 1, 1996

Mattresses:

(1) E0271, Mattress, inner spring (replacement for patient owned hospital bed) -- OMAP will purchase;

(2) E0272, Mattress, foam rubber (replacement for patient owned hospital bed) -- OMAP will purchase.

Stat. Auth.: ORS Chapter 409

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

410-122-0460

Shoes and Supports

Orthopedic Shoes. [Table not included. See ED. NOTE.]

(1) Support Hose: Cosmetic support panty hose (i.e. Leggs, No Nonsense, etc.) are not covered.

(2) Therapeutic Shoes for Diabetics:

(a) Indications and Coverage:

(A) For each patient coverage of the footwear and inserts is limited to one of the following within one calendar year:

(i) One pair of custom molded shoes (including inserts provided with such shoes) and two additional pair of inserts; or

(ii) One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts.

(B) An individual may substitute modification(s) 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:

(i) Rigid rocker bottoms;

(ii) Roller bottoms;

(iii) Metatarsal bars;

(iv) Wedges;

(v) 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 practitioner managing the patient'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.

(b) Documentation:

(A) The practitioner who is managing the individual's systemic diabetic condition documents that the patient has diabetes and one or more of the following conditions:

(i) Previous amputation of the other foot, or part of either foot;

(ii) History of previous foot ulceration of either foot;

(iii) History of pre-ulcerative calluses of either foot;

(iv) Peripheral neuropathy with evidence of callus formation of either foot;

(v) Foot deformity of either foot; or

(vi) Poor circulation in either foot.

(B) Certifies that the patient is being treated under a comprehensive plan of care for his or her diabetes and that he or she needs therapeutic shoes;

(C) Documentation of the above criteria, may be completed by the prescribing practitioner or supplier but must be reviewed for accuracy of the information and signed and dated by the certifying practitioner to indicate agreement and must be kept on file by the DME supplier.

(c) A5500, For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(d) A5501, For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(e) A5502, For diabetics only, multiple density insert(s), per shoe -- OMAP will purchase -- Also covered for payment

by OMAP when client is a resident of a long-term care facility;

(f) A5503, For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(g) A5504, For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(h) A5505, For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(i) A5506, For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(j) A5507, For diabetics only, not otherwise specified modification (include fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(k) XX012, Miscellaneous modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe for diabetics only, per shoe -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility;

(l) K0401, For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe -- OMAP will purchase -- also covered for payment by OMAP when client is a resident of a long-term care facility.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0480

Pneumatic Compression Devices (Used for Lymphedema)

(1) A pneumatic compression device (lymphedema pump) is medically necessary only for the treatment of refractory lymphedema involving one or more limbs. 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 (e.g., after radical mastectomy);

(c) Post-radiation fibrosis;

(d) Scarring of lymphatic channels (i.e., those with generalized refractory edema from venous insufficiency which is complicated by recurrent cellulitis); when all of the following criteria have been met:

(A) There is significant ulceration of the lower extremity(ies); and

(B) The client has received repeated, standard treatment from a practitioner using such methods as a compression bandage system or its equivalent; and

(C) The ulcer(s) have failed to heal after six month of continuous treatment.

(e) Congenital anomalies.

(2) 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 patient's condition to determine medical necessity 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.

(3) All pressure devices require a one-month trial period prior to purchase. The rental period is applied toward purchase.

(4) All necessary training to utilize a pressure device is included in rental or purchase fee.

(5) Documentation:

(a) The practitioner must document the patient's condition, medical necessity 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 necessity of pneumatic compression device must include:

(A) The patient's diagnosis and prognosis;

(B) Symptoms and objective findings, including measurements which establish the severity of the condition;

(C) The reason the device is required, including the treatments which 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 patient (or caregiver) to apply the device for continued use in the home.

(c) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(d) If the client has venous stasis ulcers, documentation supporting the medical necessity for the device should include a signed and dated statement from the prescribing practitioner indicating:

(A) The location and size of venous stasis ulcer(s);

(B) How long each ulcer has been continuously present;

(C) Whether the patient has been treated with regular compression bandaging for the past six months;

(D) Whether the patient 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(s) during the past six months;

(F) Whether the patient has been seen regularly by a practitioner for treatment of venous stasis ulcer(s) during the past six months. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0500

Transcutaneous Electrical Nerve Stimulator (TENS) - Effective for Services Provided On or After June 1, 1996

(1) Indications and Coverage:

(a) A Transcutaneous Electrical Nerve Stimulator (TENS) is covered when it is medically necessary in the treatment of patients with chronic, intractable pain or acute post-operative pain who meet the criteria;

(b) May be covered for acute post-operative pain for no more than one month following day of surgery. Continued coverage requires further documentation;

(c) Not covered:

(A) To treat motor function disorders;

(B) For acute pain (less than three months duration) other than post-operative pain;

(C) For etiology that is not accepted as responding to TENS (e.g. headache, visceral abdominal pain, pelvic pain, temporomandibular joint (TMJ) pain and others).

(d) Included in the rental or purchase price are:

(A) Adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches or covers, all necessary training and one month's worth of TENS supplies;

(B) A two-month trial period of rental is required prior to purchase. The rental period is applied toward purchase price.

(e) There should be no separate billing and there will be no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630) or a battery charger.

(2) Documentation:

(a) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider;

(b) The following documentation must be received with the initial request for rental:

(A) For post-operative pain include type and date of surgery and diagnosis, other appropriate treatment modalities tried, including names and dosage of medication, length of each treatment time and the results;

(B) For chronic intractable pain include etiology, length of time pain has been present (must have been present for at least three months), location of pain and other treatment tried and failed;

(C) The following documentation must be received every six months to continue supplies:

(i) A new CMN; or

(ii) Other documentation of medical necessity.

(3) E0720, TENS, two lead, localized stimulation -- Prior authorization required OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility -- Item considered purchased after 16 months of rent.

(4) E0730, TENS, four lead, larger area/ multiple nerve stimulation -- Prior authorization required OMAP will purchase, rent and repair -- Also covered for payment by OMAP when client is a resident of a long-term care facility -- Item considered purchased after 16 months of rent.

(5) A4557, Lead wires, (e.g., apnea monitor) -- Prior authorization required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility. 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.

(6) A4595, TENS supplies -- one month allowance for supplies for a patient-owned 2 lead TENS -- Prior authorization required -- OMAP will purchase -- Also covered for payment by OMAP when client is a resident of a long-term care facility. 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 prep-aration materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used). One unit of service represents supplies needed for one month for a 2 lead TENS assuming daily use. Two units of service for one month for a 4-lead TENS.

Stat. Auth.: ORS Chapter 409

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

410-122-0510

Electronic Stimluators

(1) Indications and Coverage:

(a) Use of the noninvasive osteogenesis stimulator is only covered for:

(A) Nonunion of long bone fractures after six months have elapsed without healing of the fracture; or

(B) Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery; or

(C) Congenital pseudarthroses.

(b) Nonunion of long bone fractures is considered to exist only after six or more months, and a failed fusion is considered to exist only after 12 or more months have elapsed without healing of the fracture or fusion;

(c) Procedure Codes:

(A) E0745, Neuromuscular stimulator electronic shock unit. Covered for treatment of disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for

disuse are causing atrophy; relaxation of muscle spasm; prevention of retardation of disuse atrophy; re-education of muscle; increase local blood circulation; mantaining or increasing range of motion. Submit the following for authorization: copies of prescribing practitioner's progress records; statement of medical necessity from prescribing practitioner; copy of practitioner's prescription -- Prior Authorization Required -- OMAP will rent -- Also covered for payment by OMAP if client is a resident of a long term care facility;

(B) E0747, Osteogenic stimulator electrical (non-invasive) other than spinal application. One time rental per condition -- Prior Authorization Required -- OMAP will rent -- Also covered for payment by OMAP if client is a resident of a long term care facility;

(C) A4556, Electrodes, (e.g., apnea monitor) -- Prior authorization required -- OMAP will purchase -- also covered for payment by OMAP if client is a resident of a long-term care facility;

(D) A4557, Lead wires (e.g., apnea monitor) -- Prior authorization required -- OMAP will purchase -- also covered for payment by OMAP if client is a resident of a long-term care facility.

(2) The following must be submitted for authorization for osteogenesis stimulators:

(a) Documentation of other alternative treatments tried but found ineffective;

(b) Copies of prescribing practitioner's progress records;

(c) Copies of X-ray reports;

(d) Statement of medical necessity or copy of CMN from prescribing practitioner.

(3) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider.

Stat. Auth.: ORS Ch. 409

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

410-122-0520

Diabetes Supplies

(1) Indications and Coverage:

(a) Home blood glucose monitors are indicated for patients who are insulin-treated diabetics and who can better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment;

(b) Coverage of home blood glucose monitors is limited to patients meeting one of the following conditions:

(A) The patient is an insulin-treated diabetic;

(B) The device will improve compliance in non-insulin treated diabetics;

(C) The client is pregnant with gestational diabetes and the condition cannot be controlled or monitored through other means.

(c) Coverage is also based on:

(A) The practitioner documents the patient or caregiver is capable of being trained to use the particular device prescribed in an appropriate manner; and

(B) The device is designed for home rather than clinical use.

(2) Documentation of medical necessity which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider.

(3) Purchase fee includes normal, low and high calibrator solution/chips.

(4) E0607, Home blood glucose monitor -- Prior authorization required -- OMAP will purchase -- OMAP will repair.

(5) E0609, Blood glucose monitor with special features (eg., voice synthesizers, automatic timers, etc.) -- Prior Authorization required -- OMAP will purchase -- OMAP will repair. Covered when the following conditions are met:

(a) The patient and device meet one of the conditions listed above for coverage of standard home blood glucose monitors; and

(b) The patient's physician certifies a severe visual impairment (>=20/200 corrected).

(6) A4253, Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips -- OMAP will purchase.

(7) A4772, Dextrostick or glucose test strips, per box -- OMAP will purchase.

(8) A4259, Lancets, per box (of 100) -- OMAP will purchase.

(9) A4258, Spring-powered device for lancet, each -- OMAP will purchase.

(10) A4255, Platforms for home blood glucose monitor, 50 per box -- OMAP will purchase.

(11) A4254, Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each -- OMAP will purchase.

Stat. Auth.: ORS Ch. 409

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

410-122-0540

Ostomy Supplies

Colostomy, Ileostomy, Ureterostomy. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0560

Urological Services

Codes. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0580

Bath Supplies - Effective for Services Provided On or After June 1, 1996;

(1) Codes

Table 9

E0162 -- Sitz bath chair -- Office of Medical Assistance Programs (OMAP) will purchase

E0160 -- Sitz type bath or equipment, portable used with or without commode -- OMAP will purchase

E0161 -- With faucet attachments -- OMAP will purchase

E1300 -- Whirlpool portable (over tub type) -- Prior Authorization Required -- OMAP will purchase -- OMAP will rent -- OMAP will repair -- Item considered purchased after 16 months of rent

E0621 -- Sling or seat, patient lift, canvas or nylon -- Prior Authorization Required -- OMAP will purchase

E0630 -- Patient lift, hydraulic with seat or sling -- Prior Authorization Required -- OMAP will purchase -- OMAP will rent -- OMAP will repair -- Item considered purchased after 16 months of rent

DMA23 -- Patient lift, no seat or sling -- Prior Authorization required -- OMAP will rent -- Item considered purchased after 16 months of rent. Effective for services provided on or after April 1, 1996

E0241 -- Bath tub wall rail, each -- 12" -- OMAP will purchase

DMA24 -- Bath tub wall rail, each -- 16" -- OMAP will purchase. Effective for services provided on or after April 1, 1996

DMA25 -- Bath tub wall rail, each -- 18" -- OMAP will purchase. Effective for services provided on or after April 1, 1996

DMA26 -- Bath tub wall rail, each -- 24" -- OMAP will purchase. Effective for services provided on or after April 1,

1996

DMA27 -- Bath tub wall rail, each -- 32" -- OMAP will purchase. Effective for services provided on or after April 1, 1996

E0242 -- Bath tub rail floor base -- OMAP will purchase

E0246 -- Transfer tub rail attachment -- OMAP will purchase

E0243 -- Toilet rail, each (wall mount) -- OMAP will purchase

E0245 -- Tub stool or bench -- OMAP will purchase

DMA29 -- Tub stool or bench with back -- OMAP will purchase. Effective for services provided on or after April 1, 1996

DMA30 -- Tub transfer chair or bench -- OMAP will purchase -- OMAP will rent -- OMAP will repair. Effective for services provided on or after April 1, 1996

DMA31 -- Padded tub transfer bench with or without back -- OMAP will purchase and repair

DMA28 -- Tub mounted grab bar -- OMAP will purchase. Effective for services provided on or after April 1, 1996

DMA32 -- Rehab shower/commode chair -- standard size (if heavy duty or extra wide use E1399), elevating and/or swing away footrest, (if medically necessary), swing away arm rests (if medically necessary), non-corrosive, padded seat, wheeled, adjustable head immobilized (if medically necessary), reclining back (if medically necessary), braking system, leg and/or restraint belt (if medically necessary) -- Prior authorization required -- OMAP will purchase -- OMAP will repair. Effective for services provided on or after April 1, 1996

(2) Indications and Coverage:

(a) 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 patient would be bed-confined.

(b) For hydralizer bath tub lift, use E1309.

(3) Documentation: An order for the patient lift which is signed by the prescribing practitioner must be kept on file by the DME supplier. The prescribing practitioner's records must contain information which supports the medical necessity of the item ordered.

Stat. Auth.: ORS Chapter 409

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

410-122-0600

Toilet Supplies - Effective for Services Provided On or After June 1, 1996

(1) Codes

Table 10

E0275 -- Bedpan standard metal or plastic -- OMAP will purchase

E0276 -- Fracture metal or plastic -- OMAP will purchase

E0325 -- Urinal; male, jug-type, any material -- OMAP will purchase

E0326 -- Female, jug-type, any material -- OMAP will purchase

E0244 -- Raised toilet seat -- OMAP will purchase

E0163 -- Commode chair -- stationary with fixed arms -- OMAP will purchase -- OMAP will rent -- OMAP will repair -- Item considered purchased after 16 months of rent

E0165 -- With detachable arms -- OMAP will purchase -- OMAP will rent -- OMAP will repair -- Item considered purchased after 16 months of rent

E0164 -- Mobile with fixed arms -- OMAP will purchase -- OMAP will rent -- OMAP will repair -- Item considered purchased after 16 months of rent

E0166 -- With detachable arms -- OMAP will purchase -- OMAP will rent -- OMAP will repair -- Item considered purchased after 16 months of rent

E0167 -- Pail or pan for use with commode chair -- OMAP will purchase

DMA34 -- Three purpose commode with fixed arms -- OMAP will purchase. Effective for services provided on or after April 1, 1996

DMA33 -- Toilet safety frame (Versa frame) -- OMAP will purchase. Effective for services provided on or after April 1, 1996

DMA46 -- Positioning commode -- covered if client needs trunk stability, head stability, adduction or abduction and seat belt -- prior authorization required -- OMAP will purchase and repair. Effective for services provided on or after April 1, 1996

(2) Commodes are provided when the client is incapable of utilizing regular toilet facilities.

(3) An order for the commode which is signed by the prescribing practitioner must be kept on file by the DME supplier. The practitioner's records must contain information which supports the medical necessity of the item ordered.

Stat. Auth.: ORS Chapter 409

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

410-122-0620

Miscellaneous Supplies (Non-Reusable)

Procedure Codes. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0640

Prosthetic Eyes - Effective for services provided on or after June 1, 1996

(1) Indications and Coverage:

(a) An eye prosthesis is indicated for a patient (adult or child) with absence or shrinkage of an eye due to birth defect, trauma or surgical removal;

(b) Polishing and resurfacing will be allowed on a yearly basis;

(c) Documentation of medical necessity which has been reveiwed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider.

(2) Codes:

Table 12

V2623 -- Prosthetic Eye, plastic, custom -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long-term care facility

V2624 -- Polishing/Resurfacing of ocular prosthesis -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long term care facility

V2625 -- Enlargement of ocular prosthesis -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long term care facility

V2626 -- Reduction of ocular prosthesis -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long term care facility

V2627 -- Scleral cover shell -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long term care facility

V2628 -- Fabrication and fitting of ocular conformer -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long term care facility

V2629 -- Prosthetic Eye, other type -- OMAP will purchase -- Also covered for payment by OMAP if client is a resident of a long-term care facility

Stat. Auth.: ORS Chapter 409

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

410-122-0660

Orthotics and Prosthetics

(1) Use appropriate Health Financing Common Procedure Coding System (HCPCS) codes from the Illustrated Guide to Orthotics and Prosthetics: O&P's Comprehensive Guide to Medicare Codes and Reimbursement prepared by the American Orthotic and Prosthetic Association.

(2) The hospital is responsible for reimbursing the provider for orthotics and prosthetics on an inpatient basis.

(3) Evaluations, office visits, fittings and materials are included in the service provided.

(4) Evaluations will only be reimbursed as a separate service when the provider travels to a client's residence to evaluate the client's need.

(5) Prior authorization will be required for the following orthotic and prosthetic codes only:

(a) L3649;

(b) L2999;

(c) L1499;

(d) L3999;

(e) L5999;

(f) L7499;

(g) L8499.

(6) The following codes are not covered: [Table not included. See ED. NOTE.]

(7) All covered orthotic and prosthetic codes are also covered if client resides in a nursing facility except L1500, L1510, L1520.

(8) Medicare guidelines are to be followed as listed in DMERC Region D Supplier Manual. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-122-0680

Facial Prostheses

(1) All facial prostheses and associated services in this rule which are indicated "PA" require prior authorization from the OMAP Medical Group.

(2) 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 patient'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.

(3) Documentation: The following must be submitted for prior authorization:

(a) An order for the initial prosthesis and/or related supplies which is signed and dated by the ordering physician must be kept on file by the prosthetist/supplier and submitted with request for prior authorization;

(b) A separate physician order is not required for subsequent modifications, repairs or replacement of a facial prosthesis;

(c) A new physician 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 prior authorization request;

(e) When code K0448 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 necessity;

(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. [Table not included. See ED. NOTE.]

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 7-1997, f. 2-28-97, cert. ef. 3-1-97

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 123

DENTAL/DENTURIST SERVICES

410-123-0000

Eligibility Information -- Effective for Services Provided on or After July 1, 1992

(1) Eligibility:

(a) The Medical Card guarantees eligibility only for the time period listed on the card. Instructions for reading a Medical Card are found in the General Rules;

(b) If you plan to bill OMAP for your services, be sure to verify eligibility before providing services. It is the responsibility of the dentist to verify the client's eligibility. OMAP will not pay for services provided to an ineligible client even though services have been prior authorized. If you have questions about eligibility call ACES or check with the client's local branch office.

(2) Medically Needy Program (P2 or M5):

(a) This program has coverage limitations for certain client categories. Refer to the General Rules for these categories and limitations. The Medically Needy Program also can have a "spend-down" requirement. This means that sometimes the client is responsible for a portion of your charges incurred each month. On the day the client has met the "spend-down" requirement, he/she will be made eligible for Medicaid coverage. A Medical Card will be issued by the branch office showing eligibility on that date;

(b) If you need more general information about this program, call (503) 378-5581. If you need specific information about any one client's "spend-down" responsibility, call the client's branch worker. The number is listed on the Medical Card. Not all clients in this program have a "spend-down" requirement. These clients are identified on their Medical Cards with person level messages such as: **"Eligible for Medical Assistance this month only"**.

(3) Poverty Level Program (P2 and M5): This program covers pregnant women and children born after September 30, 1983, depending on their income. There is never a "spend-down" requirement. Dental services for adult (21 years of age and older) pregnant women are not covered. All other medical services are available for pregnant women in this program. Children and pregnant women under 21 years of age have full medical and dental coverage.

(4) Prepaid Health Plan Contracts:

(a) OMAP has contracted with Dental Care Organizations (DCO) and Physician Care Organizations (PCO) for dental coverage on a prepaid basis. The Medical Card for those enrollees has a special notation of DCO or PCO in the Managed Care and TPR Information section. (See General Rules for instructions on reading a Medical Card);

(b) OMAP is not financially responsible to other providers for services covered under the DCO/PCO contract. Therefore, except as described below, other providers cannot anticipate reimbursement from the OMAP or DCO/PCO for DCO/PCO covered services;

(c) Services rendered by other providers to DCO/PCO enrollees as life-saving emergency procedures, or when the enrollee is in need of dental care while traveling outside the DCO/PCO service area are covered by the Medical Assistance Program;

(d) Orthodontia and treatment of fractures of the mandible and maxilla are not covered in the DCO/PCO contract. A provider should continue to follow standard OMAP procedures when billing for these services for both DCO/PCO enrolled clients and non-enrolled clients.

(5) Medicare: OMAP covers some clients under the Qualified Medicare Beneficiary Program. These clients are identified on the Medical Card with one of two titles and messages:

(a) "QMB -- Qualified Medicare Beneficiary". Only Medicare services covered -- No pharmacy; or

(b) "QMN -- Qualified Medicare and Medical Assistance Beneficiary". All medicare and medical assistance services are covered;

(c) People with Medicare services may only be eligible for medical assistance through the Medically Needy "spend-down" Program. These people will have an additional person level message as follows: **"Eligible for Medical Assistance services this month only"**.

(6) Billing of Prior Resources: If a client has health insurance depicted on the Medical Card, it is an indication that the client has financial resources that must be billed prior to billing OMAP. This is found in the Managed Care and TPR Information section of the client's Medical Card.

(7) Laboratory Fabricated Prosthetics: If a dentist provides a service to an eligible client that requires the use of a dental laboratory and the course of treatment is expected to extend beyond the period of eligibility listed on the client's Medical Card, the dentist should use the earliest date of treatment as the date of service.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-320; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 29-1992, f. & cert. ef. 9-1-92

410-123-0020

Adjustment Requests

(1) Overpayments, underpayments, and payments received after OMAP has paid a claim can be resolved through the adjust-ment process. Request Individual Adjustment Request Forms from the AFS Provider Forms Distribution Center at Salem, OR. Much of the information requested on the Adjustment Request Form is printed on the Remittance Advice. Documentation may be submitted to support your request. Adjustment Requests must be submitted in writing to OMAP.

(2) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) This is a reminder to attach needed documentation;

(c) Mail the Adjustment Request to this address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**);

(e) Enter the client's identification number in this space. This number can be found on the RA in Field 6 or on the client's Medical Card;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Card;

(g) Enter your six-digit provider number in this space;

(h)This space is for provider name;

(i)Enter the date printed at the top of the RA;

(j)Description -- This column contains possible areas that may need to be corrected. Only check the box you want to change:

(A)Place of Service -- Use the following place of service indicators:

(i) 1 = Inpatient hospital;

(ii) 2 = Outpatient hospital;

(iii) 3 = Office;

(iv) 4 = Other.

(B)Type of Service -- Indicate "S" for non-emergency or "X" for emergency dental treatment;

(C)Quantity/Unit -- Check if the original quantity was incorrect;

(D)Billed Amount -- Check if the original billed amount was incorrect;

(E)NDC/Procedure -- Check if the original procedure code was incorrect;

(F)Insurance Payment/Patient Liability -- The payments from other sources (Field 35 on the OMAP 501D or Field 13 on the RA) or any payments received after submitting claim to OMAP;

(G)Other -- Use this box if none of the above address the problem.

(k)Line # -- List the line number from the original claim (OMAP 501D or ADA form) that is being adjusted;

(l)Service Date -- Enter the date the service was provided;

(m)Wrong Information -- Enter the incorrect information submitted on the original claim here;

(n)Right Information -- Enter the corrected information in this column;

(o)Remarks -- This is the area to give additional information or explain the request;

(p)Provider's Signature -- The signature of the provider or other authorized personnel must be in this space;

(q)Date -- Enter the date this form was completed

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-330; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0040

Purpose -- For Services Provided on or After October 1, 1991

The purpose of this **Guide** is to establish the rules of payment for dental services provided to children (18 months through 20 years of age) for medical assistance. The General Rules for the Oregon Medical Assistance Program and the rules in this **Guide** are to be used together to determine eligibility for services.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 16-1978(Temp), f. 4-14-78, ef. 5-1-78; AFS 17-1978(Temp), f. & ef. 5-1-78; AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 48-1982, 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-000; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-340; HR 46-1991, f. & cert. ef. 10-16-91

410-123-0060

Definitions of Terms

(1) "Emergency Services" are covered services requiring immediate treatment. This includes services to control hemorrhage, relieve pain, eliminate acute infection and operative procedures required to prevent pulpal death and immediate loss of teeth. This includes immediate treatment of injuries to both dentition and support structures. The emergency rule applies only to covered services. OMAP recognizes that some non-covered services may meet the criteria of emergency, but it is not intended to extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care.

(2) "Preventive Services" include:

(a) Oral Prophylaxis (cleaning of teeth);

(b) Topical Fluoride;

(c) Sealants.

(3) "Therapeutic Services" include:

(a) Pulp therapy for permanent and primary teeth;

(b) Restorations for primary and permanent teeth using amalgam, composite materials and stainless steel or polycarbonate crowns;

(c) Scaling and curettage;

(d) Space maintainers for primary posterior teeth lost prematurely;

(e) Removable prosthesis when masticatory function is impaired.

(4) "Orthodontics" means the detection, study, and correction of irregularities in tooth position and jaw relationship and deformities of the face produced by these conditions.

(5) "Covered Services" means the services that will be reimbursed to a provider for an eligible recipient as defined in the **Dental Guide** and General Rules of the Oregon Medical Assistance Program.

(6) "General Anesthesia" is a controlled state of unconsciousness including the inability to independently maintain an airway or to respond purposefully to physical stimulation or verbal command. The use of the following drugs either alone or in combination with other drugs, is conclusively presumed to produce general anesthesia:

(a) Ultra short acting barbiturates including but not limited to sodium methohexital, thiopental, and thiamylal;

(b) Other general anesthetics including but not limited to Ketamine or etomidate; or

(c) Rapidly acting steroids including but not limited to althesin.

(7) "Nitrous Oxide" is an anesthetic agent administered to induce loss of sensibility to pain without necessarily incurring loss of consciousness.

(8) "Oral Pre-Medication" is considered a type of "conscious sedation". Conscious sedation means a depressed level of consciousness that retains the ability to maintain, independently and continuously, an airway, and respond purposely to physical stimulation or oral command.

(9) "Sedation" means administration of a sedative drug intravenously (in a single injection or injected over an extended period of time), intramuscularly, submucosally or subcutaneously.

(10) "Direct Pulp Cap" is the direct application of calcium hydroxide or ZOE directly over an exposed pulp.

(11) "EPSDT" (Medicheck): Medicheck is the Title XIX program of Early and Periodic Screening, Diagnosis and Treatment for eligible persons under age 21.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 16-1978(Temp), f. 4-14-78, ef. 5-1-78; AFS 17-1978(Temp), f. & ef. 5-1-78; AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 78-1981, f. 11-20-81, ef. 12-1-81; AFS 48-1982, 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-005; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-350; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0100

Services Reviewed by the Office of Medical Assistance Programs (OMAP)

(1)TheOfficeofMedical Assistance Programs (OMAP) reserves the right to refuse payment for treatment performed when the prognosis was unfavorable, the treatment impractical, or a lesser cost procedure would have achieved the same ultimate results.

(2) The Office of Medical Assistance Programs, in consultation with the Oregon Dental Association, contracts with a General Practice Consultant, an Oral Surgery Consultant and an Orthodontia Consultant for professional review of certain services or billings before payment will be authorized by OMAP. If, in the opinion of the consultant, the clinical information furnished does not support the treatment or services provided, payment will be denied.

(3) The Oregon Dental Association will be requested to provide peer review on specific issues through the regularly established peer review system of the Association. The prevention of fraud and abuse may be pursued at the discretion of OMAP and is not limited to Oregon Dental Association peer review.

(4) Request for payment for dental services listed as "BR -- By Report", 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 x-rays. Payment for "BR" procedures will be approved in consultation with an OMAP dental consultant.

(5) OMAP requests for x-rays.

(6) OMAP may, in the process of utilization review and/or in determining its responsibility for payment of dental services, request the treating dentist to submit appropriate x-rays and/or other clinical information which justifies the treatment to OMAP. Payment by OMAP may be denied if the requested x-rays and/or other clinical information are not submitted.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 48-1982, 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-189; Renumbered from 461-26-040, 461-26-045 & 461-26-055; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-370; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0120

Emergency Dental Services

Payments for emergencies are restricted to services defined in OAR 410-123-0060(1). Emergency services do not require prior authorization by OMAP. Documentation of the need for the emergent services are the responsibility of the provider and subject to audit by OMAP.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 4-1982 (Temp), f. 1-21-82, ef. 2-1-82; AFS 12-1982(Temp), f. & ef. 2-9-82; AFS 48-1982, 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 71-1982(Temp), f. & ef. 7-12-82; AFS 89-1982, f. 9-30-82, ef. 10-1-82; AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-

29-89, cert. ef. 10-1-89; Renumbered from 461-26-030; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-380; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0140

Early and Periodic Screening, Diagnosis, and Treatment of Persons Under 21 (Medicheck)

(1) EPSDT (Medicheck) is the dental screening and referral for the maintenance of dental health. Recipients 18 months of age through 20 years of age are eligible for the Medicheck Program.

(2) EPSDT (Medicheck) exams are limited to the following frequency schedule:

(a) Age of Child: 18 months through 20 years old;

(b) Exam Interval: Once every six months.

(3) EPSDT (Medicheck) services include:

(a) Initial or Periodic Oral Exams;

(b) Prophylaxis and Topical Fluoride;

(c) Establishing a treatment plan and requesting prior authorization of services when necessary;

(d) X-rays for EPSDT (Medicheck) eligible recipients under the age of six. The Medical Assistance Program will reimburse for a maximum of six periapicals and two bitewings for a total of eight films;

(e) X-rays for EPSDT (Medicheck) eligible recipients, six through 11 years of age. The Medical Assistance Program will reimburse for a maximum of ten periapicals and two bitewings for a total of 12 films;

(f) X-rays for EPSDT (Medicheck) eligible recipients, 12 years of age and older. The Medical Assistance Program will reimburse for a maximum of ten periapicals and four bitewings for a total of 14 films.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 16-1978(Temp), f. 4-14-78, ef. 5-1-78; AFS 17-1978(Temp), f. & ef. 5-1-78; AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 48-1982, 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 108-1982 (Temp), f. & ef. 12-6-82; AFS 21-1983, f. 5-10-83, ef. 6-1-83; AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 46-1985, f. 7-5-85, ef. 8-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 23-1988, f. 3-21-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-010; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-390

410-123-0160

Prior Authorization of Payment

(1) The **Procedure Code Section** of this **Guide** designates those codes which require prior authorization.

(2) Requests for prior authorization of payment must be obtained through the OMAP Dental Program Coordinator on Form OMAP 501D, Dental Services Invoice, listing the specific services requested. Send requests to: OMAP, Salem, OR.

(3) Requests for prior authorization of payment for treatment relating to an EPSDT (Medicheck) exam require the date of the EPSDT (Medicheck) exam be entered on Field 21 of the OMAP 501D, Dental Invoice.

(4) Upon approval of the request for payment, the OMAP 501D will be returned to the treating dentist who will bill using the OMAP 501D. A nine-digit prior authorization number will be entered in Field 15-a on the OMAP 501D.

(5) The Medical Assistance Program will issue a decision on requests for prior authorization of payment within 30 days of receipt of the request.

(6) Prior authorization is required for all inpatient or outpatient hospitalization except for life-threatening emergencies or traumatic injuries. Prior authorization requests must include clinical information justifying the need for hospitalization and the name of the facility.

(7) Prior authorization does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service by checking the client's Medical Card, or confirming eligibility through the ACES system, or contacting the local branch office.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770,409.010, 409.110, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 16-1978(Temp), f. 4-14-78, ef. 5-1-78; AFS 17-1978(Temp), f. & ef. 5-1-78; AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 24-1980, f. 4-22-80, ef. 5-1-80; AFS 48-1982, 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 89-1982, f. 9-30-82, ef. 10-1-82; AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-015; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-400; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0180

Procedures Never Considered Emergent

(1) Appliances (not related to immediate trauma/injury).

(2) Crowns (Types: Ceramco, gold, or other full cast, and porcelain fused to metal).

(3) Dentures, full or partial.

(4) Diagnostic Casts (study models).

(5) Exostosis (Tori) Removal.

(6) Flippers.

(7) Frenectomy, Frenulectomy.

(8) Gingivectomy, Gingivoplasty.

(9) Remake or Repair of Archwire, Space Maintainer.

(10) Space Maintainers.

(11) Stay Plates.

(12) Tissue Conditioning.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 14-1988, f. 2-24-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-031; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-410

410-123-0200

Services Considered Part of Total Treatment -- Not Separate Services

The following services do not warrant an additional fee and are considered to be either minimal services that are included in the examination, part of another service, or included in routine post-op or follow-up care:

(1) Cardiac Monitor.

(2) Curettage and Root Planing -- Per tooth.

(3) Dietary Counseling.

(4) Dressing Change.

(5) Electrosurgery.

(6) Equilibration.

(7) Gingival Curettage -- Per tooth.

(8) Gingivectomy/Gingivoplasty -- Per tooth.

(9) Local Anesthesia.

(10) Medicated Pulp Chambers.

(11) Odontoplasty.

(12) Denture Adjustments.

(13) Palliative Treatment.

(14) Periodontal Charting, Probing.

(15) Post Extraction Treatment for Alveolaritis.

(16) Suture Removal.

(17) Smooth Broken Tooth.

(18) Special Infection Control Procedures.

(19) Alveolectomy, in Conjunction with Extractions.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-056; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-420; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0220

Services not Covered

The following general categories of dental services are not covered. All codes listed in section (17) of this rule are not covered for any Medical Assistance Program recipients:

(1) Dental services for adults age 21 and older.

(2) Bridges -- Fixed prosthodontics.

(3 Desensitization.

(4) Disking.

(5) Dry socket treatment (if performed by the provider of the extraction).

(6) Equilibration.

(7) Full mouth x-rays.

(8) Mastique or veneer procedure.

(9) Medicated or sedative filling.

(10) Occlusal adjustments.

(11) Overhang removal.

(12) Polishing fillings.

(13) Procedures, appliances or restorations solely for aesthetic/cosmetic purposes.

(14) Remineralization.

(15) Temporary fillings.

(16) Tooth bleaching.

(17) Not covered procedures: May be obtained from the Department of Human Resources.

Stat. Auth.: ORS 184.750, 184.770, 409.010, 409.110, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-062; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-430; HR 23-1990(Temp), f. & cert. ef. 7-20-90; HR 38-1990, f. & cert. ef. 11-15-90; HR 27-1991 (Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0240

Instructions for Completing the Dental Claim Invoice

(1) The OMAP 501D, Dental Service Invoice, or the American Dental Association, (ADA) claim form are acceptable for billing for dental services.

(2) All prior authorization requests must be made on the OMAP 501D.

(3) Emergency and non-emergency dental services cannot be billed on the same invoice.

(4) OMAP will accept ADA claim forms how-ever, the ADA form must be adapted to the OMAP information requirements and format. The posi-tions of the fields must correspond to the OMAP 501D claim form for the data to be input correctly. The titles of the field will be different, provide the information according to the instructions regardless of the ADA field title. The following steps are a guide:

(a) Provide information in each field as requested on the OMAP 501D. For example, where the ADA requests "Employee/ Subscriber, Soc. Sec. Number", OMAP requires "Patient Medicaid I.D. No.";

(b) Create a "Quantity" column next to the "Surface" column and complete as appropriate;

(c) Check your ADA form for other differences.

(5) When requesting prior authorization for services, check the top box in the upper left-hand corner. When requesting payment after completing emergency treatment, check the bottom box in the upper left-hand corner. If neither applies, leave boxes blank. If appropriate, these boxes must be completed regardless of which form is used, the OMAP 501D or the ADA Form.

(6) How to fill out the Dental Claim Invoice:

(a) Enter client's first name, middle initial, and last name as it appears on the client's Medical Card;

(b) Enter client's date of birth in MM/DD/YY numeric format. Six digits are requested;

(c) Enter client's Medicaid ID Number as it appears on the client's Medical Card;

(d) Indicate if the client has other dental insurance. If no payment is made by this insurance carrier enter "0" and give an explanation why no payment was made;

(e) The prior authorization number must be shown on the claim if the dental services have been prior authorized. You must use an OMAP 501D;

(f) Enter OMAP six-digit provider number;

(g) Enter date of EPSDT exam if dental services being prior authorized are a result of an EPSDT exam visit;

(h)Check place of treatment. IH is inpatient hospital and OH is outpatient hospital;

(i)To be completed if applicable to the claim;

(j) Examination and treatment plan:

(A)Tooth Number or Letter:

(i)This field must be completed for each line, use one of the codes below;

(ii)A-T -- Deciduous teeth as shown on chart on claim form;

(iii)1-32 -- Permanent teeth as shown on chart on claim form;

(iv)33 -- To be used for all procedures that cannot be assigned a specific tooth number or letter. (e.g., prophylaxis and fluoride). To be used for entire mouth. (Computer will insert);

(v)34 -- Supernumerary tooth.

(B)Surface Code: The surface codes listed below must be used for any procedure related to a specific tooth:

(i) A -- Whole tooth used for all procedures that involve the entire tooth or entire mouth. (Computer will insert);

(ii)B&endash; Buccal;

(iii)M&endash; Mesial;

(iv)D &endash; Distal;

(v)O &endash; Occlusal;

(vi)L &endash; Lingual;

(vii)I&endash; Incisal;

(viii)F &endash; Facial.

(C)Quantity -- Enter the QTY of 1 in this field -- Unless you are billing for more than one service, and the description of the procedure code indicates only one service (i.e., 00230 intraoral periapical -- each additional film). Then, enter the number of services provided;

(D)Description of service -- Describe service performed;

(E)Date service performed -- Enter the date the service was performed in MM/DD/YY numeric format (e.g., 11/01/91). Six digits are required;

(F)ADA Code -- Enter the applicable ADA Procedure Code. Five digits are required;

(G)Fee -- Enter the fee for the service;

(H) Performing Provider Number (clinics only) -- If the dentist or dental specialist performing the service is a member of a clinic, group practice, teaching institution, or department of a teaching institution under whose OMAP provider number the claim is being billed, enter the OMAP provider number of the performing dentist or dental specialist for each line item billed. Otherwise leave blank.

(k) Enter your total fee;

(l) Enter insurance payment, client liability or "0";

(m) Enter net charges;

(n) Enter any required documentation or remarks that would be helpful in processing the claim.

Stat. Auth.: ORS 184.750, 1784.770, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-440; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0260

Exams

Payment for examinations is provided as follows:

(1) Initial and periodic exams are for Medicheck services only;

(2) Eighteen months through 20 years old may have an exam once every six months.

Code -- **Description**

00110 -- Initial oral examination

00120 -- Periodic oral examination

00130 -- Emergency oral examination

Stat.: Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-450; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0280

Radiographs

Payment for radiographs is provided as follows:

(1) The maximum number of x-rays payable for any one emergency is six;

(2) X-rays for routine screening are allowed every 12 months;

(3) Panoramic films are limited to one every three years and must be documented in your records with medical justification such as fractures, third molars, or trismus;

(4) Routine panoramic films are not covered;

(5) Payment for some or all multiple x-rays of the same tooth or area may be denied if OMAP determines the number to be excessive;

(6) X-rays are required with the claim when requesting prior authorization for the following procedures:

(a) Cast crown;

(b) Orthodontic requests;

(c) Periodontal treatment;

(d) Removable prosthodontics.

(7) X-rays should be:

(a) Originals or duplicates;

(b) Mounted or loose;

(c) In envelope, stapled to invoice;

(d) Clearly labeled with dentist's name and address and patient's name.

Code -- **Description**

00220 -- Intraoral-periapical - First film

00230 -- Intraoral-periapical - Each additional film

00240 -- Intraoral - occlusal film

00270 -- Bitewings - Single film

00272 -- Bitewings - Two film

00274 -- Bitewings - Four films

00290 -- Posterior-anterior or lateral skull and facial bone survey film

00330 -- Panoramic film

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-460; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0300

Preventive Services

Payment for preventive services is provided as follows.

(1) Prophylaxis:

(a) Recipient must be 18 months through 20 years of age;

(b) Prophylaxis is allowed once every six months.

Code -- **Description**

01120 -- Prophylaxis - Child

01201 -- Topical application of fluoride (including prophylaxis) - Child

(2) Sealants:

(a) Sealants are covered for permanent molars only for children 15 years or younger. One treatment/tooth/every five years;

(b) Payment for sealants is not allowed when an occlusal restoration has been done except on teeth #2, 3, 14, 15, 19, 30.

Code -- **Description**

01351 -- Sealant - Per tooth

(3) Space Management:

Code -- **Description**

01510 -- Space maintainer - Fixed - Unilateral

01515 -- Space maintainer - Fixed - Bilateral

01550 -- Recementation of space maintainer

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 101-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-470; HR 46-1991, f. & cert. ef. 10-16-91

410-123-0320

Restorations

Payment for restorations is provided as follows:

(1) Amalgam and Composite:

(a) Payment for restorations is limited to the maximum restoration fee of four surfaces per tooth;

(b) All surfaces must be combined and billed one line per tooth using the appropriate code;

(c) Payment for an amalgam or composite restoration and a crown on the same tooth will be denied;

(d) Payment for more than one restoration on the occlusal surface is not allowed except for teeth #2, 3, 14, 15;

(e) Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee;

(f) Composite or similar restorations in posterior teeth will be reimbursed at the amalgam rate. Use appropriate posterior resin codes 02380 through 02387.

Code -- **Description**

02110 -- Amalgam - One surface, primary

02120 -- Amalgam - Two surfaces, primary

02130 -- Amalgam - Three surfaces, primary

02131 -- Amalgam - Four or more surfaces, primary

02140 -- Amalgam - One surface, permanent

02150 -- Amalgam - Two surfaces, permanent

02160 -- Amalgam - Three surfaces, permanent

02161 -- Amalgam - Four or more surfaces, permanent

02330 -- Resin - One surface, anterior

02331 -- Resin - Two surfaces, anterior

02332 -- Resin - Three surfaces, anterior

02335 -- Resin - Four or more surfaces or involving incisal angle (anterior)

02336 -- Composite resin crown - Anterior- Primary

02380 -- Resin - One surface, posterior - Primary

02381 -- Resin - Two surfaces, posterior - Primary

02382 -- Resin - Three or more surfaces, posterior - Primary

02385 -- Resin - One surface, posterior - Permanent

02386 -- Resin - Two surfaces, posterior- Permanent

02387 -- Resin - Three or more surfaces, posterior - Permanent

(2) Crowns:

(a) Acrylic heat or light cured crowns are allowed for anterior permanent teeth only;

(b) Prefabricated plastic crowns are allowed for anterior teeth only, permanent or primary;

(c) Permanent crowns are allowed for anterior permanent teeth only. Recipients must be between 16 and 21 years of age. X-rays must be submitted;

(d) Payment for crowns for posterior teeth, permanent or primary is limited to stainless steel crowns;

(e) Payment for preparation of the gingival tissue is included in the fee for the crown;

(f) Retention pins are limited to two per tooth.

Code -- **Description**

02710 -- Crown - Resin (laboratory)

02740 -- Crown - Porcelain/ceramic substrate - This procedure requires prior authorization

02750 -- Crown - Porcelain fused to high noble metal - This procedure requires prior authorization

02751 -- Crown - Porcelain fused to predominantly base metal -- This procedure requires prior authorization

02752 -- Crown - Porcelain fused to noble metal- This procedure requires prior authorization

02910 -- Recement inlay

02920 -- Recement crown

02930 -- Prefabricated stainless steel crown - Primary tooth

02931 -- Prefabricated stainless steel crown - Permanent tooth

02932 -- Prefabricated resin crown

02950 -- Core buildup, including any pins

02951 -- Pin retention - Per tooth, in addition to restoration

02954 -- Prefabricated post and core in addition to crown

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-480; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0340

Endodontics

(1) Pulp Capping: Indirect pulp caps are included in the restoration fee -- No additional payment will be made:

Code -- **Description**

03110 -- Pulp cap - Direct (excluding final restoration)

(2) Pulpotomy:

Code -- **Description**

03220 -- Therapeutic pulpotomy (excluding final restoration)

(3) Root Canal Therapy:

(a) Payment for a direct pulp cap is not covered when root canal therapy is performed on a tooth;

(b) Separate reimbursement for open and drain or pulpotomy procedures is only allowed when the root canal is not completed;

(c) Root canal therapy is not covered for third molars;

(d) Root canal therapy is limited to permanent teeth, and only if the treatment will lead to a favorable prognosis;

(e) Teeth #4 and #13 are one canal root canals unless x-rays are submitted indicating otherwise;

(f) Apicoectomy is limited to anterior teeth only;

(g) Retrograde filling is limited to anterior teeth only;

(h) Apexification is limited to a maximum of five treatments on permanent anterior teeth and permanent first molars.

Code -- **Description**

03310 -- One canal (excluding final restoration)

03320 -- Two canals (excluding final restoration)

03330 -- Three canals (excluding final restoration)

03351 -- Apexification/recalcification - Initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

03352 -- Apexification/recalcification - Interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

03353 -- Apexification/recalcification -- Final visit (includes completed root canal therapy - Apical closure/calcific repair of perforations, root resorption, etc.)

03410 -- Apicoectomy/periradicular surgery - Anterior

03430 -- Retrograde filling - Per root

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-490; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0360

Periodontics

(1) Periodontal procedures are limited to four quadrants (full mouth) per year regardless of the number of visits required.

(2) Cavitron scaling/gross scaling does not qualify for a separate fee -- It is included in other periodontal procedures.

(3) Emergency periodontal scaling is allowed only for the treatment of acute pain and infection.

(4) Gingivectomy or gingivoplasty is covered for medically induced gingival hyperplasia, e.g., dilantin hyperplasia. X-rays are required.

(5) Records must document the clinical indications for periodontal scaling and root planing -- i.e., x-rays and/or periodontal charting.

Code -- **Description**

04210 -- Gingivectomy or gingivoplasty Per quadrant - This procedure requires prior authorization

04260 -- Osseous surgery (including flap entry and closure) -- Per quadrant -- This procedure requires prior authorization

04341 -- Periodontal scaling and root planing -- Per quadrant -- This procedure requires prior authorization

04345 -- Periodontal scaling performed in the presence of gingival inflammation (full mouth)

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-500; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0380

Removable Prosthodontics

(1) Removable prosthodontics are limited to the replacement of permanent teeth. X-rays are required.

(2) Removable prosthodontics are limited to recipients between 16 and 21 years of age.

(3) Adjustments to dentures during the six month period following delivery to recipients are included in the fee for dentures.

(4) Reline of complete or partial dentures is allowed once per year.

(5) Adjustments after six month are included in the examination.

Code -- **Description**

05110 -- Complete upper - This procedure requires prior authorization

05120 -- Complete lower - This procedure requires prior authorization

05211 -- Upper partial - Resin base (including any conventional clasps, rests and teeth) - This procedure requires prior authorization

05212 -- Lower partial - Resin base (including any conventional clasps, rests and teeth) - This procedure requires prior authorization

05213 -- Upper partial - Cast metal base with resin saddles (including any conventional clasps, rests and teeth) - This procedure requires prior authorization

05214 -- Lower partial - Cast metal base with resin saddles (including any conventional clasps, rests and teeth) - This procedure requires prior authorization

05510 -- Repair broken complete denture base

05520 -- Replace missing or broken teeth - Complete denture (each tooth)

05610 -- Repair resin saddle or base

05630 -- Repair or replace broken clasp

05640 -- Replace broken teeth - Per tooth- Partial denture

05750 -- Reline complete upper denture (laboratory)

05751 -- Reline complete lower denture (laboratory)

05760 -- Reline upper partial denture (laboratory)

05761 -- Reline lower partial denture (laboratory)

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-510; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0400

Maxillofacial Prosthetics -- For Services Provided on or After October 1, 1991

Intraoral prostheses -- Congenital defects:

Code -- **Description**

05952 -- Speech aid - Prosthesis pediatric - This procedure requires prior authorization

05955 -- Palatal lift prosthesis - Definitive - This procedure requires prior authorization

05959 -- Palatal lift prosthesis, modification - By report - This procedure requires prior authorization

05960 -- Speech and prosthesis, modification - By report - This procedure requires prior authorization

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-520; HR 46-1991, f. & cert. ef. 10-16-91

410-123-0420

Fixed Prosthodontics

Fixed prosthodontics are not covered:

Code -- **Description**

06930 -- Recement bridge

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-530; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-0440

Oral Surgery

(1) Procedures include local anesthesia, suturing, postoperative care and follow-up visits. X-rays may be requested.

(2) All codes listed as "By Report" (BR) require an operative report.

(3) Code 07241 requires a description of unusual circumstances in the "Remarks" field.

(4) Payment for tooth replantation is covered only in cases of traumatic avulsion where there are good indications of success.

(5) Surgical Assistance:

(a) Reimbursement for surgical assistance is restricted to services by dentists and physicians;

(b) Surgical assistance will be reimbursed only when the assistant's services qualify as a dental or medical necessity;

(c) Only one surgical assistant will be reimbursed unless clinical justification is submitted for an additional assistant;

(d) Primary surgeons, assistant surgeons, anesthesiologists and nurse anesthetists not in common practice must bill separately for their services.

(6) Extractions -- Includes local anesthesia and routine postoperative care:

Code -- **Description**

07110 -- Single tooth

07120 -- Each additional tooth

(7) Surgical extractions -- Includes local anesthesia and routine postoperative care:

Code -- **Description**

07210 -- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

07220 -- Removal of impacted tooth - Soft tissue

07230 -- Removal of impacted tooth - Partially bony

07240 -- Removal of impacted tooth - Completely bony

07241 -- Removal of impacted tooth - Completely bony, with unusual surgical complications - By report

07250 -- Surgical removal of residual tooth roots (cutting procedure)

(8) Other surgical procedures:

Code -- **Description**

07260 -- Oral antral fistula closure

07270 -- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus

07280 -- Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments) - This procedure requires prior authorization

(9) Alveoloplasty -- Surgical preparation of ridge for dentures:

Code -- Description

07320 -- Alveoloplasty not in conjunction with extractions - Per quadrant - This procedure requires prior authorization

(10) Other repair procedures:

Code -- Description

07960 -- Frenulectomy (frenectomy or frenotomy) - Separate procedure

07970 -- Excision of hyperplastic tissue - Per arch -This procedure requires prior authorization

07971 -- Excision of pericoronal gingiva

(11) Surgical incision:

Code -- Description

07510 -- Incision and drainage of abscess - Intraoral soft tissue

(12) The following dental-related procedures are covered for payment by the Physician's Medical program when performed by a physician or dentist and billed on a HCFA-1500. Rules and billing instructions for this program are found in the OMAP **Medical-Surgical Services Provider Guide**.

05931 07520 07770 07877
05932 07530 07780 07910
05933 07540 07810 07911
07285 07550 07820 07912
07286 07560 07830 07941
07410 07610 07840 07942
07420 07620 07850 07943
07430 07630 07852 07944
07431 07640 07854 07945
07440 07650 07856 07946
07441 07660 07858 07947
07450 07670 07860 07948
07451 07680 07865 07949
07460 07710 07870 07950
07461 07720 07872 07955
07465 07730 07873 07980
07470 07740 07874 07981
07480 07750 07875 07983

07490 07760 07876 07990

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-540; HR 39-1990(Temp), f. & cert. ef. 11-15-90; HR 1-1991, f. & cert. ef. 1-4-91; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0460

Orthodontia

(1) Orthodontia services are limited to EPSDT (Medicheck) eligible recipients.

(2) Prior authorization is required and must be requested from the OMAP Dental Program Coordinator.

(3) All requests for prior authorization of payment must include the diagnosis and length and type of treatment. Study models, cephalometric and panoramic radiographs and photographs (when available) must be submitted for full orthodontic treatment.

(4) Payment for appliance therapy includes the appliance and all follow-up visits.

(5) Orthodontic treatment will be approved only where there is evidence of a favorable prognosis and a high probability of compliance in completing the treatment program.

(6) Payment for orthodontia will be made in one lump sum at the beginning of treatment. If the patient transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to OMAP any unused amount of payment, after applying the following formula:

(a) Total payment minus $300 (for banding) multiplied by the percentage of treatment remaining. For example, the dentist was paid $1,800 for a 24-month treatment plan and 18 months of treatment were completed. The dentist would have to refund $375 or ($1,800 - $300) x 6/24;

(b) The length of the treatment plan from the original request for authorization will be used to determine the number of treatment months remaining;

(c) As long as the orthodontist continues treatment no refund will be required even though the patient may become ineligible for medical assistance sometime during the treatment period. If an orthodontia case is not approved for payment, OMAP will pay the orthodontist for the required records, plus an examination fee. If the case is approved for payment, the examination fee and the records report fee will be paid in addition to the treatment.

(7) The Orthodontia Scorecard is adopted to help providers determine whether to submit the case to OMAP. This scorecard will be used as the minimum requirement to be considered for orthodontia services. It will be forwarded to the OMAP Orthodontic Consultant along with the following required information: Diagnosis, length and type of treatment, study models, cephalometric and panoramic radiographs and photographs, when available.

Code -- Description

08100 **--** Orthodontia records - This procedure requires prior authorization

08200 **--** Orthodontic examination -- This procedure requires prior authorization

(8) Minor treatment for tooth guidance:

Code -- Description

08110 **--** Removable appliance therapy - This procedure requires prior authorization

08120 **--** Fixed appliance therapy - This procedure requires prior authorization

(9) Minor treatment to control harmful habits:

Code -- Description

08210 **--** Removable appliance therapy - This procedure requires prior authorization

08220 **--** Fixed appliance therapy - This procedure requires prior authorization

(10) Interceptive orthodontic treatment:

Code -- Description

08360 **--** Removable appliance therapy - This procedure requires prior authorization

08370 **--** Fixed appliance therapy - This procedure requires prior authorization

(11) Comprehensive orthodontic treatment -- Permanent dentition:

Code -- Description

08560 **--** Class I malocclusion -- This procedure requires prior authorization

08570 **--** Class II malocclusion -- This procedure requires prior authorization

08580 **--** Class III malocclusion -- This procedure requires prior authorization

(12) How to Use the Orthodontia Scorecard. The scored index must be submitted to the OMAP Dental Program Coordinator with records and models for each case. The following information should help to clarify the categories on the index. The Angle class diagnosis must be completed:

(a) Cleft Palate. Submit a cleft palate in the mixed dentition only if you can justify in a report why the youngster should be treated before he is in the full dentition. Will there be intermittent treatment?

(b) Severe Traumatic Deviations. This refers to facial accidents rather than congenital deformity, and it is seen infrequently. It does not include traumatic occlusions or cross-bites;

(c) Overjet in Millimeters. Score exactly as measured. Since 2 mm overjet is considered normal, this amount will be subtracted from the score;

(d) Overbite in Millimeters. Score exactly as measured. Since coverage of the incisal third of lower anterior is considered normal overbite, 3 mm will be subtracted from the score;

(e) Mandibular Protrusion in Millimeters. Score exactly as measured;

(f) Open Bite in Millimeters. Score exactly as measured. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse;

(g) Ectopic Eruption. This refers to an unusual pattern of eruption, such as high labial cuspids. Do not include teeth in this category if they are to be scored in the next category (No. 8 Crowding);

(h) Anterior Crowding. This refers to anteriors that are so badly crowded that extractions are a prerequisite to treatment. Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to striping or mild expansion procedures are not to be scored as "crowded";

(i) Labio-Lingual Spread. The score for this category should be the total, in millimeters, of the anterior spaces.

(13) Please be conservative in scoring. Liberal scoring will not be helpful in the evaluation and acceptance of the case. The case must be considered dysfunctional and have a minimum of 15 points on the index to be considered.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: AFS 16-1978(Temp), f. 4-14-78, ef. 5-1-78; AFS 17-1978(Temp), f. & ef. 5-1-78; AFS 27-1979, f. 8-20-79, ef. 9-1-79; AFS 48-1982, ef. 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 for North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 2-1988, f. 1-13-88, cert. ef. 4-1-88; AFS 61-1989, f. 19-29-89, cert. ef. 10-1-89; Renumbered from 461-26-020; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-550; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0480

Anesthesia

(1) General anesthesia is paid for the first 30 minutes (09220) and each additional 15 minutes (09221) up to three hours on the same day of service.

(2) Nitrous oxide is paid per date of service, not by time.

(3) Sedation is paid per date of service.

(4) Oral pre-medication:

(a) Limited to four times per year;

(b) Monitoring and nitrous oxide included in the fee;

(c) Use of multiple agents is required to receive payment;

(d) Must document the medical necessity in record.

(5) Providers are required to submit a copy of their permit to administer anesthesia, analgesia and/or sedation to OMAP, upon request.

Code -- Description

09212 **--** Trigeminal division block anesthesia

09220 **--** General anesthesia -- First 30 minutes

09221 **--** General anesthesia -- Each additional 15 minutes

09230 -- Analgesia

09240 -- Intravenous sedation

09260 -- Oral pre-medication, conscious monitored sedation using multiple agents

Stat. Auth.: ORS 184.750, 184.770, 409.010, 409.110, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 10-1985, f. 2-28-85, ef. 3-1-85; AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; Renumbered from 461-26-063; HR 4-1990(Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-560; HR 39-1990 (Temp), f. & cert. ef. 11-15-90; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0500

Adjunctive General Services

Code -- Description

09310 -- Consultation (diagnostic service provided by dentist - Or physician other than practitioner providing treatment)

09420 -- Hospital call

09440 -- Office visit - After regularly scheduled hours

09610 -- Therapeutic drug injection (indicate drug and dosage) - By report

09930 -- Treatment of complications (post-surgical) - Unusual circumstances - By report

09999 -- Unspecified adjunctive procedure - By report

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-570; HR 1-1991,

f. & cert. ef. 1-4-91; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38, 1991, f. 9-16-91, cert. ef. 10-1-91; HR 10-1993, f. & cert. ef. 4-1-93

410-123-0520

Schedule for Denturist

(1) Removable prosthodontics are limited to the replacement of permanent teeth.

(2) Removable prosthodontics are limited to recipients between 16 and 21 years of age.

(3) Adjustments to dentures during the six- month period following delivery to the recipient are included in the fee for dentures.

(4) Reline of complete dentures is allowed once per year.

Code -- Description

05110 **--** Complete upper - This procedure requires prior authorization

05120 **--** Complete lower - This procedure requires prior authorization

05510 **--** Repair broken complete denture base

05520 **--** Replace missing or broken teeth - Complete denture (each tooth)

05750 **--** Reline complete upper denture (laboratory)

05751 **--** Reline complete lower denture (laboratory)

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: AFS 61-1989, f. 9-29-89, cert. ef. 10-1-89; HR 4-1990 (Temp), f. 3-29-90, cert. ef. 4-1-90; HR 14-1990, f. & cert. ef. 5-16-90; Renumbered from 461-26-580; HR 27-1991(Temp), f. & cert. ef. 7-1-91; HR 38-1991, f. 9-16-91, cert. ef. 10-1-91

410-123-1000

Eligibility Information

(1) Eligibility:

(a) If you plan to bill OMAP for your services, be sure to verify eligibility before providing service. It is the responsibility of the dentist to verify the client's eligibility. OMAP will not pay for services provided to an ineligible client even though services have been authorized. Always check the client's Medical Care Identification or call the Automated Information System (AIS) to verify eligibility;

(b) The Medical Care Identification guarantees eligibility only for the time period listed on the card. Instructions for reading a Medical Care Identification are found in the General Rules;

(c) Clients in this program will have the following message printed on their Medical Care Identifications: "Basic Health Care Package";

(d) Many clients in the Oregon Health Plan will be enrolled with a prepaid health plan (Fully Capitated Health Plan, Physician Care Organization, Dental Care Organization) or restricted to a Primary Care Case Manager (PCCM). Some Fully Capitated Health Plans and all Dental Care Organizations are prepaid to cover dental services. If the client is enrolled with a DCO or an FCHP that covers dental, an authorization or referral from the plan is required before dental services are provided, except for emergency dental services. If a client is enrolled with an FCHP or PCO or restricted to a PCCM, an authorization or referral from the plan or PCCM is required before providing medical services, except in emergent situations.

(2) Billing of Prior Resources: If other health insurance is named on the Medical Care Identification, it means that the client has financial resources that must be billed prior to billing OMAP. This is found in the Managed Care and TPR Information (Third Party Resources) section of the client's Medical Care Identification.

(3) Fabricated Prosthetics: If a dentist provides a fabricated prosthetics to an eligible client that requires the use of a dental laboratory and the fabrication is expected to extend beyond the period of eligibility listed on the client's Medical Care Identification, the dentist should use the date of impression as the date of service.

Stat. Auth.: ORS Ch. 409

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

410-123-1020

Adjustment Requests

(1) Overpayments, underpayments and payments received after OMAP has paid a claim can be resolved through the adjustment process. Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation and the Remittance Advice may be submitted to support your request. Adjustment requests must be submitted in writing to Office of Medical Assistance Programs (OMAP).

(2) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) This is a reminder to attach needed documentation;

(c) Mail your Adjustment Request to this address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**);

(e) Enter the client's identification number in this space. This number can be found on the RA in Field 6, or on the Medical Care Identification;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Care Identification;

(g) Enter your six-digit provider number in is space;

(h) This space is for your provider name;

(i) Enter the date printed at the top of the RA;

(j) Description: This column contains possible areas that may need to be corrected. Only check the box that needs to change:

(A) Place of Service -- Use the following place of service indicators:

(i) 1 = Inpatient hospital;

(ii) 2 = Outpatient hospital;

(iii) 3 = Office;

(iv) 4 - Other.

(B) Type of Service -- Indicate "S" for non-emergency and "X" for emergency dental treatment;

(C) Quantity/Unit -- Check if the original quantity was incorrect; NDC/Procedure -- Check if the original procedure code was incorrect;

(D) Revenue Center Code (Hospital Only) -- Do not check this box. This is for hospital billing only;

(E) Insurance Payment/Patient Liability -- The payments from other sources (Field 35 on the OMAP 501D or Field 13 on the RA) or any payments received after submitting claim to OMAP;

(F) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(G) Billed Amount -- Check if the original billed amount was incorrect;

(H) Other -- Use this box if none of the above address your problems.

(k) Line # -- List the line number from the original claim (OMAP 501D or ADA Form) which is being adjusted;

(l) Service Date -- Enter the date the service was performed;

(m) Wrong Information -- Enter the incorrect information submitted on the original claim here;

(n) Right Information -- Enter the corrected information in this column;

(o) Remarks -- This is the area to give additional information or explain the request;

(p) Provider's Signature -- The signature of the provider or other authorized personnel must be in this space;

(q) Date -- Enter the date this form was completed.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94

410-123-1040

Purpose

The purpose of this Guide is to establish the rules of payment for dental services provided to clients determined eligible for medical assistance under the Oregon Health Plan Medicaid Demonstration Project. The General Rules for the Oregon Medical Assistance Program and the rules in this Guide are to be used together to determine eligibility for services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94

410-123-1060

Definition of Terms

(1) "Dental Services Documentation" must meet the requirements of the Oregon Dental Practice Act statutes; administrative rules for patient records and requirements of OAR 410-120-1360, "Requirements for Financial, Clinical and Other Records".

(2) "Emergency Dental Services" are covered services requiring immediate treatment. This includes services to control hemorrhage, maintain an adequate airway, and prevent life-threatening situations. The emergency rule applies only to covered services. OMAP recognizes that some non-covered services may meet the criteria of emergency, but this rule does not extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care.

(3) "Preventive Services" include:

(a) Oral Prophylaxis (cleaning of teeth);

(b) Topical Fluoride;

(c) Sealants.

(4) "Therapeutic Services" include:

(a) Pulp therapy for permanent and primary teeth;

(b) Restorations for primary and permanent teeth using amalgam, composite materials and stainless steel or polycarbonate crowns;

(c) Scaling and curettage;

(d) Space maintainers for primary posterior teeth lost prematurely;

(e) Removable prosthesis when masticatory function is impaired.

(5) "Covered Services" are services on the Health Services Commission List that have been funded by the Legislature for clients receiving the Basic Health Care Package and those ancillary services necessary to perform the covered services.

(6) "General Anesthesia" is a controlled state of unconsciousness including the inability to independently maintain an airway or to respond purposefully to physical stimulation or verbal command. The use of the following drugs either alone or in combination with other drugs, is conclusively presumed to produce general anesthesia:

(a) Ultra short acting barbiturates including but not limited to sodium methohexital, thiopental, thiamylal;

(b) Other general anesthetics including but not limited to ketamine or etomidate; or

(c) Rapidly acting steroids including but not limited to althesin.

(7) "Nitrous Oxide" is an analgesic agent administered to induce loss of sensibility to pain without necessarily incurring loss of consciousness.

(8) "Oral Premedication" anesthesia for conscious sedation means a depressed level of consciousness that retains the ability to maintain, independently and continuously, an airway, and respond purposely to physical stimulation or oral command.

(9) "Direct Pulp Cap" is the direct application of calcium hydroxide or ZOE directly over an exposed pulp.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94

410-123-1100

Services Reviewed by the Office of Medical Assistance Programs (OMAP)

The Office of Medical Assistance Programs will not prior authorize treatment when the prognosis is unfavorable, the treatment impractical, or a lesser-cost procedure would achieve the same ultimate results. Rampant caries should be arrested and a period of adequate oral hygiene, as defined by the provider, demonstrated, before dental prosthesis are proposed.

(1) Consultants:

(a) The Office of Medical Assistance Programs, in consultation with the Oregon Dental Association, contracts with a General Practice consultant, an Oral Surgery consultant and an Orthodontia consultant for professional review of certain services or billings before payment will be authorized by OMAP. If, in the opinion of the consultant, the clinical information furnished does not support the treatment or services provided, payment will be denied;

(b) The Oregon Dental Association may be requested to provide peer review on specific issues through the regularly established peer review system of the Association.

(2) BR - By Report: Request for payment for dental services listed as "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 an OMAP dental consultant.

(3) Treatment Justification: In the process of utilization review/or prior authorization and/or in determining its responsibility for payment of dental services, OMAP may request the treating dentist to submit appropriate radiographs or other clinical information which justifies the treatment.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1160

Prior Authorization of Payment

(1) The Procedure Code Section of this Guide designates those codes which require prior authorization.

(2) Prior authorization is required for all inpatient or outpatient hospitalization except for life-threatening emergencies. Prior authorization requests must include clinical information justifying the need for hospitalization and the name of the facility.

(3) Prior authorization does *not* guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service by:

(a) Checking the client's Medical Care Identification; or

(b) Confirming eligibility through the AIS system; or

(c) Contacting the local branch office.

(4) When radiographs are required they must be:

(a) Readable copies;

(b) Mounted or loose;

(c) In an envelope, stapled to the prior authorization form;

(d) Clearly labeled with dentist's name and address and patient's name.

(5) Requests for prior authorization of payment must be obtained through the Dental Program Coordinator on either Form OMAP 501D, (Dental Services Invoice) or an approved ADA form, listing the specific services requested. Send requests to Dental-OMAP.

(6) Upon approval of the request for payment a nine-digit prior authorization number will be entered on the requesting form and the form will be returned to the treating provider.

(7) The Medical Assistance Program will issue a decision on requests for prior authorization of payment within 30 days of receipt of the request.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1200

Services Considered Part of Total Treatment -- Not Separate Services

The following services do not warrant an additional fee and are considered to be either minimal services that are included in the examination, part of another service, or included in routine post-op or follow-up care:

(1) Alveolectomy/Alveoloplasty in Conjunction with Extractions.

(2) Cardiac and Other Monitoring.

(3) Curettage and Root Planing - Per Tooth.

(4) Diagnostic Casts.

(5) Dietary Counseling.

(6) Discing.

(7) Dressing Change.

(8) Electrosurgery.

(9) Equilibration.

(10) Gingival Curettage -- Per Tooth.

(11) Gingivectomy/Gingivoplasty -- Per Tooth.

(12) Local Anesthesia.

(13) Medicated Pulp Chambers.

(14) Occlusal Adjustments.

(15) Occlusal Analysis.

(16) Odontoplasty.

(17) Oral Hygiene Instruction.

(18) Peridontal Charting, Probing.

(19) Polishing Fillings.

(20) Post Extraction Treatment for Alveolaritis (dry socket treatment) (if done by the provider of the extraction).

(21) Pulp Vitality Tests.

(22) Smooth Broken Tooth.

(23) Special Infection Control Procedures.

(24) Surgical Procedure for Isolation of Tooth with Rubber Dam.

(25) Surgical Stent.

(26) Surgical Splint.

(27) Suture Removal.

(28) Indirect pulp cap.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1220

Services Not Covered

(1) The following general categories of Dental Services are not covered. All codes listed in section 2 of this rule are not covered for any client receiving the Basic Health Care Package:

(a) Apicoectomy/Periradicular services;

(b) Desensitization;

(c) Implant and implant services;

(d) Mastique or veneer procedure;

(e) Orthodontia (except when it is treatment for cleft palate/ cleft lip);

(f) Overhang Removal;

(g) Procedures, appliances or restorations solely for aesthetic/ cosmetic purposes;

(h) Remineralization;

(i) Temporomandibular Joint Dysfunction treatment;

(j) Tooth Bleaching.

Stat. Auth.: ORS Chapter 409

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

410-123-1240

Instructions for Completing the Dental Claim Invoice

(1) The OMAP 501D, Dental Service Invoice, or the American Dental Association (ADA) claim form are acceptable for billing for dental services.

(2) All prior authorization requests *must* be made on the OMAP 501D.

(3) OMAP will accept ADA claim forms; however, the ADA Form must be adapted to the OMAP information requirements and format. The positions of the field *must* correspond to the OMAP 501D claim form for the data to be input correctly. The titles of the field will be different; provide the information according to the instructions regardless of the ADA field title.

(4) Use the following steps:

(a) Provide information in each field as requested on the OMAP 501D. *Check your ADA Form for other differences*;

(b) Create a "Quantity" column next to the "Surface" column and complete as appropriate.

(5) When requesting prior authorization for services, check the top box in the upper left-hand corner.

(6) If appropriate, these boxes must be completed regardless of which form is used, the OMAP 501D or the ADA Form.

(7) How to Fill Out the Dental Claim Invoice:

(a) Field 1: Enter client's first name, middle initial, and last name as it appears on the client's Medical Care Identification;

(b) Field 4: Enter client's date of birth in MM/DD/YY numeric format (e.g., 10/12/68). Six digits are required. (Required when applicable;

(c) FIeld 7: Enter client's Medicaid ID Number as it appears on the client's Medical Care Identification;

(d) Field 11: If client has other dental insur-ance, answer "yes" and complete Fields 12-a, 12-b, 14-a and 14-b. If no payment is made by this insurance carrier enter "0" in Field 35 and give an explanation why no payment was made in

Field 37. (Required when applicable);

(e) Field 15-a: The prior authorization number must be shown here if the dental services on the invoice have been prior authorized. An OMAP 501D must be used. (Required when applicable);

(f) Field 19: Enter OMAP six-digit provider number;

(g) Field 21: Enter date of Medicheck exam if dental services being prior authorized are a result of a Medicheck exam visit. (Required when applicable);

(h) Field 22: Check place of treatment. IH is inpatient hospital and OH is outpatient hospital;

(i) Fields 23 - 30: To be completed if applicable to the claim;

(j) Field 31: Examination and treatment plan:

(A) Tooth Number or Letter: This field must be completed for each line, use one of the codes below:

(i) A-T deciduous teeth as shown on chart on claim form;

(ii) 1-32 permanent teeth as shown on chart on claim form;

(iii) 33 to be used for all procedures that cannot be assigned a specific tooth number or letter (e.g., prophylaxis and fluoride). To be used for entire mouth (computer will insert);

(iv) 34 supernumerary tooth.

(B) Surface Code: The surface codes listed below must be used for any procedure related to a specific tooth:

(i) A -- Whole tooth -- Used for all procedures that involve the entire tooth or entire mouth (computer will insert);

(ii) B -- Buccal;

(iii) M -- Mesial;

(iv) D -- Distal;

(v) O -- Occlusal;

(vi) L -- Lingual;

(vii) I -- Incisal;

(viii) F -- Facial.

(C) Quantity -- Enter the QTY of 1 in this field -- Unless billing for more than one service, and the description of the procedure code indicates only one service (i.e., 00230 intraoral periapical -- each additional film). Then, enter the number of services provided;

(D) Description of Service -- Describe service performed;

(E) Date Service Performed -- Enter the date the service was performed in MM/DD/YY numeric format. Six digits are required;

(F) ADA Code -- Enter the applicable ADA Procedure Code from the list found in this guide. *Five digits are required*;

(G) Fee -- Enter your fee for the service;

(H) Performing Provider Number (clinics only) -- If the dentist or dental specialist performing the service is a member of a clinic, group practice, teaching institution, or department of a teaching institution under whose OMAP provider number the claim is being billed, enter the OMAP provider number of the performing dentist or dental specialist for each line item billed. Otherwise leave blank.

(k) Field 34: Enter total fee;

(l) Field 35: Enter insurance payment, client liability or "0". (Required when applicable);

(m) Field 36: Enter net charges;

(n) Field 37: Enter any required documentation or remarks that would be helpful in processing the claim.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94

410-123-1260

Exams

(1) Exams (billed as 00110, 00120, 00150 or 00160) by the same practitioner are payable once every six months. OMAP may pay for more frequent exams or evaluations if by a specialist or by a different dentist.

(2) Emergency exams (00130 and 00140) based on documented need are payable per emergent episode. Do not bill for an emergency exam for each visit during the treatment.

(3) Code And Description:

(a) 00110, Initial oral examination;

(b) 00120, Periodic oral evaluation;

(c) 00130, Emergency oral examination;

(d) 00140, Limited oral evaluation - problem focused;

(e) 00150, Comprehensive oral evaluation;

(f) 00160, Detailed and extensive oral evaluation - problem focused, by report.

Stat. Auth.: ORS Ch. 409

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

410-123-1280

Radiographs

(1) The maximum number of radiographs payable for any one emergency is six.

(2) Intraoral-complete series (00210) are payable once every three years.

(3) The minimum standards for payment of Intraoral complete services are:

(a) The minimum age for billing code 00210 is six years. For clients under six years of age radiographs may be billed separately as follows:

(A) Procedure code 00220 may be billed once;

(B) Procedure code 00230 may be billed a maximum of five times;

(C) Procedure code 00270 may be billed a maximum of two times, or procedure code 00272 may be billed once.

(b) For eligible recipients, six through 11 years of age, a minimum of ten periapicals and two bitewings for a total of 12 films;

(c) For eligible recipients, 12 years of age and older, a minimum of ten periapicals and four bitewings for a total of 14 films.

(4) Bitewing x-rays for routine screening are payable every 12 months.

(5) Payment for routine panoramic films is limited to one every three years. Additional films are covered when medically justified, e.g., fractures.

(6) Payment for some or all multiple radiographs of the same tooth or area may be denied if OMAP determines the number to be excessive.

(7) If the number and type of radiographs taken is equal to or greater than an intraoral complete series, bill the 00210 codes.

(8) Code and Description:

(a) 00210 -- Intraoral -- Complete series (including bitewings);

(b) 00220 -- Intraoral-periapical -- First film;

(c) 00230 -- Intraoral-periapical -- Each additional film;

(d) 00240 -- Intraoral-occlusal film;

(e) 00250 -- Extraoral -- First film;

(f) 00260 -- Extraoral -- Each additional film;

(g) 00270 -- Bitewings -- Single film;

(h) 00272 -- Bitewings -- Two films;

(i) 00274 -- Bitewings -- Four films;

(j) 00290 -- Posterior-anterior or lateral skull and facial bone survey film;

(k) 00310 -- Sialography;

(l) 00320 -- Temporomandibular joint arthrogram, including injection;

(m) 00321 -- Other temporomandibular joint films, by report;

(n) 00322 -- Tomographic survey;

(o) 00330 -- Panoramic film;

(p) 00340 -- Cephalometric film (when done for orthodontia, payment is included in the records report fee).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1290

Tests and Laboratory Examinations

Code and Description:

(1) 00415 -- Bacteriologic studies for determination of pathologic agents.

(2) 00501 -- Histopathologic examinations.

(3) 00502 -- Other oral pathology procedures, by report.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1300

Preventive Services

(1) Prophylaxis:

(a) Allowed once every six months;

(b) Code and Description:

(A) 01110 -- Prophylaxis -- Adult, age 14 and older;

(B) 01120 -- Prophylaxis -- Child.

(2) Topical Fluoride Treatment (Office Procedure):

(a) Payable once every six months for recipients through 18 years of age;

(b) Not covered for recipients over 18 years of age;

(c) Code and Description:

(A) 01201 -- Topical application of fluoride (including prophylaxis) -- Child;

(B) 01203 -- Topical application of fluoride (excluding prophylaxis) -- Child.

(3) Sealants:

(a) Sealants are covered for *permanent molars* only for children 15 years or younger. One treatment/tooth/every five years;

(b) Code and Description: 01351 -- Sealant -- Per tooth.

(4) Space Management:

(a) Removable space maintainers *will not* be replaced if lost or damaged;

(b) Code and Description:

(A) 10510 -- Space maintainer -- Fixed -- Unilateral;

(B) 01515 -- Space maintainer -- Fixed -- Bilateral;

(C) 01520 -- Space maintainer -- Removable -- Unilateral;

(D) 01525 -- Space maintainer -- Removable -- Bilateral;

(E) 01550 -- Recementation of space maintainer.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1320

Restorations -- Effective for Services Provided on or After February 1, 1994

(1) Amalgam and Composite:

(a) Payment for restorations is limited to the maximum restoration fee of four surfaces per tooth;

(b) All surfaces must be combined and billed one line per tooth using the appropriate code;

(c) Payment for an amalgam or composite restoration and a crown on the same tooth will be denied;

(d) Payment is provided for a surface once in each episode of treatment regardless of the number or combination of restorations;

(e) Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee;

(f) Descriptions for restorations vary from ADA CDT interpretation;

(g) Composite or similar restorations in posterior teeth will be reimbursed at the amalgam rate. Use appropriate posterior resin codes 02380 through 02387.

(2) Code and Description:

(a) 02110 -- Amalgam -- One surface -- Primary;

(b) 02120 -- Amalgam -- Two surfaces -- Primary;

(c) 02130 -- Amalgam -- Three surfaces -- Primary;

(d) 02131 -- Amalgam -- Four or more surfaces -- Primary;

(e) 02140 -- Amalgam -- One surface -- Permanent;

(f) 02150 -- Amalgam -- Two surfaces -- Permanent;

(g) 02160 -- Amalgam -- Three surfaces -- Permanent;

(h) 02161 -- Amalgam -- Four or more surfaces -- Permanent;

(i) 02330 -- Resin -- One surface -- Anterior;

(j) 02331 -- Resin -- Two surfaces -- Anterior;

(k) 02332 -- Resin -- Three surfaces -- Anterior;

(l) 02335 -- Resin -- Four or more surfaces or involving incisal angle -- Anterior;

(m) 02336 -- Composite resin crown -- Anterior -- Primary;

(n) 02380 -- Resin -- One surface, posterior -- Primary;

(o) 02381 -- Resin -- Two surfaces, posterior -- Primary;

(p) 02382 -- Resin -- Three or more surfaces, posterior -- Primary;

(q) 02385 -- Resin -- One surface, posterior --Permanent;

(r) 02385 -- Resin -- Two surfaces, posterior -- Permanent;

(s) 02387 -- Resin -- Three or more surfaces, posterior -- Permanent.

Stat. Auth.: ORS Ch. 409

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

410-123-1330

Crowns

(1) Acrylic heat or light cured crowns are allowed for anterior permanent teeth only.

(2) Prefabricated plastic crowns are allowed for anterior teeth only, permanent or primary.

(3) Permanent crowns are allowed for anterior permanent teeth only. Recipients must be 16 years of age or older. Radiographs required; history, diagnosis and treatment plan may be requested.

(4) Payment for crowns for posterior teeth, permanent or primary is limited to stainless steel crowns.

(5) Payment for preparation of the gingival tissue is included in the fee for the crown.

(6) Payment for retention pins is limited to four per tooth.

(7) There is a five year limit on replacement for crowns. At OMAP's discretion, exceptions to this limitation may be made for crown damage due to trauma, based on the following factors:

(a) extent of crown damage;

(b) extent of damage to other teeth or crowns;

(c) extent of impaired mastication;

(8) Crowns are approved only when there is significant loss of clinical crown and no other restoration will restore function. Endodontic therapy alone (with or without a post) is not a consideration, nor are aesthetics.

(9) Multiple crowns in the anterior will be considered only if the arch can be restored without major reconstruction, which is not covered.

(10) Prior authorization for crowns will be denied in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.

(11) Code and Description:

(a) 02710, Crown-resin (laboratory);

(b) 02721, Crown-resin with predominantly base metal - Prior Authorization Required, submit radiographs;

(c) 02722, Crown-resin with noble metal - Prior Authorization Required, submit radiographs;

(d) 02740, Crown-porcelain/ceramic substrate - Prior Authorization Required, submit radiographs;

(e) 02751, Crown-porcelain fused to predominantly base metal - Prior Authorization Required, submit radiographs;

(f) 02752, Crown-porcelain fused to noble metal - Prior Authorization Required, submit radiographs;

(g) 02910, Recement inlay ;

(h) 02920, Recement crown;

(i) 02930, Prefabricated stainless steel crown - primary tooth;

(j) 02931, Prefabricated stainless steel crown - permanent tooth;

(k) 02932, Prefabricated resin crown;

(l) 02933, Prefabricated stainless steel crown with resin window;

(m) 02940, Sedative filling;

(n) 02950, Core buildup, including any pins;

(o) 02951, Pin retention - per tooth, in addition to restoration;

(p) 02954, Prefabricated post and core in addition to crown;

(q) 02970, Temporary Crown (fractured tooth);

(r) 02980, Crown repair - By Report;

(s) 02955, post removal (not in conjunction with endodontic therapy).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95

410-123-1340

Endodontics

(1) Pulp Capping:

(a) Indirect pulp caps are included in the restoration fee - no additional payment will be made;

(b) Code and Description:

(A) 03110, Pulp cap - direct (excluding final restoration);

(B) 03120, Pulp cap - indirect (excluding final restoration).

(2) Pulpotomy: Code and Description: 03220, Therapeutic pulpotomy (excluding final restoration).

(3) Endodontic Therapy:

(a) Payment for a direct pulp cap is not covered when root canal therapy is performed on a tooth;

(b) Separate reimbursement for open and drain as a palliative procedure is only allowed when the root canal is not completed on the same date of service;

(c) Root canal therapy is not covered for third molars;

(d) Root canal therapy is limited to permanent teeth, and only if the treatment is expected to lead to a favorable prognosis;

(e) Apexification is limited to a maximum of five treatments on permanent teeth only;

(f) Code and Description:

(A) 03310, Anterior (excluding final restoration);

(B) 03320, Bicuspid (excluding final restoration);

(C) 03330, Molar (excluding final restoration);

(D) 03346, Retreatment of previous root canal therapy - anterior, by report - By Report;

(E) 03347, Retreatment of previous root canal therapy - bicuspid, by report - By Report;

(F) 03348, Retreatment of previous root canal therapy - molar, by report - By Report;

(G) 03351, Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.);

(H) 03352, Apexification/recalcification - interim medication replacement (apical closure/ calcific repair of perforations, root resorption, etc.);

(I) 03353, Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).

(4) Endodontic Therapy on Primary Tooth:

(a) 03230, Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - primary incisors and cuspids;

(b) 03240, Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) - primary first and second molars;

(5) Periapical services: Code and Description: 03950, Canal preparation and fitting of preformed dowel or post.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95

410-123-1360

Periodontics

(1) Gingivectomy or gingivoplasty (04210) is covered for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g. dilantin hyperplasia.

(2) Gingival Flap (04240) and Osseous surgery (04260) are allowed once every three years unless there is a documented medical/dental indication.

(3) Periodontal scaling and root planing (04341) is allowed once every two years. A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances. Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 4mm or greater.

(4) Periodontal maintenance procedures (04910) are allowed once every six months.

(5) Records must clearly document the clinical indications for all periodontal procedures these include current pocket depth charting and/or radiographs.

(6) Surgical procedures include six months routine postoperative care.

(7) (04220) Currettage, surgical, is allowed once in a two-year period.

(8) The following procedure codes will not be reimbursed by OMAP if performed on the same date of service: 04341,

04355 01110, 01120, 04220, 04210, 04260 or 04910).

(9) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs.

(10) When billing for quadrants, use quadrant UL, LL, UR, LR or No. 33.

(11) Code and Description:

(a) 04210, Gingivectomy or gingivoplasty - per quadrant;

(b) 04220, Gingival curettage, surgical, per quadrant, by report;

(c) 04240, Gingival flap procedure. including root planing - per quadrant;

(d) 04260, Osseous surgery (including flap entry and closure) - per quadrant.

(12) Adjunctive periodontal services: Code and Description:

(a) 04320, Provisional splinting - intracoronal - By Report;

(b) 04321, Provisional splinting - extracoronal - By Report;

(c) 04341, Periodontal scaling and root planing - per quadrant;

(d) 04381, Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth - By report. Must submit complete treatment plan and justification - prior authorization required;

(e) 04910, Periodontal maintenance procedures (following active therapy);

(f) 04920, Unscheduled dressing change (by someone other than treating dentist) - By Report;

(g) 04355, Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, limited to once every 24 months.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95

410-123-1380

Removable Prosthodontics

(1) Removable resin based partial dentures (flippers) are limited to the replacement of permanent teeth.

(2) Removable cast metal prosthodontics and full dentures are limited to recipients age 16 or older.

(3) Adjustments to removable prosthodontics during the six month period following delivery to recipients are included in the fee.

(4) Reline of complete or partial dentures is allowed once per year.

(5) Replacement of dentures and cast metal partials is limited to once every five years

(6) Replacement of resin base partials is limited for adults to once every five years.

(7) Laboratory relines are not payable within five months after placement of an immediate denture.

(8) Tissue conditioning is allowed a maximum of four times per denture unit in conjunction with immediate dentures. Tissue conditioning is allowed once per year for codes 05110, 05120, 05213 and 05214.

(9) Cast partial dentures:

(a) Will not be approved if stainless steel crowns are used as abutments;

(b) Must have three or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating severe impairment of mastication. (Third molars are not a consideration when counting missing teeth.);

(c) Teeth to be replaced and teeth to be clasped are to be noted in the "remarks" section of the form.

(10) Code and Description:

(a) 05110, Complete upper -- Prior Authorization Required;

(b) 05120, Complete lower -- Prior Authorization Required;

(c) 05130, Immediate upper -- Full mouth radiographs are required -- Prior Authorization Required;

(d) 05140, Immediate lower -- Full mouth radiographs are required -- Prior Authorization Required;

(e) 05211, Upper partial -- resin base (including any conventional clasps, rests and teeth);

(f) 05212, Lower partial -- resin base (including any conventional clasps, rests and teeth);

(g) 05213, Upper partial -- cast metal base with resin saddles (including any conventional clasps, rests and teeth) -- Prior Authorization Required -- full mouth radiographs are required ;

(h) 05214, Lower partial -- cast metal base with resin saddles (including any conventional clasps, rests and teeth) -- Prior Authorization Required -- Full mouth radiographs are required .

(11) Adjustments to removable prostheses: Code and Description:

(a) 05410, Adjust complete denture -- upper;

(b) 05411, Adjust complete denture -- lower;

(c) 05421, Adjust partial denture -- upper;

(d) 05422, Adjust partial denture -- lower.

(12) Repairs to complete dentures: Code and Description:

(a) 05510, Repair broken complete denture base;

(b) 05520, Replace missing or broken teeth -- complete denture (each tooth).

(13) Repairs to partial dentures: Code and Description:

(a) 05610, Repair denture base;

(b) 05620, Repair cast framework;

(c) 05630, Repair or replace broken clasp;

(d) 05640, Replace broken teeth -- per tooth;

(e) 05650, Add tooth to existing partial denture;

(f) 05660, Add clasp to existing partial denture.

(14) Denture reline procedures: Code and Description:

(a) 05730, Reline complete upper denture (chairside) -- limited to once per year;

(b) 05731, Reline complete lower denture (chairside) -- limited to once per year;

(c) 05740, Reline upper partial denture (chairside) -- limited to once per year;

(d) 05741, Reline lower partial denture (chairside) -- limited to once per year;

(e) 05750, Reline complete upper denture (laboratory) -- limited to once per year;

(f) 05751, Reline complete lower denture (laboratory) -- limited to once per year;

(g) 05760, Reline upper partial denture (laboratory) -- limited to once per year;

(h) 05761, Reline lower partial denture (laboratory) -- limited to once per year.

(15) Other removable prosthetic devices: Code and Description:

(a) 05850, Tissue conditioning, maxillary -- per denture unit;

(b) 05851, Tissue conditioning, lower -- per denture unit;

(c) 05860, Overdenture -- complete, by report, Full mouth radiographs required -- Prior Authorization Required;

(d) 05861, Overdenture -- partial, by report, Full mouth radiographs required -- Prior Authorization Required.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95

410-123-1400

Maxillofacial Prosthetics

(1) For patients enrolled in managed care, maxillofacial prosthetics are to be billed using CPT or HCPCS coding to the client's medical managed care plans (FCHPs, PCOs). FCHPs and PCOs are capitated to cover these services. DCOs are not.

(2) For fee-for-service clients, bill OMAP using CPT or HCPCS coding.

(3) Code and Description:

(a) 05911 -- Facial moulage (sectional);

(b) 05912 -- Facial moulage (complete);

(c) 05913 -- Nasal prosthesis;

(d) 05914 -- Auricular prosthesis -- Prior authorization required;

(e) 05915 -- Orbital prosthesis;

(f) 05916 -- Ocular prosthesis;

(g) 05919 -- Facial prosthesis;

(h) 05922 -- Nasal septal prosthesis;

(i) 05923 -- Ocular prosthesis, interim;

(j) 05924 -- Cranial prosthesis;

(k) 05925 -- Facial augmentation implant prosthesis;

(l) 05926 -- Nasal prosthesis, replacement;

(m) 05927 -- Auricular prosthesis, replacement;

(n) 05928 -- Orbital prosthesis, replacement;

(o) 05929 -- Facial prosthesis, replacement;

(p) 05931 -- Obturator prosthesis, surgical;

(q) 05932 -- Obturator prosthesis, definitive;

(r) 05933 -- Obturator prosthesis, modification;

(s) 05934 -- Mandibular resection prosthesis with guide flange;

(t) 05935 -- Mandibular resection prosthesis without guide flange;

(u) 05936 -- Obturator prosthesis, interim;

(v) 05937 -- Trismus appliance (not for TMJ treatment);

(w) 05951 -- Feeding aid;

(x) 05952 -- Speech aid prosthesis -- Pediatric ;

(y) 05953 -- Speech aid prosthesis -- Adult;

(z) 05954 -- Palatal augmentation prosthesis;

(aa) 05955 -- Palatal lift prosthesis, definitive;

(bb) 05958 -- Palatal lift prosthesis, interim;

(cc) 05959 -- Palatal lift prosthesis, modification -- By report;

(dd) 05960 -- Speech aid prosthesis, modification -- By report;

(ee) 05983 -- Radiation carrier;

(ff) 05984 -- Radiation shield;

(gg) 05985 -- Radiation cone locator;

(hh) 05986 -- Fluoride gel carrier;

(ii) 05987 -- Commissure splint.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1420

Fixed Prosthodontics

(1) Permanent bridges are allowed for anterior permanent teeth only. Recipients must be 16 years of age or older. Full mouth radiographs must be submitted for prior authorization.

(2) Permanent bridges are limited to four units. Four units includes the abutment teeth. If greater than four units a partial denture may be approved.

(3) If anterior and posterior teeth are missing a partial denture may be approved.

(4) Bridges are not allowed in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.

(5) Replacement bridges are limited to once every five years.

(6) Code and Description:

(a) Bridge pontics:

(A) 06211 -- Pontic -- Cast predominantly base metal -- radiographs required -- Prior authorization required;

(B) 06212 -- Pontic -- Cast noble metal -- Prior authorization required;

(C) 06241 -- Pontic -- Porcelain fused to predominantly base metal -- Prior authorization required;

(D) 06242 -- Pontic -- Porcelain fused to noble metal &endash; Prior authorization required;

(E) 06251 -- Pontic -- Resin with predominantly base metal -- Prior authorization required;

(F) 06252 -- Pontic -- Resin with noble metal -- Prior authorization required;

(b) Retainers: 06545 -- Retainer -- Cast metal for acid etched fixed prosthesis -- Prior authorization required;

(c) Bridge retainers -- Crowns:

(A) 06751 -- Crown -- Porcelain fused to predominantly base metal -- Prior authorization required;

(B) 06752 -- Crown -- Porcelain fused to noble metal -- Prior authorization required;

(C) 06791 -- Crown -- Full cast predominantly base metal -- Prior authorization required;

(D) 06792 -- Crown -- Full cast noble metal -- Prior authorization required.

(d) Other fixed prosthetic services:

(A) 06930 -- Recement bridge;

(B) 06970 -- Cast post and core in addition to bridge retainer -- Prior authorization required;

(C) 06971 -- Cast post as part of bridge retainer -- Prior authorization required;

(D) 06972 -- Prefabricated post and core in addition to bridge retainer -- Prior authorization required;

(E) 06973 -- Core build up for retainer, including any pins -- Prior authorization required;

(F) 06975 -- Coping -- Metal -- Prior authorization required;

(G) 06980 -- Bridge repair -- By report -- Prior authoriza-tion required.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94

410-123-1440

Oral Surgery

(1) All surgical procedures directly related to the teeth and supporting structures that would be reported as a dental diagnosis must be billed using ADA CDT coding. For clients enrolled in managed care plans these procedures are covered by the dental care organizations. If the services are a result of a medical condition/diagnosis (e.g., fracture, cancer) appropriate AMA CPT-4 procedure codes and billing procedures must be used. For clients enrolled in managed care plans, these procedures are covered by the FCHP or PCO.

(2) Procedures include local anesthesia, suturing, postoperative care and follow-up visits. Radiographs may be requested. General anesthesia is reimbursed separately (see rule 410-123-1480) and does not require prior authorization. All codes listed as "By Report" (BR) require an operative report.

(3) Code 07241 requires an operative report and X-ray.

(4) Payment for tooth reimplantation is covered only in cases of traumatic avulsion where there are good indications of success.

(5) Surgical Assistance:

(a) Reimbursement for surgical assistance is restricted to services by dentists and physicians;

(b) Surgical assistance will be reimbursed only when the assistant's services qualify as a dental or medical necessity;

(c) Only one surgical assistant will be reimbursed unless clinical justification is submitted for an additional assistant;

(d) Primary surgeons, assistant surgeons, anesthesiologists and nurse anesthetists not in common practice must bill separately for their services.

(6) Extractions - includes local anesthesia and routine postoperative care:

(a) 07110, Single tooth;

(b) 07120, Each additional tooth;

(c) 07130, Root removal - exposed roots.

(7) Surgical extractions - includes local anesthesia and routine postoperative care:

(a) 07210, Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;

(b) 07220, Removal of impacted tooth - soft tissue;

(c) 07230, Removal of impacted tooth - partially bony;

(d) 07240, Removal of impacted tooth - completely bony;

(e) 07241, Removal of impacted tooth - completely bony, with unusual surgical complications - By Report;

(f) 07250, Surgical removal of residual tooth roots (cutting procedure).

(8) Other surgical procedures:

(a) 07260, Oral antral fistula closure;

(b) 07270, Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;

(c) 07281, Surgical exposure of impacted or unerupted tooth to aid eruption;

(d) 07285, Biopsy of oral tissue - hard;

(e) 07286, Biopsy of oral tissue - soft.

(9) Alveoloplasty -surgical preparation of ridge for dentures:

(a) 07320, Alveoloplasty not in conjunction with extractions - per quadrant;

(b) Vestibuloplasty:

(A) 07340, Vestibuloplasty ridge extension (secondary epithelialization);

(B) 07350, Vestibuloplasty ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue).

(c) Removal of tumors, cysts, and neoplasms:

(A) 07430, Excision of benign tumor - lesion diameter up to 1.25 cm;

(B) 07431, Excision of benign tumor - lesion diameter greater than 1.25 cm;

(C) 07440, Excision of malignant tumor - lesion diameter up to 1.25 cm;

(D) 07441, Excision of malignant tumor - lesion diameter greater than 1.25 cm;

(E) 07450, Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm;

(F) 07451, Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm;

(G) 07460, Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm;

(H) 07461, Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm;

(I) 07465, Destruction of lesion(s) by physical or chemical method, by report.

(d) Excision of bone tissue:

(A) 07470, Removal of exostosis - maxilla or mandible;

(B) 07480, Partial ostectomy (guttering or saucerization);

(C) 07490, Radical resection of mandible with bone graft.

(e) Surgical incision:

(A) 07510, Incision and drainage of abscess - intraoral soft tissue;

(B) 07520, Incision and drainage of abscess - extraoral soft tissue;

(C) 07530, Removal of foreign body, skin, or subcutaneous areolar tissue;

(D) 07540, Removal of reaction-producing foreign bodies - musculoskeletal system;

(E) 07550, Sequestrectomy for osteomyelitis;

(F) 07560, Maxillary sinusotomy for removal of tooth fragment or foreign body.

(f) Treatment of fracture - simple:

(A) 07610, Maxilla open reduction - (teeth immobilized if present);

(B) 07620, Maxilla - closed reduction (teeth immobilized if present);

(C) 07630, Mandible open reduction (teeth immobilized if present);

(D) 07640, Mandible - closed reduction (teeth immobilized if present);

(E) 07650, Malar and/or zygomatic arch - open reduction;

(F) 07660, Malar and/or zygomatic arch - closed reduction;

(G) 07670, Alveolus - stabilization of teeth, open reduction;

(H) 07680, Facial bones - complicated reduction with fixation and multiple surgical approaches.

(g) Treatment of fractures - compound:

(A) 07710, Maxilla - open reduction;

(B) 07720, Maxilla - closed reduction;

(C) 07730, Mandible - open reduction;

(D) 07740, Mandible - closed reduction;

(E) 07750, Malar and/or zygomatic arch - open reduction;

(F) 07760, Malar and/or zygomatic arch - closed reduction;

(G) 07770, Alveolus - stabilization of teeth, open reduction splinting;

(H) 07780, Facial bones - complicated reduction with fixation and multiple surgical approaches.

(h) Reduction of dislocation and management of other TMJ dysfunctions:

(A) The following are not covered as dental procedures on the Health Services Commission list. They are covered as medical procedures. Bill using CPT coding;

(B) 07810, Open reduction of dislocations;

(C) 07820, Closed reduction of dislocations; and

(D) 07830, Manipulation under anesthesia.

(i) Repair of traumatic wounds - 07910, Suture of recent small wounds up to 5 cm;

(j) Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):

(A) 07911, Complicated suture - up to 5 cm;

(B) 07912, Complicated suture - greater than 5 cm;

(k) Other repair procedures:

(A) 07920, Skin grafts (identify defect covered, location, and type of graft) - Prior Authorization Required;

(B) 07950, Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible - autogenous or nonautogenous;

(C) 07955, Repair of maxillofacial soft and hard tissue defects ;

(D) 07960, Frenulectomy (frenectomy or frenotomy) - separate procedure. Not covered for tongue-tied ICD-9 750.0 - 750.1;

(E) 07970, Excision of hyperplastic tissue - per arch;

(F) 07971, Excision of pericoronal gingiva;

(G) 07980, Sialolithotomy;

(H) 07981, Excision of salivary gland - By Report;

(I) 07982, Sialodochoplasty;

(J) 07983, Closure of salivary fistula;

(K) 07990, Emergency tracheotomy;

(L) 07991, Coronoidectomy.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; 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

410-123-1460

Orthodontia

(1) Orthodontia Services are limited to eligible recipients for the ICD-9-CM diagnosis of cleft palate with cleft lip.

(2) Prior authorization is required for orthodontia exams and records. All requests must be submitted in writing on an OMAP 501-D or ADA form and must include a referral letter from physician or dentist indicating diagnosis of cleft palate/lip.

(3) Prior authorization for treatment is required and should be requested from the Dental Program Coordinator. The request must include diagnosis, length and type of treatment.

(4) Payment for appliance therapy includes the appliance and all follow-up visits.

(5) Orthodontia treatment for cleft palate/cleft lip is evaluated as two phases. Each phase requires prior authorization. Each phase is reimbursed individually (separately).

(6) Payment for orthodontia will be made in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the patient transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to OMAP any unused amount of payment, after applying the following formula:

(a) Total payment minus $300.00 (for Banding) multiplied by the percentage of treatment remaining.

(7) The length of the treatment plan from the original request for authorization will be used to determine the number of treatment months remaining.

(8) As long as the orthodontist continues treatment no refund will be required even though the patient may become ineligible for medical assistance sometime during the treatment period.

(9) Code and Description:

(a) 08100, Orthodontia records - Prior Authorization Required;

(b) 08200, Orthodontic examination - Prior Authorization Required;

(c) Codes 08010 through 08999 - Orthodontic Treatment - Prior Authorization Required.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95

410-123-1480

Anesthesia

(1) General anesthesia is paid for the first 30 minutes (09220) and each additional 15 minutes (09221) up to three hours on the same day of service.

(2) Nitrous oxide is paid per date of service, not by time.

(3) IV Sedation is paid per date of service.

(4) Oral premedication anesthesia for conscious sedation:

(a) Limited to recipients through 12 years of age;

(b) Limited to four times per year;

(c) Monitoring and nitrous oxide included in the fee;

(d) Use of multiple agents are required to receive payment.

(5) Providers are required to submit a copy of their permit to administer anesthesia, analgesia and/or sedation to OMAP, upon request.

(6) Unclassified Treatment: 09110 Palliative (emergency) treatment of dental pain - minor procedures 09210, local anesthesia not in conjunction with operative or surgical procedures.

(7) Code and Description:

(a) 09210, Local anesthesia not in conjunction with operative or surgical procedures;

(b) 09211, Regional block anesthesia;

(c) 09212, Trigeminal division block anesthesia;

(d) 09220, General anesthesia first 30 minutes;

(e) 09221, General anesthesia each additional 15 minutes;

(f) 09230, Analgesia;

(g) 09240, Intravenous sedation;

(h) 09260, Oral premedication, conscious monitored sedation using multiple agents.

Stat. Auth.: ORS Ch. 409

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

410-123-1500

Adjunctive General Services

(1) Professional consultation: 09310, Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

(2) Professional visits:

(a) Code 09430 is limited to three visits per year;

(b) 09420, Hospital call;

(c) 09430, Office visit for observation (during regularly scheduled hours) - no other services performed;

(d) 09440, Office visit - after regularly scheduled hours - By Report.

(3) Drugs:

(a) 09610, Therapeutic drug injection - By Report ;

(b) 09630, Other drugs and/or medicaments - By Report.

(4) Miscellaneous services:

(a) 09930, Treatment of complication (post-surgical) - unusual circumstances - By Report;

(b) 09999, Unspecified adjunctive procedure - By Report.

Stat. Auth.: ORS Ch. 409

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

410-123-1520

Schedule for Denturist

(1) Removable prosthodontics are limited to the replacement of all permanent teeth, per maxilla/ mandible.

(2) Removable prosthodontics are limited to recipients age 16 or older.

(3) Adjustments to dentures during the six month period following delivery to recipients are included in the fee for dentures.

(4) Reline of complete dentures is allowed once per year.

(5) Periodic exams are payable once every 12 months.

(6) Replacement of dentures is limited to once every five years.

(7) Tissue conditioning is allowed a maximum of four times per denture unit in conjunction with immediate dentures.

(8) Tissue conditions is allowed once per year for codes 05110 and 05120.

(9) Laboratory relines are not payable within five months after placement of an immediate denture.

(10) Code and Description:

(a) 05110, Complete upper - Prior Authorization Required;

(b) 05120, Complete lower - Prior Authorization Required;

(c) 05510, Repair broken complete denture;

(d) 05520, Replace missing or broken teeth - complete denture;

(e) 05750, Reline complete upper denture (laboratory) (payable once every 12 months);

(f) 05751, Reline complete lower denture (laboratory) (payable once ever 12 months);

(g) 00110, Initial oral examination;

(h) 00120, Periodic oral examination;

(i) 05130, Complete immediate upper - Radiographs are required - prior authorization required;

(j) 05140, Complete immediate lower - Radiographs are required - prior authorization required;

(k) 05410, Adjust complete upper;

(l) 05411, Adjust complete lower;

(m) 05730, Reline complete upper, chairside - payable once every 12 months;

(n) 05731, Reline complete lower, chairside - payable once every 12 months;

(o) 05850, Tissue conditioning, complete upper;

(p) 05851, Tissue conditioning, complete lower;

(q) 09430, Office visit for observation (during regularly scheduled hours) - no other services performed. Limited to three per year;

(r) 00140, Limited oral evaluation - problem focused;

(s) 058060, Overdenture, complete, by report, full-mouth radiographs required - prior authorization required;

(t) Overdenture, partial, by report, full-mouth radiographs required, prior authorization required.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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1998 Compilation

DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 124

TRANSPLANT SERVICES

410-124-0000

Transplant Services - Effective for Services Provided On or After June 1, 1997

(1) The Office of Medical Assistance Programs (OMAP) will make payment for prior authorized and emergency transplant services identified in these rules as covered, for eligible clients receiving the Basic Health Care Package and when OMAP transplant criteria described in OAR 410-124-0010 and 410-124-0060 through 410-124-0160 is met. Clients receiving the Limited Benefit Package are not eligible for transplant services; these clients are only eligible for mental health, alcohol/drug, pharmacy and medical transportation services. All transplants require prior authorization, except for kidney and cornea, which require prior authorization only if performed out-of-state.

(2) The following types of transplants and transplant-related procedures are covered under the Medical Assistance program:

(a) Bone Marrow, Autologous and Allogeneic;

(b) Bone Marrow Harvesting and Peripheral Stem Cell Collection, Autologous;

(c) Cord blood, Allogeneic;

(d) Cornea;

(e) Heart;

(f) Heart-Lung;

(g) Kidney;

(h) Liver;

(i) Liver-Kidney;

(j) Simultaneous Pancreas and Kidney transplants and Pancreas after Kidney transplants;

(k) Peripheral stem cell, Autologous and Allogeneic;

(l) Single lung;

(m) Bilateral lung;

(n) Any other transplants the Health Services Commission and the Oregon Legislature determine are to be added to the Prioritized List of Health Services.

(3) The following types of transplants are not covered by the Oregon Medical Assistance program:

(a) Any transplants not listed in subsection (2) of this rule;

(b) Transplants which are considered experimental or investigational or which are performed on an experimental or investigational basis, as determined by OMAP;

(c) Transplant services which are contraindicated, as described in 410-124-0060 through 410-124-0160.

(4) Transplant services will be reimbursed only when provided in a transplant center that provides quality services, demonstrates good patient outcomes and compliance with all OMAP 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 OMAP 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 OMAP clients. No OMAP transplant contract, prior approval or reimbursement will be made to consortia for transplant services where, as determined by OMAP, there is no assurance that the individual facilities that make up the consortia independently meet OMAP criteria. OMAP 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 OMAP transplant services, it is obliged to report immediately to OMAP 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 OMAP coverage of transplants performed at the facility;

(c) FCHPs without OMAP stop-loss that contract with non-OMAP contracted facilities for Basic Health Care Package 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 OMAP'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) OMAP 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.

(5) Standards for Transplant Centers:

(a) Heart, lung and heart-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 (autologeous and allogeneic) and cord blood (allogeneic) transplants: One-year patient survival rate of at least 50%;

(c) Liver and liver-kidney transplants: One year patient survival rate of 70% and a one year graft survival rate of 60%;

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants: One year patient survival rate of 90% and one year graft survival rate of 60%.

(6) 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 OMAP criteria; or

(d) It would be cost effective as determined by OMAP. 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.

(7) Professional and other services will be covered according to administrative rules in the applicable provider guides.

(8) Covered Transplant services are transplants which:

(a) Are described in OAR 410-124-0000(2) and have been prior authorized for payment by OMAP, or the client's managed health care plan; or

(b) Meet the guidelines for an emergency transplant (OAR 410-124-0040).

(9) Non-Covered Transplant services are transplants and transplant related services which:

(a) Are not described in this guide in OAR 410-124-0000(2); or

(b) Are described in this guide in OAR 410-124-0000(3); or

(c) Have not been prior authorized for payment by OMAP or the client's managed health care plan; or

(d) Do not meet the guidelines for an emergency transplant in OAR 410-124-0040; or

(e) Are not described as covered in OAR 410-141-0480.

(10) Reimbursement for covered transplants and follow-up care for transplant services is as follows:

(a) For transplants for fee-for-service or PCCM clients:

(A) By agreement between OMAP and the transplant center;

(B) For emergency services, when no special agreement has been established, the rate will be:

(i) 75% of standard inpatient billed charge; and

(ii) 50% of standard outpatient billed charge; or

(iii) The payment rate set by the Medical Assistance program of the state in which the center is located, whichever is lower.

(b) For clients enrolled in Managed Health Care plans, reimbursement for transplant services will be by agreement between the managed care plan (FCHP) and the transplant center.

Stat. Auth.: ORS Ch. 409

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

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 Limited Benefit Package do not have coverage for transplants.

(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, OMAP 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) OMAP prior authorization is valid for transplant services provided only while the client is enrolled under fee-for-service, PCO or a PCCM. If a client moves from the fee-for-service arena to managed care, any prior authorizations which had been approved by OMAP are void and prior authorization must be obtained from the new managed care plan. If a client moves out of a managed care plan into another plan, or into fee-for-service, any prior authorizations approved by the original managed care plan or OMAP are void, and prior authorization must again be obtained from the new plan or OMAP.

Stat. Auth.: ORS Ch. 409

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

410-124-0020

Prior Authorization for All Covered Transplants, Except Cornea and Kidney - Effective for Services Provided On or After June 1, 1997

(1) Prior authorization is required as follows:

(a) All non-emergency transplant services require prior authorization of payment;

(b) Pre-transplant evaluations provided by the transplant center require prior authorization. Prior Authorization will only be made for evaluations for covered transplants.

(2) The prior authorization request for all covered transplants is initiated by the client's in-state referring physician. The initial request should contain all available information outlined in subsection (3) of this rule, below:

(a) For fee-for-service and PCCM clients, the request should be sent to OMAP;

(b) For clients enrolled in an FCHP, requests for transplant services other than lung or heart/lung transplants for the diagnosis of emphysema should be sent directly to the FCHP;

(c) Prior authorization for lung or heart/lung transplants for the diagnosis of emphysema shall always be obtained from OMAP regardless of managed care enrollment.

(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 is provided at the end of the Transplant Services guide for provider convenience in submitting the request:

(a) The name, age, Medical Assistance I.D. number, and birth date of the client;

(b) A description of the medical condition and full ICD-9 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 Office of Medical Assistance Programs does not obligate the Office of Medical Assistance Programs 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 and/or enrolled with a PCCM:

(A) After receiving a completed request OMAP 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 Oregon Medical Assistance Program's criteria.

(b) For OHP transplant eligible clients who are in a fully capitated health plan (FCHP): Refer to the managed care plan for approval process and requirements.

(c) The prior authorization request will be approved if:

(A) All OMAP criteria are met; and

(B) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized;

(C) The transplant service/diagnosis is covered under the Prioritized List of Health Services.

(5) The referring physician, transplant center, and the client will be notified in writing by OMAP or the FCHP 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 Ch. 409

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

410-124-0040

Emergency Transplants

(1)An Emergency Transplant is one in which medical necessity 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 OMAP (or the managed care plan for clients enrolled in a fully capitated health plan) 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. OMAP will make payment as described in OAR 410-124-0000(10) for OMAP-covered transplants. Managed care plans will make payment as described in their contract.

Stat. Auth.: ORS Ch. 409

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

410-124-0060

Criteria and Contraindications for Heart Transplants

(1) The client must have a maximum probability of a successful clinical outcome, i.e., the probability of the client's survival for a period of five years or more subsequent to the transplant must be at least 25 percent.

(2) Coverage for transplantation is based on the OHP prioritized list of diagnoses/treatments for clients receiving the Basic Health Care Package.

(3) A client considered for a heart transplant must have one of the following diagnoses:

(a) Heart failure, NYHA Class IV or rapidly progressive (over months) NYHA Class III;

(b) Progressive but reversible pulmonary hypertension with heart failure such that delay of transplantation would result in irreversibility and the inability to perform heart transplantation at a later time;

(c) Heart disease with intractable ventricular arrhythmias not responsive to either medical or surgical therapy.

(4) A client considered for a heart transplant must have a poor prognosis, i.e., less than a 50 percent chance of survival for one year without a transplant as a result of poor cardiac functional status or cardiac/pulmonary functional status.

(5) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart transplantation must have been tried or considered.

(6) 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 transplant is likely to improve the outcome.

(7) 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.

(8) 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 cerebro-, 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.

Stat. Auth.: ORS Ch. 409

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

410-124-0063

Criteria and Contraindications for Heart-Lung Transplants

(1) The client must have a maximum probability of a successful clinical outcome, i.e., the probability of the client's survival for a period of five years or more subsequent to the transplant must be at least 25 percent.

(2) Coverage for transplantation is based on the OHP Prioritized List of Health Services.

(3) A client considered for a heart-lung transplant must have one of the following diagnoses:

(a) Eisenmenger's Syndrome;

(b) Cystic Fibrosis; or

(c) Primary pulmonary hypertension;

(d) Emphysema - Contact OMAP for prior authorization and payment, even when the client is in a managed health care plan.

(4) 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 cardiac/ pulmonary functional status.

(5) 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.

(6) 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.

(7) 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.

(8) 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 cerebro-, or peripheral vascular disease;

(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

Stat. Auth.: ORS Ch. 409

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

410-124-0065

Criteria and Contraindications for Single Lung Transplants

(1) The client must have a maximum probability of a successful clinical outcome, i.e., the probability of the client's survival for a period of five years or more subsequent to the transplant must be at least 25 percent.

(2) Coverage for transplantation is based on the OHP Prioritized List of Health Services.

(3) A client considered for a single lung transplant must have one of the following diagnoses:

(a) Fibrotic lung disease;

(b) Pulmonary hypertension with reversible RV function;

(c) Alpha 1-antitrypsin deficiency; or

(d) Eisenmenger's Syndrome with correctable intracardiac defect and recoverable RV function;

(e) Emphysema - Contact OMAP for prior authorization and payment, even when the client is in a managed health care plan.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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 cerebro-, or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

Stat. Auth.: ORS Ch. 409

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

410-124-0070

Criteria and Contraindications for Bilateral Lung Transplants

(1) The client must have a maximum probability of a successful clinical outcome, i.e., the probability of the client's survival for a period of five years or more subsequent to the transplant must be at least 25 percent.

(2) Coverage for transplantation is based on the OHP Prioritized List of Health Services.

(3) A client considered for a bilateral lung transplant must have one of the following diagnoses:

(a) Fibrotic lung disease;

(b) Alpha 1-antitrypsin deficiency;

(c) Pulmonary hypertension with reversible RV function;

(d) Eisenmenger's Syndrome with correctable intracardiac defect and recoverable RV function; or

(e) Cystic Fibrosis;

(f) Emphysema - Contact OMAP for prior authorization and payment, even when the client is in a managed health care plan.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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 cerebro-, or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

Stat. Auth.: ORS Ch. 409

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

410-124-0080

Criteria and Contraindications for Bone Marrow, Peripheral Stem Cell and Allogeneic Cord Blood Transplants and for the Harvesting of Autologous Bone Marrow and Peripheral Stem Cells - Effective for Services Provided On or After June 1, 1997

(1) For autologous or allogeneic bone marrow, and peripheral stem cell transplants and allogeneic cord blood transplants, the client must have one of the following diagnoses:

(a) Acute lymphocytic leukemia;

(b) Acute non-lymphocytic leukemia, (i.e., myeloid, monocytic, or megakaryocytic leukemia);

(c) Hodgkin's disease;

(d) Non-Hodgkin's lymphoma;

(e) Neuroblastoma, treatable (high risk Stage III or IV);

(f) Lymphoid leukemias other than acute lymphocytic leukemia;

(g) Multiple myeloma and chronic leukemias;

(h) Relapsed Wilms' tumor non-responsive to standard therapies, with minimal tumor burden, and where autologous bone marrow transplant is intended to cure.

(2) The following diagnoses are appropriate only for allogeneic bone marrow, allogeneic peripheral stem cell and allogeneic cord blood transplants:

(a) Aplastic anemia;

(b) Agranulocytosis;

(c) Other genetic defects for which bone marrow transplantation has been successful, such as:

(A) Thalassemia and hemoglobinopathies (e.g. sickle cell);

(B) Osteopetrosis;

(C) Wiskott-Aldrich syndrome;

(D) Severe combined immunodeficiency (SCID); and

(E) Inborn errors of metabolism.

(d) Myelodysplastic syndrome;

(e) Constitutional aplastic anemias (e.g., Fanconi's anemia);

(f) Chronic myelogenous leukemia.

(3) Peripheral stem cell (buffy coat) transplants are covered for all leukemias only when:

(a) There is early relapse post allogeneic bone marrow transplant; and

(b) Peripheral stem cells are from the original allogeneic donor.

(4) Coverage for transplantation is based on the OHP Prioritized List of Health Services.

(5) Authorization for payment for transplants will be approved only when the following conditions are also met:

(a) The following criteria will be used to evaluate the prior authorization request for all bone marrow 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 10% five year survival; that is, treatment by bone marrow transplantation must have been shown to be an effective treatment (survival of five or more years) considering each of the following factors:

(i) The type of transplant, i.e., autologous or allogeneic;

(ii) The specific diagnosis of the individual;

(iii) The stage of illness, i.e., in remission, not in remission, in second remission;

(iv) Satisfactory antigen match between donor and recipient in allogeneic transplants.

(C) All alternative treatments with a one year survival rate compared to that of bone marrow transplantation must have been tried or considered.

(b) 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 donor search is prior authorized;

(c) Autologous transplants (bone marrow and peripheral stem cell) will be approved for payment if:

(A) The client has one of the conditions listed in subsection 1 of this rule; and

(B) Documentation in the current peer-reviewed medical literature indicates that the disease is potentially curable when an autologous bone marrow transplant or peripheral stem cell transplant is performed in conjunction with:

(i) Total body radiation; and/or

(ii) High dose chemotherapy; and

(iii) The client has no other contraindications for bone marrow transplant or peripherastem cell reinfusion.

(d) The harvesting and storage of autologous bone marrow and autologous peripheral stem cell collection alone will be approved for payment under the following conditions:

(A) The client has had one of the conditions listed in section (1) of this rule; and

(B) The client's marrow meets the clinical standards of remission at the time of storage; and

(C) A Board Certified hematologist/oncologist with specific experience in bone marrow transplant (BMT) services (e.g., cryopreservation and immunosuppressive treatment) has recommended the storage of autologous bone marrow or peripheral stem cell collection for a possible future transplant/reinfusion;

(D) The client has no other contraindications for bone marrow transplant or peripheral stem cell reinfusion.

(6) The following are contraindications for bone marrow, peripheral stem cell and cord blood transplants and for the harvesting of autologous bone marrow or peripheral stem cell collection:

(a) Incurable malignancy;

(b) Irreversible terminal state (moribund or on life support);

(c) An irreversible disease of any other major organ system likely to limit life expectancy to five years or less;

(d) Positive HIV test results.

(7) 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.

(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 Ch. 409

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

410-124-0100

Criteria and Contraindications for Liver and Liver-Kidney Transplants

(1) Payment for liver transplants will be approved for clients in whom irreversible, progressive liver disease has

advanced to the point where conventional therapy offers no prospect for prolonged survival, life expectancy is two years or less, and there is no reasonable alternative medical or surgical therapy and there is a maximum probability of a successful clinical outcome (i.e., the probability of the client's survival for a period of five years or more subsequent to the transplant must be at least 25 percent.

(2) Payment for liver-kidney transplants will be approved for clients with damage to the renal system which may be corrected by a liver-kidney transplant.

(3) All clients must also have one of the following diagnoses:

(a) End stage or acute liver failure (cirrhosis; acute/subacute necrosis of the liver);

(b) Inborn errors of metabolism or other genetic defects that do not respond to other treatments or will produce severe neurological damage and physical disability;

(c) Failure of a previous liver transplant;

(d) The following malformations:

(A) Biliary atresia;

(B) Choledochal cyst, when there is chronic biliary cirrhosis or end-stage renal disease;

(C) Congenital hepatic vein thrombosis (Budd-Chiari);

(D) Intrahepatic vascular malformations which have no other treatment, and for which liver transplantation is indicated as a last-resort therapy; or

(E) Massive polycystic liver disease when there is chronic biliary cirrhosis or end-stage kidney disease and hepatomegaly renders the patient in a nonfunctioning status.

(e) Hepatic vein thrombosis inappropriate for, or not responding to, portacaval anastomosis.

(4) Coverage for transplantation is based on the OHP Prioritized List of Health Services.

(5) The following are contraindications for liver and liver-kidney transplants:

(a) Incurable or 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 or kidney, (excluding short-bowel syndrome or congenital intractable diarrhea);

(h) Hepatitis B e antigen positive (HBe Ag).

(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 these condition(s) may interfere

significantly with the recovery process:

(a) Bacterial or fungal infection outside the hepatobiliary system;

(b) Hepatitis B;

(c) Crigler-Najjar Syndrome Type II;

(d) Amyloidosis;

(e) Other major system diseases affecting brain, lung, heart, or renal systems;

(f) Major, not correctable congenital anomalies;

(g) Serious psychological disorders.

(7) The transplant center will review for current risk of alcohol or other substance abuse and risk of recidivism and will inform OMAP of its findings prior to the provision of the transplant.

Stat. Auth.: ORS Ch. 409

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

410-124-0120

Criteria and Contraindications for Simultaneous Pancreas-Kidney and Pancreas After Kidney Transplants

(1) The client must have a critical medical need for transplantation and a maximum probability of a successful clinical outcome, i.e., the likelihood of survival of the patient after transplantation for a period of three or more years is 80% or more and the likelihood of the survival of the donor organ for a period of three or more years is 40% or more.

(2) SPK (simultaneous pancreas-kidney transplant) and PAK (pancreas transplant after successful kidney transplant) transplantation will be considered for clients suffering from insulin dependent Type I diabetes and end-stage renal failure or non-uremic renal dysfunction.

(3) Coverage for transplantation is based on the OHP Prioritized List of Health Services.

(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.

(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.

Stat. Auth.: ORS Ch. 409

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

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 Office of Medical Assistance Programs or the fully capitated health plan (FCHP):

(a) Submit the request to the FCHP or OMAP;

(b) The request must contain the following information:

(A) Name and Medical Assistance I.D. 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 Ch. 409

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

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 Office of Medical Assistance Programs or the fully capitated health plan (FCHP):

(a) Submit the request to the FCHP or OMAP;

(b) The request must contain the following information:

(A) Name and Medical Assistance I.D. 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 Ch. 409

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

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 125

OREGON MEDICAL ASSISTANCE PROGRAMS

Hospital Services

410-125-0000

Determining When the Patient Has Medical Assistance

(1) The Medical Card gives information about the client's eligibility and benefits.

(2) Eligibility may change on a monthly basis. In some instances, eligibility will change during the month. Request to see the Medical Card or contact ACES each time services are provided in order to assure that the client is eligible. Call the ACES Hotline (1-800-422-7012) for assistance with ACES.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 409.010

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 461-15-150; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0020

Retroactive Eligibility

(1) Office of Medical Assistance Programs (OMAP) may pay for services provided to a person who does not have Medicaid coverage at the time services are provided if the person 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 you contact the branch may be considered the date of application for eligibility.

(2) When clients are not eligible at the time services are provided, it is not possible to get prior authorization for service*. However authorization for payment may be given after the service is provided under some circumstances. See the Prior Authorization Section for further information.

* See OAR 410-125-0102 for exception for Medically Needy Program clients.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 409.010

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 461-15-160, 461-15-230 & 461-15-370; HR 42-1991, f. & cert. ef. 10-1-91; Renumbered from 410-125-160 & 410-125-440

410-125-0040

Title XIX Clients (Medicaid)

(1) Title XIX clients are eligible for medical assistance through a program which was established by the federal government and for which the state receives federal assistance. Most clients are Title XIX clients and have the full range of covered benefits. See the General Rules for more information on eligibility and covered services. Some Title XIX clients are also PCO, HMO, or DCO clients. Some Title XIX clients are Medicare Beneficiaries. Some Title XIX clients are in the Medically Needy Program.

(2) PCO, MHO, and DCO Clients. The Office of Medical Assistance Programs (OMAP) contracts with Prepaid Health Plans: Health Maintenance Organizations (HMOs), Physician Care Organizations (PCOs), and Dental Care Organizations (DCOs), to provide certain medical and/or dental services on a prepaid basis:

(a)HMOs 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)PCOs provide physician, laboratory, x-ray and other diagnostic imaging, Medicheck (EPSDT), and case management services. Other services, such as drugs, dental, podiatry, or physical therapy, are optional services that may be covered by a PCO;

(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 Card. Always check with the plan listed on the card if there is a question about coverage;

(e)Prepaid Health Plan clients receive most of their primary care services through the PCO or HMO or upon referral from the PCO or HMO. In emergency situations, all services may be provided without prior authorization or referral. However, all claims for emergency services must be reviewed by the Prepaid Health Plan and the Prepaid Health Plan referral number put in Field 93 of the UB-82 before OMAP can pay the claim. The hospital should work with the plan to arrange for billing for emergency and non-emergency services. See the sections on Prior Authorization and Billing for further information on services provided to PCO/HMO clients;

(f)Services which can be provided by the PCO or HMO and which are included in the PCO/HMO contract as a covered service will not be reimbursed by OMAP. When services are covered by the PCO or HMO, reimbursement is a matter between the provider of service and the PCO/HMO.

(3) Medicare Clients. Some Title XIX clients also have Medicare coverage. The majority of 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. See the sections on

Billing and Reimbursement for further information.

(4) Medically Needy Clients. Medically Needy clients are those clients who have too much income to qualify for Medicaid. However, their medical bills may be deducted from their income in order for them to qualify for Title XIX coverage if they meet other Medicaid standards. The amount of income by which they exceed the Medicaid standards is referred to as the "spend-down". Medically Needy clients make application for Medicaid, but must present medical bills to the branch which permit the case to be opened. Once the spend-down amount has been met, the branch will issue a Medical Card to the client, effective the day spend-down was met. Only children under 21 and pregnant women are eligible for hospital services through the Medically Needy Program. Always contact the ACES Hot-Line Operators for information about eligibility for Medically Needy clients.

Stat. Auth.: ORS 184.750, 184.770, 409.010, 409.110, Ch. 411 & 414

Stats. Implemented: ORS 414.032, 414.038 & 414.039

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 461-15-170 & 461-15-180; 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 410-125-060; HR 22-1992, f. 7-31-92, cert. ef. 8-1-92

410-125-0041

State Funded Services for Clients not Eligible for Title XIX Programs

(1) State-funded clients are clients who have not qualified for a Title XIX 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 GA Clients. Program GA clients are children in foster care, in CSD custody, who are not eligible for Title XIX programs. They have access to the full range of Medicaid covered services, but payment for services provided to these children may be different from that for Title XIX clients. See the Reimbursement Section for further information.

(3) Program SF Clients. Program SF clients are individuals who are receiving treatment in a state facility, such as Dammasch, Oregon State Hospital, or the Eastern Oregon Training School. They sometimes need to receive hospital care outside the state facility. They are entitled to the full range of Medicaid covered services. These individuals will be referred by the state facility for services. They do not have Medical Assistance Cards.

Stat. Auth.: ORS Ch. 409

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

410-125-0045

Coverage and Limitations

In general, most medically necessary services are covered for all clients. There are, however, some restrictions and limitations. Please refer to the General Rules for information on general scope of coverage and limitations. Some of the limitations and restrictions which apply to hospital services are:

(1) Prior Authorization: Some services require prior authorization. Check the Prior Authorization section for further information;

(2) Non-Covered Services:

(a) Services which are not medically necessary, for which medical efficacy has not been proven, or services which are the responsibility of another Division are not-covered by OMAP;

(b) Service coverage is based on the Health Services Commission's Prioritized List of Services;

(c) See the General Rules and other provider guides for a list of not-covered services. Further information on some not-covered services is found in the Revenue Code section of the Hospital Service guide.

(3) Limitations on Hospital Benefit Days: Clients have no hospital benefit day limitations for treatment of services identified as covered on the Prioritized List of Health Services (OAR 410-141-0520);

(4) Dental Services: Clients have dental/denturist services identified as covered on the Prioritized List of Health Services (OAR 410-141-520);

(5) Services Provided Outside of Facility: Services which are delivered outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by OMAP 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-9 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules.

Stat. Auth.: ORS Ch. 409

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

410-125-0080

Inpatient Services

(1) Elective (not Urgent or Emergent) Admission:

(a) FCHP and PCO clients -- Contact the client's PCO or FCHP (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than OMAP;

(b) Medicare clients -- OMAP does not require prior authorization for inpatient services provided to clients with Medicare Part A or B coverage;

(c) All other OMAP clients:

(A) Hospital admissions for any of the medical and surgical procedures shown in **Table 1** require prior authorization, unless they are urgent or emergent;

(B) Contact OMPRO (unless indicated otherwise in **Table 1**).

(2) Transplant Services:

(a) Complete rules for Transplant Services are in the **Transplant Services Provider Guide**:

(b) Clients are eligible for transplants covered by the Health Services Commission's Prioritized List. See the **Transplant**

Services Provider Guide for criteria. For clients enrolled in managed care, contact the plan for authorization. Clients not in managed care, contact OMAP.

(3) Out-of-State, Non-Contiguous Hospitals:

(a) All non-emergency/non-urgent services provided by hospitals more than 75 miles from the Oregon border require prior authorization;

(b) Contact - OMAP for authorization for clients not in managed care. For clients enrolled in managed care - contact the plan;

(c) Services provided by contiguous-area hospitals are prior authorized following the same rules and procedures as instate providers (see Elective Admission).

(4) Transfers to Another Hospital:

(a) Transfers for the purpose of providing a service listed in section (6) of this rule, e.g., physical rehabilitation care require prior authorization -- Contact OMPRO;

(b) Transfers to a skilled nursing facility, intermediate care facility or swing bed -- Contact the Senior and Disabled Services Division (SDSD). SDSD reimburses nursing facilities and swing beds through contracts with the facilities. FCHP clients - transfers require authorization and payment (for first 20 days) from the plan;

(c) Transfers to the same or lesser level of inpatient care -- OMAP will cover transfers, including back transfers, which are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social/psychological benefit to the patient. 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. Transfers not meeting these guidelines may be denied on the basis of post-payment review;

(d) Exceptions:

(A) Emergency transfers do not require prior authorization;

(B) Non-emergency transfers for the purpose of providing care which is unavailable in the transferring hospital do not require prior authorization, unless the planned service is listed in section (6) of this rule;

(C) All non-urgent transfers to out-of-state non-contiguous hospitals require prior authorization.

(5) Dental Procedures:

(a) PCOs and DCOs do not cover any dental services (**ICD-9 Codes 521 through 525.9**) when provided by a hospital. All inpatient procedures require approval from OMAP;

(b) Emergency dental services do not require prior authorization

[ED. NOTE: Table 1 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Department of Human Resources.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-15-190; 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

410-125-0085

Outpatient Services

(1) Outpatient services which require prior authorization include:

(a) Physical Therapy;

(b) Occupational Therapy;

(c) Speech Therapy;

(d) Audiology;

(e) Hearing Aids;

(f) Dental Procedures;

(g) Drugs;

(h) Apnea Monitors, Services, and Supplies;

(i) Out-of-State Services;

(j) Home Parenteral/Enteral Therapy;

(k) Durable Medical Equipment;

(l) Certain Surgical Procedures. See more specific guidelines in section (2) of this rule.

(2) Surgical Procedures:

(a) FCHP and PCO clients. Contact the client's PCO or FCHP (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than OMAP. Some services are not covered under PCO/FCHP contracts and require prior authorization from OMPRO or the OMAP Dental Program Coordinator;

(b) Medicare clients enrolled in FCHPs or PCOs. These services must be authorized by the plan even if Medicare is the primary payer. Without this authorization, the provider will not be paid beyond any Medicare payments (see also OAR 410-125-0103;

(c) All other OMAP clients:

(A) Surgical procedures listed in OAR 410-125-0080 require prior authorization when performed in an outpatient or day surgery setting, unless they are urgent or emergent;

(B) Contact OMPRO (unless indicated otherwise in OAR 410-125-0080).

(3) Physical Therapy, Occupational Therapy, Speech Therapy, Audiology:

(a) For prior authorization of services for AFS and CSD clients -- Contact the OMAP Medical Group:

(A) SDSD clients -- Contact the Senior and Disabled Services Division branch;

(B) PCO/FCHP clients -- All FCHPs and PCOs cover these services. Contact the plan.

(b) Exceptions:

(A) Evaluations, and diagnostic testing do not require prior authorization;

(B) Medicare clients enrolled in FHCPs or PCOs - these services must be authorized by the plan even if Medicare is the primary payer. Without this authorization, the provider will not be paid beyond any Medicare payment. See OAR 410-125-0103;

(C) Augmentative communication devices are prior authorized by the OMAP Medical Group for all clients.

(c) Occupational therapy, physical therapy, speech therapy and audiology services provided in the outpatient hospital settings are subject to the limitations established in the appropriate provider guides.

(4) Hearing Aids:

(a) For prior authorization of services for AFS and CSD clients -- Contact the OMAP Medical Group;

(b) SDSD clients -- Contact the Senior and Disabled Services Division branch;

(c) PCO/FCHP clients -- For PCO clients, contact the OMAP Medical Group. FCHPs and PCOs cover the full range of hearing services including hearing aids. For prior authorization for hearing aids, contact the Medical Group.

(5) Dental Procedures:

(a) Dental benefits are covered as shown in the Prioritized List of Health Services.

(b) For prior authorization contact: OMAP Dental Program Coordinator, Claims Management Group;

(c) FCHP/PCO/DCO clients -- Some FCHPs/PCOs cover outpatient dental services. Other clients are enrolled with Dental Care Organizations (DCOs). If the FCHPs/PCO/DCO client's dental needs require hospital surgical services, the hospital services must be prior authorized by the Plan.

(d) Exceptions: Emergency dental procedures do not require piror authorization.

(6) Durable Medical Equipment:

(a) For prior authorization of services for AFS and CSD clients -- Contact the OMAP Medical Group;

(b) SDSD clients -- Contact the Senior and Disabled Services Division branch;

(c) PCO clients -- Contact the OMAP Medical Group.

(d) FCHP clients -- FCHPs provide these services through their own providers;

NOTE: Costly Durable Medical Equipment items, such as wheelchairs, generally require prior authorization. Smaller items, such as medical supplies, do no require prior authorization. A complete list of items which require prior authorization is available in the **Durable Medical Equipment and Medical Supplies Guid**e.

(e) Pulse oximeters, ventilators, home uterine monitoring apnea monitors and special air beds are prior authorized by the OMAP Medical Group for all clients, unless covered by an FCHP. Durable medical equipment and medical supplies in

the outpatient hospital setting are subject to the limitations established in the **Durable Medical Equipment and Medical Supplies Provider Guide**.

(7) Apnea Monitors, Services, and Supplies:

(a) For prior authorization of services for AFS, SDSD and CSD clients -- Contact the OMAP Medical Group;

(b) PCO clients -- Contact the OMAP Medical Group;

(c) FCHP clients -- FCHPs provide these services through their own providers.

(8) Out-of-State Services. For prior authorization contact OMAP Medical Group. Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require prior authorization unless specified in these rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require prior authorization.

(9) Home Parenteral/Enteral Therapy:

(a) Home Parenteral/Enteral Therapy includes: Home Hyperalimentation (TPN), Home Enteral Nutrition, Home IV Antibiotics, Home IV Analgesics, Home IV Chemotherapy, Home IV Hydrational Fluids, Home IV -- Other Drugs;

(b) OMAP does not cover home enteral/parenteral therapy as a hospital service. Hospital-based home health agencies and retail pharmacies which are enrolled by OMAP with separate provider numbers can provide home enteral/parenteral therapy. These services are not billed on the UB-92 form. Please see the **Home Enteral/Parenteral Nutrition and IV Services Provider Guide** for coverage and prior authorization rules.

(10) Drugs:

(a) A few medications, such as human growth hormone and Isotretinoin require prior authorization when provided in the outpatient setting. See the **Pharmaceutical Services Guide** for a complete list of drugs requiring prior authorization:

(b) PCO/FCHP clients -- FCHPs provide drugs. Some PCOs cover drugs. Contact the PCO/FCHP;

(c) Exceptions: Medications provided in an emergency do not require prior authorization.

(11) Private Duty Nursing:

(a) For prior authorization of services for AFS and CSD clients -- Contact the OMAP Medical Group;

(b) SDSD clients -- Contact the Senior and Disabled Services Division branch;

(c) PCO/FCHP clients:

(A) PCO clients -- Contact the OMAP Medical Group;

(B) FCHP clients -- Contact the FCHP.

NOTE: See the **Private Duty Nursing Services Guide** for additional information.

(12) Home Health Services:

(a) For prior authorization of services for AFS and CSD clients -- Contact the OMAP Medical Group;

(b) SDSD clients -- Contact the Senior and Disabled Services Division branch;

(c) PCO/FCHP clients:

(A) PCO clients -- Contact the OMAP Medical Group;

(B) FCHP clients -- Contact the FCHP.

NOTE: See the **Home Health Services Guide** for additional information.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-125-0086

Prior Authorization of Services Provided to PCO/HMO Clients

(1) Most non-emergency inpatient and outpatient services require the prior authorization of the PCO/HMO. Referral from the PCO/HMO is not required in an emergency. A "medical emergency" is defined, for purposes of the PCO/HMO contracts, as a condition in which treatment is required immediately in order to avoid death, serious disability, or other serious adverse medical consequences.

(2) Claims for emergency services are reviewed by the PCO/HMO for a decision on payment. This includes emergency out-of-state services. Some PCO/HMOs require that they be contacted as soon as possible when emergency services are provided. Work out the procedure with the PCO or HMO for obtaining the PCO/HMO's referral number. Once the PCO/HMO has reviewed the claim, the PCO or HMO will enter the referral number in Form Locator 83 and send the claim to OMAP for payment. HMOs will pay the claim directly. Contact the Plan directly with any questions about the process.

(3) The billing rules contain information on how to submit these claims.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93

410-125-0090

Inpatient Rate Calculations -- Type A and B Rural Oregon Hospitals

Hospitals designated as Type A and B Oregon hospitals by the Office of Rural Health receive retrospective cost-based reimburse-ment for all covered inpatient services effective with admissions occurring on or after July 1, 1991:

(1) Costs are derived from the most recent audited Medicare Cost Report and are adjusted to reflect the Medicaid mix of services;

(2) Payment for inpatient services provided to an individual age 21 and older is prorated to the number of hospital benefit days remaining at the time the claim is received. The claim is prorated to the number of hospital days remaining from the fiscal year in which the admission occurred;

(3) Type A and B hospitals are eligible for disproportionate share reimbursements (see OAR 410-125-0150), but do not receive cost outlier, capital, or medical education payments. Dispro-portionate share reimbursement to Type A and B hospitals is calculated as described in OAR 410-125-0150. Type A and B hospitals must meet the same standards for eligibility for disproportionate share payment as other hospitals, as described in OAR 410-125-0150.

Stat. Auth.: ORS Ch. 409

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 461-15-120(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 461-15-006, 461-15-036; 461-15-065 & 461-15-124; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-580; 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 410-125-860; HR 36-1993, f. & cert. ef. 12-1-93

410-125-0095

Hospitals Providing Specialized Inpatient Services

(1) Some hospitals provide specific highly specialized inpatient services by arrange-ment with OMAP.

(2) Reimbursement is made according to the terms of a contract between OMAP and the hospital.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-036; 461-15-065 & 461-15-124; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-580; 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 410-125-860

410-125-0100

OMPRO (Oregon Medical Professional Review) Procedures

(1)TheOfficeofMedical Assistance Programs (OMAP) approves or denies a request for non-emergency inpatient services based on recommendations from OMPRO's physician review findings. Requests to OMPRO for non-emergency inpatient hospital admissions may be submitted in writing or by phone.

(2) OMPRO has three working days to respond to a completed request for prior authorization. A completed request must contain all the information necessary for OMPRO staff to recommend approval, denial, or to require a second opinion.

(3) Criteria used by OMPRO to screen requests are: OMPRO developed surgical criteria, Interqual Adult and Pediatric Medical criteria, OMPRO Specialty Criteria for Psychiatric and Inpatient Rehabilitation Services, HCFA Generic Quality Screens, and criteria for services developed by OMAP in conjunction with OMPRO.

(4) OMPRO staff have the right to require that a client seek a second opinion from a contracted second opinion physician if the appropriate criteria have not been met, or if adequate information has not been submitted by the physician. If the requesting physician disagrees with the opinion of the second opinion physician, OMPRO has the right to require that a client seek a third opinion. If the second opinion physician disagrees with the requesting physician, the requesting physician may ask OMPRO to review the case after additional information is provided or may ask for a third opinion.

(5) If the second and third opinion physicians determine that the requested procedure or treatment is not likely to improve the basic health status of the client, or is not medically necessary, OMAP will deny the request for prior authorization of payment based upon the recommendation of OMPRO.

(6) The requesting physician may appeal a decision to deny reimbursement to OMAP.

(7) No payment will be made to the hospital or to the attending physician providing services during an inpatient hospital stay if the service is not authorized.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-200; HR 42-1991, f. & cert. ef. 10-1-91

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 Senior and Disabled Services Division (SDSD). These services must be provided, billed, and accounted for separately from other hospital services and in accordance with SDSD rules. Contact SDSD for further information.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-036; 461-15-065 & 461-15-124; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-580; 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 410-125-860

410-125-0102

Medically Needy Clients

(1) OMPRO 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 OMAP Medical/ Dental Group once the client has been made eligible and request retroactive authorization.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91

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 OMAP is the primary payer because the service is not covered by Medicare, the prior authorization requirements listed in these rules apply.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91

410-125-0115

Non-Contiguous Area Out-of-State Hospitals -- Effective for Hospital Services Provided on or After July 1, 1991

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 OMAP for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement. 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 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-020 & 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-570; 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 410-125-840

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 client's branch office for prior authorization for the transport or instruct the transportation provider to contact the branch.

(4) No prior authorization is required when the client's condition requires emergency transport.

(5) 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 rules for additional information.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-210; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0121

Contiguous Area Out-of-State Hospitals -- Effective for Hospital Services Provided on or After July 1, 1991

Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the border of Oregon. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement. 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 used to calculate the unit value at the 50th percentile). 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 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-020 & 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-570; 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 410-125-840

410-125-0124

Retroactive Authorization

(1) Authorization for payment can be granted after the service is provided. When the individual was not yet eligible for Medicaid at the time the services were provided. Payment can be made if the services are covered Medicaid services and the client's eligibility is extended back to the date the hospital provided services. See the billing rules for further information.

(2) Payment can be made for services which are covered Medicaid, services when another insurer denied the claim because the service was not covered by that insurer and the hospital did not obtain prior authorization because it had good reason to believe the service was covered by the insurer.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91

410-125-0125

Free-Standing Inpatient Psychiatric Facilities (IMDS)

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 Mental Health and Developmental Disability Services Division and the hospital.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-036; 461-15-065 & 461-15-124; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-580; 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 410-125-860

410-125-0130

Spinal Cord Injured Program

Reimbursement under the Spinal Cord Injured Program is made on a prospective payment basis for inpatient rehabilitative services provided by CARF and/or Joint Commission on Accreditation of Health Care Organizations (JCAHO) rehabilitative certified facilities for treatment of severe disabling spinal cord injuries. Services must be authorized by the Spinal Cord Injured Committee in order for payment to be made. Authorization for payment is given

only when the client meets the criteria established by the Committee and the client has used all hospital benefit days prior to admission to the rehabilitation unit. Contact OMAP for further information.

Stat. Auth.: ORS 184.750, 184.770, 409.010, 409.110, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-036; 461-15-065 & 461-15-124; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-580; 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 410-125-860; HR 54-1991, f. & cert. ef. 12-16-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93

410-125-0140

Prior Authorization Does not Guarantee Payment

(1) Prior authorization 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 prior authorization 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 Office of Medical Assistance Programs (OMAP) for payment.

(2) All prior authorized treatment is subject to retrospective review. If the information provided to obtain prior authorization cannot be validated in a retrospective review, payment will be denied or recovered.

(3) Hospitals should develop their own internal monitoring system to determine if the admitting physician has received prior authorization of service from OMPRO or OMAP.

(4) Refer to the **Quick Reference Prior Authorization Chart** in the **Hospital Services Guide** for prior authorization information and contacts on specific services. Hospitals may also verify prior authorization by calling OMPRO or OMAP provider services.

Stat. Auth.: ORS 184.750, 184.770, 409.010, 409.110, Ch. 411 & 414

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 461-15-220; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93

410-125-0141

Inpatient Rate Calculations for Other Hospitals (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 Classfication of Diseases, 9th Revision, Clinical Modification (ICD-9-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 individual claims to a DRG category. Medicare revises the Grouper program each year in October. OMAP 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, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals which may be affected by grouper logic changes in reaching a cooperative decision regarding changes.

(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, OMAP establishes a relative weight based on billed charges taken from the OMAP Title XIX claims history. OMAP employs a statistically valid methodology to determine whether enough claims exist to establish a reasonable weight for each DRG;

(c) For DRGs lacking sufficient volume, OMAP sets a relative weight using:

(A) OMAP non-Title XIX claims data;

(B) Federal DRG weights; or,

(C) Data from other sources expected to reflect a population similar to the OMAP Title XIX caseload.

(d) Relative weights will be recalculated when changes are made to the DRG Grouper logic. When relative weights are recalculated, the overall average CMI will be kept constant. Reweighting 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 Indexed: 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) Operating Costs:

(a) For the purposes of determining costs for all non-Type A and Type B hospitals, costs are defined as costs derived from the Medicare cost reports for the hospital FY ending during the State FY 87 (July 1, 1986 through June 30, 1987) adjusted to the Medicaid mix of services and trended forward using DRI inflation factors;

(b) For the purposes of determining each hospital's unit value for services beginning July 1, 1991, the following procedure was used:

(A) The Medicaid cost per discharge was derived from each hospital's Medicare cost report as described above, and adjusted to the Medicaid mix of services. The costs of capital and direct and indirect medical education were deducted from this amount (capital and education costs were taken from the Medicare cost report for the hospital's fiscal year ending during the State 1987 Fiscal Year). The resultant amount is referred to as the "operating cost" per discharge;

(B) The operating cost per discharge as described in (5)(A) of this rule (Operating Costs) for each hospital was adjusted in order to bring all hospitals to the same 1987 mid-point, using HCFA-DRI inflation adjustments. The operating cost was then inflated forward to the mid-point of Oregon Fiscal Year 1992 (January, 1992) using the compounded HCFA-DRI inflation factor.

(6) Unit Value:

(a) The Unit Value for each hospital effective for services beginning on or after July 1, 1991, was established as follows:

(A) The Oregon Fiscal Year 1992 operating cost per discharge from (5)(B) of this rule (Operating Costs) was multiplied by the ratio of the projected 1992 CMI to the 1987 CMI to adjust for changes in the CMI between 1987 and the CMI for 1992;

(B) The CMI-trend adjusted cost per discharge from (6)(A) of this rule (Unit Value) is divided by the hospital's projected 1992 CMI in order to compare all hospitals as though they had a CMI of 1.0;

(C) All hospitals, including Type A and B hospitals, are ranked by their Case Mix Index adjusted cost per discharge;

(D) Each hospital below the 70th percentile is assigned a Preliminary FY 1992 Unit Value equal to its CMI adjusted operating costs per discharge described in (5), Operating Costs. This preliminary FY 1992 Unit Value is reduced by the cost outlier payments which had been projected for FY 1992 (the projections which were the basis for the FY 1992 prospective rates). This preliminary unit value is further reduced by 2.45% to get the Final Unit Value for FY 1992. This shall also be the hospital's Unit Value for the period beginning December 1, 1993;

(E) Each hospital at or above the 70th percentile is assigned a Preliminary FY 1992 Unit Value equal to the Preliminary Unit Value of the hospital at the 70th percentile. This Preliminary FY 1992 Unit Value is adjusted downwards as required in order that the outlier payments which had been projected for FY 1992 combined with the Operational Payment will not exceed the hospital's FY 1992 Operating Cost per Discharge as described in (5), above. This preliminary unit value is further reduced by 2.45% to get the final Unit Value for FY 1992. This shall also be the hospital's Unit Value for the period beginning December 1, 1993;

(F) For services beginning on or after October 1, 1996 the Unit Values for each hospital shall be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors.

(7) DRG Payment: The DRG payment to each hospital is calculated by multiplying the Relative Weight for the DRG by the Hospital-Specific Unit Value. This is also referred to as the Operational Payment.

(8) Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services provided to Title XIX and SF (State Facility) clients;

(b) Effective for services beginning on or after July 1, 1991, the calculation to determine the cost outlier payment for all 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 case load;

(C) If the hospital's net costs as determined above are greater than 300 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 300% of the DRG payment, whichever is greater) are reimbursed at a percentage. The percentage of net costs (costs above the threshold) to be paid is established by OMAP and may be adjusted monthly as needed to maintain total cost outlier expenditures for the 1991-93 biennium at $8.0 million in Total Funds, excluding cost outlier payment made to Oregon Health Sciences University Medical Center;

(E) Third party reimbursements are deducted from the OMAP calculation of payable amount.

(c) Formula for Cost Outlier Calculation:

Table 3

Billed charges less non-covered charges

x Hospital-specific cost-to-charge ratio

= Net Costs

- 300% of the DRG or $25,000 (whichever is greater)

= Outlier Costs

x Cost Outlier Percentage

= Cost Outlier Payment

(A) The cost outlier percentage necessary to fully expend the cost outlier pool is estimated to be 30% for the biennium. OMAP will reimburse cost outlier claims at 50% of costs above the threshold and will monitor payments to determine the relationship between projected and actual outlier payments. An adjustment to the 50% reimbursement rate will be made as needed to fully expend the cost outlier pool. The amount of the cost outlier pool ($8.0 million) will not be exceeded. Cost outlier payments made to Oregon Health Sciences University Medical Center will not be deducted from this pooled amount;

(B) When hospital cost reports are audited, 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 OMAP 42, adjusted to reflect the Medicaid mix of services.

(9) Day Outliers:

(a) Effective for services beginning on or after July 1, 1991, a payment adjustment will be made to Oregon disproportionate share hospitals for services provided to Title XIX and SF children under the age of six who have exceptionally long lengths of stay. The threshold for day outlier claims is the Oregon Medicaid Geometric Average Length of Stay for the DRG plus 1.5 standard deviations or 30 days, whichever is the greater. (See appendices for Day Outlier Thresholds);

(b) Calculations to determine day outlier reimbursement for a claim are as follows: If the claim exceeds the day outlier threshold, the Oregon DRG payment is divided by the Average Length of Stay (ALOS), yielding a per diem payment. The hospital receives the DRG payment, plus the per diem payment multiplied by the number of days above the threshold, less third party reimbursements;

(c) Hospitals must apply for a day outlier payment. Claims reimbursed under the cost outlier methodology will not be considered for day outlier status.

(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 Office of Medical Assistance Programs uses the Medicare definition and

calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Capital cost per discharge is calculated as follows:

(A) The capital cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is divided by the number of Title XIX non-Medicare discharges. This results in the Title XIX Capital Cost per discharge. The Title XIX capital cost per discharge for each hospital above the 50th percentile will be set at the 50th percentile for Oregon hospitals receiving DRG reimbursement;

(B) The Title XIX Capital Cost per discharge for this period is inflated forward to Oregon FY 1992, using the compounded HCFA-DRI market basket adjustment.

(c) Capital Payment Per Discharge:

(A) The number of Title XIX discharges paid during the quarter for each hospital is multiplied by the Title XIX cost per discharge from 1987 trended forward as described above. This determines the current quarter's capital costs. Reimbursement is made at 85% of this amount. Payment is made within thirty days of the end of the quarter;

(B) The capital 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.

(12) 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 Office of Medical Assistance Programs 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 is 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%. 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.

(13) 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 Office of Medical Assistance Program's indirect medical education factor. This factor is used for the entire Oregon fiscal year;

(d) The calculation for the Indirect Medical Education Factor is as follows: Total relative weights from claims paid during the quarter multiplied by Indirect Medical Education Factor equals Indirect Medical Education Payment;

(e) 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.

[ED NOTE: The Appendices referenced in this rule are not printed in the OAR Compilation. Copies are available from the Department of Human Resources.] [Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

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410-125-0150

Disproportionate Share

(1) The Disproportionate Share payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs.

(2) A hospital's eligibility for disproportionate share payments is determined at the beginning of each fiscal year. Hospitals which 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 disproportionate share payments if they have been designated by their state Title XIX Medicaid program as eligible for disproportionate share reimbursements within that state:

(a) Criteria 1:

(A) The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days to total inpatient days is one or more standard deviations above the mean for all Oregon hospitals;

(B) Information on total inpatient days is taken from the most recent audited Medicare Cost Report;

(C) Information on total paid Medicaid days is taken from Office of Medical Assistance Program reports of paid claims for the same fiscal period as the Medicare Cost Report.

(b) Criteria 2:

(A) A Low Income Utilization Rate exceeding 25 percent;

(B) The low income utilization rate is the sum of percentages (3)(b)(B)(i) and (3)(b)(B)(ii) below:

(i) The Medicaid Percentage: The total of Medicaid inpatient and outpatient revenues paid to the hospital plus any cash subsidies received directly from State and local governments in a 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 audited 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 audited 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 care provided to individuals who have no source of payment, including third party and personal resources.

(C) 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 health insurance or third party payers, such as HMO's, Medicare, Medicaid, etc;

(D) The information used to calculate the Low Income Utilization rate is taken from the following sources:

(i) The most recent audited Medicare Cost Reports;

(ii) OMAP 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 which OMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

(E) OMAP determines within 30 days of receipt of all required information if a hospital is eligible under the Low Income Utilization rate criteria.

(c) Other Disproportionate Share Eligibility Requirements:

(A) To receive disproportionate share payments under Criteria 1, Criteria 2, and the "Additional Disproportionate Share Adjustments" described in section (3)(e) 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 who 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 which 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 audited Medicare Cost Report;

(C) Information on total paid Medicaid days is taken from Office of Medical Assistance Programs reports of paid claims for the same fiscal period as the Medicare Cost Report.

(d) Disproportionate Share Payment Calculations:

(A) Eligibility Under Criteria 1: The quarterly payment to hospitals eligible under Criteria 1 is the sum of 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 disproportionate share payment for the current quarter. The Unit Value used for eligible Type A and Type B hospitals is the Unit Value set 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 disproportionate share 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 10% to determine the disproportionate share 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 25% to determine the disproportionate share payment.

(B) 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 OMAP 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;

(C) For out-of-state hospitals, the disproportionate share 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 which have entered into agreements with OMAP for payment are reimbursed according to the terms of the agreement or contract.

(e) Additional Disproportionate Share Adjustments:

(A) Effective with the quarter beginning July 1, 1991, an additional disproportionate share reimbursement equivalent to 25% of the hospital's unit value multiplied by the total relative weights of non-Medicare Title XIX claims will be made to any hospital which provides 15% or more of all inpatient hospital services to State General Assistance clients (Hospital specific General Assistance days divided by Total Statewide General Assistance days). Information on the total hospital days for General Assistance clients is taken from the OMAP Reports of Claims for the period corresponding to the most recent audited Medicare Cost Reporting period;

(B) In addition to the above mentioned increase, effective with the quarter beginning July 1, 1991, an additional disproportionate share reimbursement equivalent to 25% of the hospital's unit value multiplied by the total relative weights of non-Medicare Title XIX claims will be made to any hospital which provides inpatient hospital services to 15% or more of Title XIX clients whose hospital benefit days have been exhausted prior to admission (Hospital specific Title XIX days denied because benefit days have been used divided by Total Statewide Title XIX days denied because benefit days have been used). Information will be taken from the most recent complete OMAP calendar year adjudicated claims.

(f) Disproportionate Share Payment Schedule:

(A) OMAP makes disproportionate share payments quarterly based on claims paid during the preceding quarter. Payments are made within 30 days of the end of the quarter. Hospitals which were eligible during one fiscal year but which are not eligible for disproportionate share status during the next fiscal year will receive disproportionate share

payments based on claims paid in the quarter in which they were eligible;

(B) Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, disproportionate share payments to public 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-disproportionate share hospital 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) Public hospitals that qualify under the "Transition Year Rule" as a high disproportionate share hospital may receive disproportionate share payments not to exceed 200 percent of the basic limit discussed previously. A high disproportionate share public hospital must have a Medicaid utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State. The Governor of the State of Oregon, through the signatory delegation to the Director of the Department of Human Resources, will also certify that the "applicable minimum amount" will be used for health care services. The applicable minimum amount is the difference between the amount of the disproportionate share hospital payment and the amount of the basic limit;

(D) The State has a contingency plan to insure that disproportionate share hospital payments will not exceed the "State Disproportionate Share Hospital 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. Disproportionate share payments are made quarterly based on claims paid during the preceding quarter. 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 "State Disproportionate Share Hospital Allotment." If the Allotment will be exceeded, the disproportionate share payments for the last quarter will be adjusted for each qualifying hospital by applying its proportional share of payments during the previous three quarters to total disproportionate share payments to all hospitals for that period. Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to disproportionate share payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

Stat. Auth.: ORS Ch. 409

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 461-15-120(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 461-15-006 & 461-15-124; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-620; 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 410-125-940; HR 36-1993, f. & cert. ef. 12-1-93; HR 24-1995, f. 12-29-95, cert. ef. 1-1-96

410-125-0155

Upper Limits on Payment of Hospital Claims

(1) Payments will not exceed total of billed charges:

(a) The total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost outlier, capital, direct medical education, and indirect medical education payments shall not exceed the individual hospital's total billed charges for the period for these services;

(b) If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total OMAP payment for those services, the overpayment shall be recovered;

(c) For Type A and B Rural Hospitals, reim-bursement shall be limited to the lesser of allowable costs or billed charges. This limitation shall be applied separately to inpatient and outpatient services.

(2) Payments will not exceed finally approved plan:

(a) Total reimbursements to a state-operated facility made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in a finally approved plan;

(b) Total aggregate inpatient reimbursements to all hospitals made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in a finally approved plan.

Stat. Auth.: ORS Ch. 409

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

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 in the Appendices.

(3) The final discharging hospital receives the full DRG payment. Hospitals receiving cost-based reimbursement receive the cost-based reimburse-ment prorated to the remaining hospital benefit days.

[ED NOTE: The Appendices referenced in this rule are not printed in the OAR Compilation. Copies are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-135; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-390; 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 410-125-480; HR 53-1991, f. & cert. ef. 11-18-91

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 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-020 & 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-570; 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 410-125-840

410-125-0175

Hospitals Providing Specialized Outpatient Services

Some hospitals provide specific highly specialized outpatient services by arrangement with OMAP. Reimbursement is made according to the terms of a written agreement or contract.

Stat. Auth.: ORS 184.750 & 184.770

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 Office of Medical Assistance Programs (OMAP) cannot exceed the facility's public billing rate.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-015; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-240; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0181

Non-Contiguous and Contiguous Area Out-of-State Hospitals -- Outpatient Services -- Effective for Hospital Services Provided on or After July 1, 1991

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 OMAP 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 an OMAP fee schedule.

(2) All other services will be reimbursed at 50 percent of billed charges.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-540; 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 410-125-780

410-125-0190

Type A and B Rural Oregon Hospitals

(1) Type A and B Rural Oregon Hospitals are those hospitals so identified by the Office of Rural Health.

(2) Reimbursement to Type A and B Rural Oregon Hospitals for covered outpatient services is as follows for all Medical Assistance clients:

(a) Reimbursement for all services, excepting laboratory services, is at 100 percent of costs;

(b) The interim reimbursement for laboratory services is the OMAP fee schedule. An adjustment to 100 percent of costs is made during the cost settlement period.

(3) Costs are derived from the most recent audited Medicare Cost Report, adjusted to the Medicaid mix of services.

Stat. Auth.: ORS Ch. 409

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 461-15-120(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 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-540 & 461-15-550; 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 410-125-780 & 410-125-800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93

410-125-0195

Other Hospitals -- Outpatient Services

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services will be reimbursed under an OMAP fee schedule.

(2) Other services are reimbursed as follows:

(a) For Title XIX clients, reimbursement is 59 percent of costs;

(b) Program GA, Program SF clients, reimbursement is 50 percent of billed charges or 59 percent of costs, whichever is less.

Stat. Auth.: ORS Ch. 409

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 461-15-120(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 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-540 & 461-15-550; 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 410-125-780 & 410-125-800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93

410-125-0200

Time Limitation for Submission of Claims

Office of Medical Assistance Programs (OMAP) 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 184.750, 184.770, Ch. 411 & 414

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 461-15-250; 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 End-Stage Renal Dialysis Facilities

End-stage renal dialysis facilities are reimbursed for Continuous Ambulatory Peritoneal Dialysis (CAPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemodialysis Composite at 80 percent of the Medicare allowed amount, except for Epoetin. Epoetin is reimbursed at 100 percent of the Medicare maximum allowed amount. Other dialysis related charges which are allowed by Medicare, are reimbursed at 80 percent of the Medicare maximum allowed amount. Allowable laboratory charges are reimbursed according to the OMAP fee schedule. Billed charges may not exceed the Medicare maximum allowable amount.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-124; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-560; 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 410-125-820

410-125-0210

Third Party Resources and Reimbursement -- Effective for Hospital Services Provided on or After July 1, 1991

(1)TheOfficeofMedical Assistance Programs establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the OMAP maximum allowable payment.

(2) OMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the OMAP reimbursement. OMAP 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) OMAP 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 OMAP allowable payment, less the Medicare payment, up to the amount of the deductible and/or coinsurance due. For clients who are Qualified Medicare Beneficiaries OMAP does not make any reimbursement for a service which is not covered by Medicare. For clients who are Qualified Medicare/Medicaid Beneficiaries OMAP payment is the OMAP 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. OMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations Section above. Payment is the OMAP 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. OMAP payment is the OMAP 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), OMAP payment is the OMAP 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. OMAP refers to these clients as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. OMAP refers to these clients as Qualified Medicare Beneficiaries (QMB). For QMB clients, OMAP does not make reimbursement for a service which is a not-covered service for Medicare.

EXAMPLE: Take home drugs are a not-covered Medicare service. OMAP will not make reimbursement for take home drugs provided to Qualified

Medicare Beneficiaries.

(d) Clients who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services which are not covered by Medicare if those services are covered by OMAP.

EXAMPLE: Take home drugs are a not-covered Medicare service. Take home drugs are a covered OMAP service. OMAP will make reimbursement for take home drugs provided to Qualified Medicare- Medicaid Beneficiaries.

(5) Clients with PCO or HMO Coverage. OMAP payment is limited to those services which are not the responsibility of the PCO or HMO. Payment is made at OMAP rates.

(6) Other Insurance:

(a) OMAP pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any third party payments;

(b) OMAP will make any additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the OMAP reimbursement, or 100 percent of billed charges.

(7) Medically Needy with Spend-Down. Reimbursement is the OMAP maximum allowable payment for covered services less the amount of the spend-down due.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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; Renumbered from 461-15-056; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-640; 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

410-125-0220

Services Billed on the UB-92 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 UB-92.

(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 UB-92 along with other impatient 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 OMAP through direct medical education or indirect medical education payments and may not be billed on the UB-92.

(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 UB-92 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. Office of Medical Assistance Programs (OMAP) will not reimburse the other provider or hospital;

(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. OMAP will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the UB-92.

(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 UB-92, along with all other inpatient services. The hospital is responsible for reimbursing the provider. Office of Medical Assistance Programs (OMAP) 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 a UB-92, 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 Guide**;

(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 Guide**.

(7) Dental Services. Dental services provided by hospitals are billed on the UB-92. Reimbursement for dental services provided by hospitals are restricted to those identified in the **Dental Services Guide** as covered services.

(8) End-State Renal Dialysis Facilities. Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the UB-92 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 Guide** contains information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the UB-92;

(b) Providers must bill using **Revenue Code 569** and the appropriate OMAP Unique Code (see the **Medical-Surgical Guide** for the codes).

(10) Home Health Care Services. Hospitals which operate home health care services must obtain a separate provider number and bill for these services in accordance with the **Home Health Care Services Guide**. These services are billed on the HCFA-1500.

(11) Hospital Operated Air and Ground Ambulance Services. A hospital which operates an air or ground ambulance service may apply to OMAP 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. OMAP 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 HCFA-1500 in accordance with the rules and restrictions contained in the **Medical Transportation Guide**.

(12) Supervising Physicians Providing Services in a Teaching Setting. Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the HCFA-1500 or the UB-92 only in accordance with the following regulations and documentation standards:

(a) The services of supervising faculty physicians are billed by the hospital on the UB-92 with other inpatient or outpatient charges under the following circumstances:

(A) The physician is serving as an employee of the hospital 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 OMAP Cost Report. The services of supervising faculty physicians are not to be billed to OMAP on either the HCFA-1500 or the UB-92 if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and OMAP cost report.

(b) The services of supervising faculty physicians are billed on the HCFA-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the phsician is receiving no reimbursement from the hospital for the period of time during which services are provided;

(c) Payments may be made by OMAP for professional services rendered to a client by a supervising physician under the following circumstances:

(A) The supervising physician provides personal and identifiable direction to interns or residents who are participating in the care of his or her patient; and

(B) The supervising physician is identified as the attending physician;

(C) In the case of major surgical procedures or other complex and dangerous procedures or situations, such personal direction must include supervision in person by the attending physician.

(d) Payments may be made for the services of a supervising physician who involves interns and residents in the care of his or her patients only if the physician's services to the patient are of the same character as the services the physician furnishes to his or her other paying patients in terms of responsibilities to the patient that are assumed and fulfilled by the supervising physician. The physician demonstrates these responsibilities by:

(A) Reviewing the patient's history and conducting a physical examination;

(B) Personally examining the patient within a reasonable period of time after admission;

(C) Confirming or revising diagnoses;

(D) Determining the course of treatment to follow;

(E) Assuring that any supervision needed by the interns and residents is furnished; and

(F) Making frequent review of the patient's progress.

(e) Notes made by the supervising physician in the patient's record must indicate that the above services have been provided by the supervising physician, even though the resident or intern may routinely write or dictate the physician's notes or operative reports and may provide a substantial proportion of the care to the patient.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-15-055, 461-15-130, 461-15-135; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-260, 461-15-290, 461-15-300, 461-15-310, 461-15-320, 461-15-420, 461-15-430; HR 42-1991, f. & cert. ef. 10-1-91; Renumbered from 410-125-280, 410-125-300, 410-125-320, 410-125-340, 410-125-540 & 410-125-560; 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

410-125-0221

Payment in Full

The payment made by Medicaid towards any inpatient or outpatient services, including cost outlier, disproportionate share, direct and indirect medical education, and capital payments, constitutes payment in full for the service.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-006, 461-15-020 & 461-15-124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-570; 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 410-125-840

410-125-0225

Inpatient and Outpatient Services: Summary of Reimbursements by Client Program and Provider Type

Table 2 consists of a summary of reimbursements by client program and provider type for inpatient and outpatient reimbursements.

[ED. NOTE: Table 2 referenced in this rule is not printed in the OAR Compilation. Copies are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 31-1980 (Temp), f. 6-30-80, ef. 7-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 62-1980(Temp), f. & ef. 9-11-80; AFS 9-1981, f. 1-29-81, ef. 2-1-81; AFS 39-1981(Temp), f. 6-30-81, ef. 7-1-81; AFS 80-1981, f. & ef. 12-1-81; 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 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; 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 461-15-035; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 18-1990 (Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert ef.7-9-90; Renumbered from 461-15-530; 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 53-1991, f. & cert. ef. 11-18-91; Renumbered from 410-125-760; HR 22-1993(Temp), f. & cert. ef. 9-1-93

410-125-0240

When to Bill on a Hard-Copy (Paper) UB-92

(1) The hospital must bill on a hard-copy UB-92 in the following circumstances:

(a) When attachments are required;

(b) When rebilling a Medicare claim previously sent to Blue Cross. When the hospital bills Medicare the first time, the claim will "crossover" automatically to Medicaid by entering the Medicaid and client information on the third party payer screen. These claims will be forwarded on tape by Blue Cross/Medicare to OMAP;

(c) When Medicare Interactive Terminal System (MITS) will not accept a claim, or the claim cannot be billed correctly on MITS.

(2) Multiple page hard-copy UB-92s cannot be processed by OMAP. If the hard-copy claim exceeds one page, the following procedures apply:

(a) Outpatient: Separate the charges into two claims. Do not duplicate **Revenue Codes** or **HCPCS Codes** unless billing different dates of service and the different dates of service are shown in Form Locator 45. For example, if the **Revenue Code 250** (Pharmacy) appears on one claim, it must not appear on the second claim unless the services were provided on different dates and the dates of service are shown in Form Locator 45;

(b) Inpatient: Do not separate the charges into two claims. Collapse several services into a single **Revenue Code** if needed to reduce the total number of line items to 22 or less. Do not use more than 22 **Revenue Codes** or line items on an inpatient claim.

(3) The limit on electronic claims is 28 line items.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-15-055; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-270; 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

410-125-0260

When Attachments are Required

When attachments are required, the claim must be submitted on a hard-copy (paper) UB-92. Attachments for the following must be submitted:

(1) Retroactive Medical: Documentation showing medical necessity for non-emergent services must be attached to the UB-92 if the patient becomes eligible retroactive to the date the services were provided.

EXCEPTION: Attachments are not required on claims for obstetrical and newborn services.

(2) Unlisted Lab, Radiology, Nuclear Medicine, CT Scans, MRI and Other Imaging Services Codes: Unlisted codes are manually priced by the Medical Group. Documentation describing the test or procedure performed is necessary to determine the appropriate payment. Send the claim with the description of the test or the procedure to OMAP.

(3) Claims over twelve months old:

(a) If the claim is now more than 12 months old and has been billed previously, submit a corrected copy of the claim, along with all remittance advices and any other information (such as payment information from another payer) necessary to review the claim;

(b) Claims more than 15 months old will not be accepted unless the branch or OMAP has made an error which resulted in a denial of payment, an incorrect payment, or the failure of the provider to bill within the 12 month limit. See General Rules for restrictions on submission of claims. Send claims to OMAP.

Stat. Auth.: ORS Ch. 409

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 36-1993, f. & cert. ef. 12-1-93

410-125-0360

Definitions and Billing Requirements

(1) Inpatient Services. Inpatients are patients who 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 an inpatient;

(b)A patient who expires on the day of admission is an inpatient.

(2)Outpatient Services:

(a)Outpatients are those patients who are typically 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 treament or observation room, or a short-term stay bed, with the following exception;

(c)When the stay exceeds 30 hours, services provided to patients admitted for ambulatory surgery, to a birthing center, a treatment or observation room, or a short-term stay bed must be billed as inpatient.

(3)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-92 for both inpatient and outpatient services provided under these circumstances, except as follows:

(a) If on the day of discharge, the client uses outpatient services at the same hospital, these must be billed on the UB-92 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 will be reimbursed

separately. Each hospital will bill for the services provided by that hospital.

(4) Outpatient Procedures Which Result in Inpatient Admissions. If, during the course of an outpatient procedure, an emergency develops requiring an inpatient stay, place a "1" in Form Locator 19 (Type of Admission). The principal diagnosis should be the condition or complication that caused the admission. Bill charges for the outpatient and inpatient services together.

Stat. Auth.: ORS Ch. 409

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 461-15-055; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-330, 461-15-340 & 461-15-380; 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 410-125-380 & 410-125-460; 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

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-92 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another 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 OMAP 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, OMAP will assume that a transfer has occurred. OMAP 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 OMAP 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 should not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS Ch. 409

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

410-125-0401

Emergent, Urgent, Elective Definitions and Distinctions

(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) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. "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 of 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 Guide** for requirements.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

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

410-125-0410

Readmission

(1) A patient whose readmission for surgery or followup 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. Only one payment will be made by OMAP 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) Readmissions occurring more than 15 days after the date of discharge or for an unrelated diagnosis are not subject to this rule.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 36-1993, f. & cert. ef. 12-1-93

410-125-0500

Outpatient Laboratory Services -- Diagnostic and TherapeuticRadiology,Nuclear Medicine, CT Scans, MRI, and Other Imaging Services

(1) Hospitals must use **HCPCS/CPT-4 Codes**, to bill OMAP. No modifiers are needed.

(2)The Technical Component is billed under **Revenue Codes 300-359, 400-409, 610-619, 923** and **925**. Modifiers are not used.

(3)The Professional Component is billed under **Revenue Codes 970 to 974**. Modifiers are not used. The professional component for CT Scans and MRIs should be billed under **972**.

(4)Bill using the most appropriate **HCPCS/CPT-4 Code**. Do not fragment lab services and bill separately unless the test was actually run separately. If records document that the test was run separately, you may bill a separate charge for the test. Tests which are run as panels would be billed using the most appropriate **HCPCS/CPT-4 Code** for panels. Refer to the **Medical-Surgical Guide** for additional information.

(5)A hospital may bill the Office of Medical Assistance Programs (OMAP) for the collection of blood through venipuncture or the collection of a urine sample by catheterization. These services, however, will not be reimbursed more than one time per day.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-055; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-400 & 461-15-410; 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 410-125-520

410-125-0580

Outpatient Physical Therapy, Occupational Therapy, Speech-Language Therapy, Audiology, and Durable Medcal Equipment

(1) These services are subject to the limitations in the Physical and Occupational Therapy Services, Speech-Language Pathology, Audiology and Hearing Aid Services, and Durable Medical Equipment provider guides. Providers must use one of the following ICD-9 codes in Form Locator 67 for services requiring prior authorization:

(a) V57.1 - Physical Therapy;

(b) V57.2 - Occupational Therapy;

(c) V57.3 - Speech-Language Therapy;

(d) V57.9 - Audiology;

(e) V58.9 - Durable Medical Equipment.

(2) Some Physical Therapy, Occupational Therapy, Speech-Language Therapy, and Audiology services do not require prior authorization. In these instances hospitals list the client's actual diagnosis in Form Locator 67

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-15-440; 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; HR 24-1995, f. 12-29-95, cert. ef. 1-1-96

410-125-0600

Non-ContiguousOut-of-StateHospital 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 OMAP for information on enrollment.

(3) Billings are sent to Office of Medical Assistance Programs.

(4) When the service provided is emergent or urgent, no prior authorization is required. The claim should be sent to OMAP 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: OMAP.

(6) Claims must be billed on the UB-92, unless other arrangements are made for billing through the OMAP.

Stat. Auth.: ORS Ch. 409

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 461-15-450; 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

410-125-0620

Special Reports and Exams and Medical Records

(1) Administrative Reports are copies of medical records requested by the branch office. The client's branch office staff may request copies of a client's medical records to use in determining eligibility for OMAP programs or for casework planning. Payment for copies of medical records is made at the hospital's outpatient rate.

(2) Billing for Reports:

(a) Use the UB-92 to bill for reports;

(b) Use Revenue Code 229 to bill for these reports. (Do not use this Revenue Code to bill for any other services.);

(c) If the patient is not eligible at the time the report is provided, obtain an ID number from the branch office before

billing;

(d) List the patient's name in Form Locator 12;

(e) No prior authorization number is needed;

(f) Use ICD-9-CM code V68.89 in Form Locator 67;

(g) Send the reports to the branch office making the request;

(h) Send the UB-92 to Office of Medical Assistance Programs (OMAP);

(i) Retain a copy of the OMAP 729 for your records.

(3) If the hospital has an agreement with a copying service to copy these records, the copying service may be paid directly by OMAP for these reports. The copying service must have a contract with OMAP regarding covered services and reimbursement; otherwise, the hospital is responsible for billing OMAP.

(4) Administrative Exams are diagnostic exams or evaluations (usually psychological, [or] psychiatric, physical therapy or occupational therapy evaluations) requested by the branch or OMAP to assist in determining eligibility or in case management.

(5) Administrative Exams require:

(a) If the patient is not eligible at the time services are provided, obtain an ID number from the branch office before billing;

(b) List the patient's name in Form Locator 12;

(c) Use ICD-9 code V68.89 in Form Locator 67;

(d) Send the report of the exam to the requesting branch;

(e) Send the UB-92 to Office of Medical Assistance Programs (OMAP);

(f) Retain a copy of the OMAP 729 for your records.

(6) Other Medical Records: No reimbursement will be made for any medical records requested by OMAP or its medical records review contractor or any agency or organization acting on OMAP's behalf, excepting those records referred to above. The provision of medical records to OMAP or its medical review contractor is required by 410-125-1060 and 410-125-1080.

Stat. Auth.: ORS Ch. 409

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 461-15-040; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-460; 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

410-125-0640

Third Party Payers -- Other Resources, Client Responsibility and Liability

(1) Medicare: Do not send claims to OMAP 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 OMAP without billing Medicare first;

(b) See the billing instructions for additional information on billing Medicare claims.

(2) Prepaid Health Plans. Prepaid health plans cover certain services provided to Prepaid Health Plan (PCO/FCHP) clients. Bill the service to the Prepaid Health Plan. The Plan will make payment directly to the hospital from that part of the service they cover (usually outpatient lab and x-ray and physician's services for PCOs; the whole bill for FCHPs). The PCO will send the bill to OMAP for payment of the remaining line items. In some instances, the PCO authorizes the hospital to send the bill directly to OMAP. Do not show the payment made by the Prepaid Health Plan in the prior payments field. It is not necessary to take off the claim any items which were billed to and paid by the Prepaid Health Plan. OMAP's computer automatically denies payment for these line items.

(3) Other Insurance. With the exception of services described in the General Rules, bill all other insurance first before billing OMAP. Report the payments made by the other insurers in Form Locator 54. (See billing instructions.) Also see Liability.

(4) Motor Vehicle Accident Fund:

(a) Enter 01 (Auto Accident) in the Occurrence Code Block (Form Locator 32 - 35) and give the date of the accident;

(b) For all other clients, bill all other resources before billing OMAP. Do not bill the Motor Vehicle Accident Fund.

(5) Employment Related Injuries: Enter 04 (Employment Re-lated Accident) in Form Locators 32 - 35 and give the date of oc-currence.

(6) 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 OMAP. The provider may not bill both OMAP and the insurer;

(c) The provider may bill OMAP after receiving a payment denial from the insurer; however, the OMAP billing must be within 12 months of date of service. Payment accepted from OMAP is payment in full;

(d) The provider may bill OMAP without billing the liability insurer. However, payment accepted from OMAP is payment in full. The payment made by OMAP may not later be returned in order to pursue payment from the liability insurer. When the provider bills OMAP, 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 OMAP. No payment will be made by OMAP under any cicumstances once the one year limit has passed if no billing has been received within that time.

(7) Adoption Agreements. Adopting parents and/or an adoption agency may be considered a prior resource. In some instances, OMAP makes reimbursement to hospitals and other providers for services provided to a mother whose baby is to be adopted. OMAP 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 OMAP for this service.

(8) 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 OMAP;

(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.

(9) Trust Funds. Some individuals will have trust funds which 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 OMAP for services which are covered by the trust fund.

(10) 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.

(11) The hospital may not bill the client under the following circumstances:

(a) For services which are covered by OMAP;

(b) For services for which OMAP has made payment;

(c) For services billed to OMAP for which no payment is made because third party reimbursement exceeds the OMAP maximum allowed amount;

(d) For any deductible, coinsurance or co-pay amount;

(e) For services for which OMAP has denied payment to the hospital as a result of one of the following:

(A) The hospital failed to supply the correct information to OMAP 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 authori-zation as described in these rules;

(C) The service provided by the hospital was determined by OMPRO or OMAP not to be medically necessary.

Stat. Auth.: ORS Ch. 409

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 461-15-080 & 461-15-126; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-470 & 461-15-480; 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 410-125-660; 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

410-125-0641

Medicare

(1) A Medicare/Medicaid claim can automatically be sent to OMAP after it has been adjudicated by Blue Cross/Medicare, saving the effort of a second submission, as well as ensuring a more accurate and speedier payment by OMAP. The correct Medicare payment, coinsurance, and deductible information will be automatically transmitted to OMAP by Blue Cross/Medicare.

(2) When hospitals bill Blue Cross/Medicare on MITS, the Medicaid information is entered on the TPR screen. The Medicaid Provider Number, prefixed with W is entered on the screen. See **Medicare MITS Manual** for more instructions.

(3) Hard-copy billings sent to Blue Cross/ Medicare can also be automatically sent to OMAP. "Medicaid", "OMAP", or "Welfare" is entered on line B or C (as appropriate) of UB-92 Form Locator 50 and complete Form Locators 52 and 53 (enter "Y" for both), 51, 58, 59, 60, and 68.

(4) Medicare/Medicaid claims cannot be billed directly to Medicaid on "Medicaid" MITS, except for outpatient claims where the only charges are for take home drugs (**Revenue Code 253**). All other electronic billings with Medicare/Medicaid coverage must be done through Blue Cross/Medicare.

(5) Billing Medicare Claims Hard-Copy. Do not bill claims to Medicaid until they have been billed to and adjudicated by Blue Cross/Medicare.

(6) Inpatient Services Billed on Hard-Copy:

(a) Medicare Part A:

(A) The amount of unpaid deductible is entered with the value code A1 in Form Locators 39 - 41. Do not put more than one entry in this field. Failure to correctly report the Part A deductible may result in incorrect payment;

(B) The amount of the Part A payment is entered in Form Locator 54A (Prior Payments, Payor A). Show the actual Medicare payment. Do *not* adjust the prior payment amount;

(C) XOVR is entered in Form Locator 11 if billing on a hard-copy UB-92.

(b) Medicare Part B only:

(A) When the client has Part B coverage only, the full charges are billed to Medicaid, including any charges which were submitted to and paid by the Part B payer;

(B) Enter Type of Bill 121 in Form Locator 4;

(C) Enter the amount of the Part B payment in Form Locator 54A (Prior Payments);

(D) Do *not* enter XOVR in Form Locator 11.

(7) Outpatient Services Billed on Hard-Copy:

(a) Medicare Part B:

(A) The amount of the deductible due is entered as value code A1 in Form Locators 39 - 41;

(B) The amount of the coinsurance due is entered as value code A2 in Form Locators 39 - 41;

(C) The amount of the Medicare payment is entered in Form Locator 54A;

(D) XOVR is entered in Form Locator 11.

(b) Medicare patients without Part B or with Part B but Part B does not cover this service: Do *not* enter XOVR in Form Locator 11.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93

410-125-0680

How to Complete the UB-92 for Medicaid

(1) Provider Identification: Enter provider name, mailing address and zip code. This information is needed on hard copy inpatient and outpatient claims only.

(2) Patient Control Number. The patient number assigned by the provider's office. This is optional. If the patient account number is entered here, OMAP will print this information on the Remittance Advice. The Remittance Advice will show up to 12 characters.

(3) Type of Bill. Enter the appropriate numeric code identified in the **UB-92 User's Manual**. This information is required on all claims. The following Type of Bill Codes are accepted by OMAP:

(a) 111 -- Inpatient (use for most inpatient billings, including patients with Medicare Part A coverage only);

(b) 121 -- Inpatient (use for inpatient billings for patients with Medicare Part B coverage only);

(c) 131 -- Outpatient;

(d) 721 -- Independent End-Stage Renal Dialysis Facilities;

(e) 141 -- Outpatient Referenced Diagnostic Services;

(f) 831 -- Hospital-Based Ambulatory Surgery.

(4) Patient's Name. The patient's name is entered as it appears on the Medical Care Identification. This information is required on all claims.

(5) Date of Birth. Date of birth is entered in month, day, year format. This information may be helpful to OMAP in processing the claim, but is not required.

(6) Admission Date. Admission date in month, day, year format is required on inpatient claims only. Enter the actual admission date, even if the patient was not eligible on that date.

(7) Admission Hour. The hour of admission is entered, using numbers from 00 to 23:00 = midnight, 01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m., 23 = 11 p.m., and so on. The hour is required on inpatient claims only.

(8) Type of Admission or Service. Use the following codes (see definitions of emergent, urgent, and non-emergent in this **Guide**):

(a) 1 -- Emergent. Also use for emergency transfers between hospitals and for the combined out-patient and inpatient bills when a non-emergency outpatient procedure resulted in an emergent admission to the hospital. Also use to bill for outpatient emergency dental services;

(b) 2 -- Urgent;

(c) 3 -- Elective. Enter Prior Authorization Number in Form Locator 91. See Prior Authorization Section for prior authorization requirements;

(d) 4 -- Newborn.

(9) Discharge Hour. Enter the Hour of Discharge, using numbers from 00 to 23 (as in Form Locator 16). The hour is required on inpatient claims only.

(10) Patient Status. Enter appropriate code as follows:

(a) 01 -- Discharged to home or self care (routine discharge);

(b) 02 -- Discharged or transferred to another acute care hospital;

(c) 03 -- Discharged or transferred to skilled nursing facility (SNF);

(d) 04 -- Discharged or transferred to an intermediate care facility (ICF);

(e) 05 -- Discharged or transferred to another type of institution (not another acute care hospital);

(f) 06 -- Discharged or transferred to home under care of home health service organization;

(g) 07 -- Left against medical advice;

(h) 08 -- Discharged to home under care of Home Enteral/Parenteral Provider;

(i) 20 -- Expired;

(j) This code is required on inpatient claims only.

(11) Statement Covers Period -- Use month, day, and year numeric format. Required on both inpatient and outpatient claims:

(a) Inpatient:

(A) "From" date is the date of admission;

(B) "Through" date is the date of discharge, transfer, or expiration;

(C) Total days in this field must equal the number of accommodation days in Form Locator 46. Do not count the day of discharge when calculating the number of accommodation days. See the **Revenue Codes** marked with a pound (#) sign. These are codes which count as days.

(b) Outpatient:

(A) "From" date is the date services began;

(B) "Through" date is the last date services were provided;

(C) Patient must be eligible on all dates on which services were provided. If you bill for more than one service or for a series of services, make certain the patient was eligible during the entire time for which you are billing.

(12) XOVR Indicator. (See General Information About Billing for additional information about Medicare billings):

(a) When billing Medicare directly and providing the Medicaid third-party payor information to Medicare, the claim will cross-over automatically; do not put XOVR in Form Locator 27;

(b) When billing on a hard-copy claim, enter XOVR as follows:

(A) Inpatient:

(i) Patient has Part A -- Enter XOVR in Form Locator 11;

(ii) Patient has Part B only -- Do not enter XOVR in Form Locator 11.

(B) Outpatient:

(i) Patient has Part A only -- Do not enter XOVR in Form Locator 11;

(ii) Patient has Part B -- Enter XOVR in Form Locator 11;

(iii) If the patient has Part B, but the service is not covered by Medicare, do not enter XOVR in Form Locator 11. Place an NC in the Remarks Section Form Locator 84.

(13) Occurrence Codes and Dates of Occurrence:

(a) Enter one of the following codes and the date of occurrence if applicable. Required on both inpatient and outpatient claims when applicable;

(b) 01 -- (Auto accident);

(c) 04 -- (Employment related accident).

(14) Special Program Indicator Condition Codes: A1 -- EPSDT/CHAP (Medicheck);

(15) HCPCS/Rates:

(a)Inpatient: No entry required;

(b)Outpatient: HCPCS codes are required for most services. Revenue codes requiring HCPCS are indicated in Table 1 of the **Hospital Services Provider Guide**;

(c)Enter the five-digit code. Modifiers are no longer required on either electronically billed or hard-copy UB-92 claims;

(d)When using unlisted HCPCS codes, a description is required for pricing. It is best to attach an explanation of the services which were provided and to bill on hard-copy.

(16)**Revenue Codes**. **Revenue Codes** are required on all claims:

(a) On each line of the claim, enter the **Revenue Code** which most accurately describes the service provided;

(b)Use an accommodation day **Revenue Code** if the patient was admitted and discharged, transferred or expired on the same day. **Revenue Codes** that count as accommodation days are designated by a pound sign (#) to the right of the **Revenue Code**. The accommodation day **Revenue Codes** may be used when the patient is seen in the outpatient setting (for example, for ambulatory surgical procedures). No days are deducted from the patient's hospital day benefits when an accommodation day **Revenue Code** is billed on an outpatient claim;

(c) The same **Revenue Code** may not appear on more than one line of an inpatient claim. You may report the same **Revenue Code** on multiple lines of an outpatient claim, as long as the lines are distinguishable by different HCPCS Codes in Form Locator 44 and/or different dates of service in Form Locator 45;

(d) Outpatient laboratory, diagnostic and therapeutic radiology, etc. -- Billing for technical and professional components;

(f)Bill using the appropriate **Revenue Code** for the technical component. If you are also billing for the professional component, use the appropriate **Revenue Code** from **Revenue Codes 971 through 979**. Bill the technical component using **Revenue Codes 300X, 310X, 32X, 33X, 34X, 35X, 40X,61X**;

(g)Bill The Professional Component Using **Revenue Codes 971, 972, 973, 974**.

NOTE:Revenue Codes are required on all claims.

(17)Units of Service:

(a) Enter total units of service or accommodation days. **Revenue Codes** marked with a # sign (see **Revenue Codes**) count as accommodation days on inpatient claims. A leave of absence day(s) counts as an accommodation day. MITS will not accept leave of absence of days. Bill these claims hard-copy;

(b) The total number of accommodation days must equal the number of days in Form Locator 7. The day of discharge (the date in the through Form Locator 6) is not counted by our computer as a day. However, the hospital should bill charges incurred on the day of discharge;

(c)For outpatient services which are provided over a period of time, more than one service may be billed on a single claim form. The From and Through Dates (Form Locator 6) must reflect the range of dates services were provided. The number of units of service for each **Revenue Code** should appear in Form Locator 46. For services which require prior authorization, such as physical therapy or occupational therapy, the units of service should not exceed the number of services prior authorized for that period of time. Units of Service are required on all claims after every **Revenue Code**.

(18)Total Charges. Enter the total charges. At the bottom of Form Locator 42, enter **Revenue Code 001**. At the bottom of Form Locator 47, enter the total charges. Do not include charges for noncovered services in this column. Total charges are required on all claims.

(19) Not Covered. Enter charges for not covered services in this field. Do not total these charges and do not include these charges in the total charges appearing in Form Locator 47.

(20) Payer Identification:

(a) Identify by name up to three payor organizations from which the provider might expect some payment for the bill;

(b) The block comprised of Form Locators 50 through 66 are identified as lines A, B and C. The information entered on line A in each of these form locators is for the primary payor, line B is for a secondary payor, and line C for an additional secondary payor. When billing a claim to OMAP, providers will need to reserve one line in this block for OMAP information. OMAP is secondary to all other insurances;

(c) If OMAP is the primary payor (i.e., there are no other insurances or prior resources), enter "OMAP" or "Oregon Medicaid" on Form Locator 50 line A. If there is a primary payor other than OMAP, e.g., Medicare, enter this insurer's name on line A, and enter "OMAP" on line B (or on line C if there is more than one payor primary to OMAP);

(d) This information is required.

(21) Principal Diagnosis Codes is required on all claims. Enter the **ICD-9-CM Diagnosis Code** best describing the principal discharge diagnosis (the condition responsible for admission of the patient to the hospital).

(22) Other Diagnosis Codes are required on all claims when applicable. Enter the **ICD-9-CM Diagnosis Codes** for up to four conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. "Other diagnoses" are conditions that affect patient care in terms of requiring clinical evaluation, or therapeutic treatment, or diagnostic procedures, or extended length of hospital stay, or increased nursing care and/or monitoring. This may affect the DRG assignment on inpatient stays.

(23) Principal Procedure required on inpatient and outpatient claims when procedures are performed. Enter the **ICD-9-CM Procedure Code** which best identifies the procedure completed. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or to treat a complication, or the procedure most related to the principal diagnosis.

(24)Other Procedure Codes and Dates are required on inpatient claims only. Enter **ICD-9-CM Codes** for up to two other procedures performed and the date on which the procedure was performed. Hospitals are not required to code diagnostic and therapeutic procedures such as CT scans, physical, occupational, or respiratory therapy, or radiological studies.

(25) Attending Physician ID:

(a) Enter the six-digit OMAP Provider Number or the UPIN of the attending physician;

(b) If the attending physician has no OMAP Provider Number, or the number is unknown, enter 999999 and the physician's name;

(c) The physician provider number is required on all inpatient claims, and required on all outpatient claims except Medicare/ Medicaid "crossover" claims received by OMAP directly from Medicare.

(26) Other Physician ID:

(a)Enter the provider number of any other physician who provided care, such as a surgeon. For patients referred by a Prepaid Health Plan or PCCM, the PCCM or Prepaid Health Plan's number appears in this field, with an R in front of the number. Generally, claims for services provided to PCO clients are submitted to the PCO for review and the PCO enters the PCO provider identification number;

(b)Required on inpatient and outpatient claims for most PCO services.

(27)Remarks:

(a) Use this space for Third Party Resource (TPR) explanation codes. These are two letter identifiers (in OAR 410-125-0681);

(b)Other information which may appear in this field includes:

(A) Itemization of services provided under **Revenue Code 512** (dental clinic) unless itemized on a separate attachment;

(B)A description of "unlisted" laboratory or radiology HCPCS Codes which will allow manual pricing;

(C)Other information helpful in processing the claim.

(c)Claims billed electronically have a limit of 100 characters which can appear in this field. Information other than Third Party Resource explanation codes appearing in the Remarks Section of an electronically billed UB-92 may not be reviewed. When you have important information about the claim, it is best to submit the claim hard-copy with the explanatory documentation attached.

(28) Value Codes: Units and Amounts: When billing OMAP, use these form locators to report Family Planning Percentage and Medicare Coinsurance and Deductible amounts, when applicable. Each Value Code data element consists of a two-character alphanumeric Value Code, along with a numeric Value Code Amount:

(a) Value Code -- A1 Deductible Payor A -- When Medicare is the primary payor, identify Medicare as Payer A in Form Locator 50. Use Value Code A1 to report the Part A or B deductible amount (show the dollars and cents money amount of the deductible in the amount portion of the form locator);

(b) Value Code -- A2 Coinsurance Payor A -- When Medicare is the primary payor, identify Medicare as Payor A in Form Locator 50. Use Value Code A2 to report the Part A or B coinsurance amount (show the dollars and cents money amount of the deductible in the amount portion of the form locator).

NOTE: OMAP does not require providers to report deductible and coinsurance value codes and amounts for primary insurers other than Medicare. When Medicare coverage is present, it will normally be reported as "Payor A" on the UB-92. However, in situations where Medicare is "Payor B",

use Value Codes "B1" and "B2" to report Medicare coinsurance and deductible.

(c) Value Code X0 Family Planning Percent -- When family planning services are a component of services billed on the claim, OMAP requests that providers estimate the portion of the total charges related to family planning. Use Value Code "XO" and report the percentage of family planning in the cents area of the amount field. Round to the nearest whole percentage. Report 100 percent as $1.

(29) Provider Number:

(a) Enter the six-digit OMAP provider number on the line (A, B, or C) which corresponds to the line used to identify OMAP in Form Locator 50;

(b) The OMAP provider number is required. OMAP does not require the provider number for other payers listed in Form Locator 50.

(30) Prior Payments -- Enter the actual amount of any payments received from a third party resource such as Medicare Part A, Part B, or other insurance on the line which corresponds to that payor's identification in Form Locator 50.

(31) Estimated Amount Due -- OMAP does not require the completion of this form locator, this information will not be used in processing claims.

(32) Cert -- SSN -- HIC -- ID Number:

(a) Use this field to report the patient's Medicaid Client ID number (aka "Prime Number"), using the line (A, B, or C) which corresponds to OMAP's identification in Form Locator 50. Enter the number as it appears on the client's Medical Care Identification Form (aka "Medical Card");

(b) Required on all claims.

(33) Treatment Authorization Codes -- For services which have been prior authorized by OMAP, enter the nine-digit authorization number in the line (A, B, or C) which corresponds to OMAP's identification in Form Locator 50.

(34) Service Date:

(a) Inpatient -- Not required;

(b) Outpatient -- Enter in MMDDYY format when applicable;

(c) There are two acceptable methods for billing for a series of services:

(A) You may list each date of service in Form Locator 45;

(B) You may bill for a series of services by indicating the number of units of service provided (Form Locator 45) and billing for the date range during which services were provided (Form Locator 6).

NOTE: If the method in paragraph (B) of this subsection is used, be sure all services requiring prior authorization are billed on a single claim. If a service is later billed for the same date range, the claim will be denied as a duplicate service already paid.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-490; 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 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; HR 4-1995, f. & cert. ef. 3-1-95

410-125-0681

Third Party Resource Explanation Codes

ThirdParty Resource Explanation codes, or "TPR" Codes are used in Form Locator 84 on the UB-92 when the client has other insurance. Select one code from either the single or the multiple insurance coverage lists below. Enter in Form Locator 84 on the UB-92. (Using more than one TPR code on a claim can delay processing):

(1) Single Insurance Coverage: Select most appropriate code below when patient has only one insurance policy in addition to Medicaid:

(a) UD -- Service Under Deductible;

(b) NC -- Service not Covered by Insurance Policy;

(c) PN -- Patient not Covered by Insurance Policy;

(d) IC -- Insurance Coverage Cancelled/ Terminated;

(e) IL -- Insurance Lapsed or not in Effect on Date of Service;

(f) IP -- Insurance Payment Went to Policyholder;

(g) PP -- Insurance Payment Went to Patient;

(h) NA -- Service not Authorized or Prior Authorized by Insurance;

(i) NE -- Service not Considered Emergency by Insurance;

(j) NP -- Service not Provided by Primary Care Provider/Facility;

(k) MB -- Maximum Benefits Used for Diagnosis/ Condition;

(l) RI -- Requested Information not Received by Insurance from Patient;

(m) RP -- Requested Information not Received by Insurance from Policyholder;

(n) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(o)AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days;

(p) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(2) Multiple Insurance Coverage: Select most appropriate code below when patient has more than one insurance policy in addition to Medicaid:

(a) MP -- Primary Insurance Paid -- Secondary Paid;

(b) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(c) MU -- Primary and Secondary Under Deductible;

(d) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(e) SS -- Primary Insurance Paid -- Secondary Service not Covered;

(f) SC -- Primary Insurance Paid -- Secondary Patient not Covered;

(g) ST -- Primary Insurance Paid -- Secondary Insurance Cancelled/Terminated;

(h) SL -- Primary Paid -- Secondary Lapsed or not in Effect;

(i) SP -- Primary Paid -- Secondary Payment Went to Patient;

(j) SH -- Primary Paid -- Secondary payment Went to Policyholder;

(k) SA -- Primary Paid -- Secondary Denied -- Service not Authorized or Prior Authorized;

(l) SE -- Primary Paid -- Secondary Denied -- Service not Considered Emergency;

(m) SF -- Primary Paid -- Secondary Denied -- Service not Provided by Primary Care Provider/ Facility;

(n) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(o) SI -- Primary Paid -- Secondary Denied -- Requested Information not Received from Policyholder;

(p) SR -- Primary Paid -- Secondary Denied -- Requested Information not Received from Patient;

(q) MC -- Service not Covered by Primary or Secondary Insurance;

(r)AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days;

(s) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: 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

410-125-0700

Revenue Codes -- For Services Provided on or After July 1, 1990

Revenue Codes may be added or deleted to conform with national billing standards and changes in Medicare. When Revenue Codes are altered or added to conform with national standards or to simplify billing procedures, the Revenue Code table will be updated and hospitals will be informed of the changes:

11X -- Room and Board -- Private (Medical or General)

0 -- General Classification

1 -- Medical/Surgical/Gyn

2 -- OB

3 -- Pediatric

4 -- Psychiatric

5 -- Hospice (not covered)

6 -- Detoxification

7 -- Oncology

8 -- Rehab/Private

9 -- Other

12X -- Room and Board -- Semi-Private (Medical or General)

0 -- General Classification

1 -- Medical Surgical/Gyn

2 -- OB

3-- Pediatric

4 -- Psychiatric

5 -- Hospice (not covered)

6 -- Detoxification

7 -- Oncology

8 -- Rehab/Semi-Private

9 -- Other

13X -- Semi-Private -- Three and Four Beds

0-- General Classification

1 -- Medical/Surgical/Gyn

2 -- OB

3 -- Pediatric

4 -- Psychiatric

5 -- Hospice (not covered)

6 -- Detoxification

7 -- Oncology

8 -- Rehab/3-4 Beds

9 -- Other

14X -- Private (Deluxe)

0 -- General Classification

1 -- Medical/Surgical/Gyn

2 -- OB

3 -- Pediatric

4 -- Psychiatric

5 -- Hospice (not covered)

6 -- Detoxification

7 -- Oncology

8 -- Rehab/Deluxe

9 -- Other

15X -- Room and Board Ward (Medical or General)

0 -- General Classification

1 -- Medical/Surgical/Gyn

2 -- OB

3 -- Pediatric

4 -- Psychiatric

5 -- Hospice (not covered)

6 -- Detoxification

7 -- Oncology

8 -- Rehab/Ward

9 -- Other

16X -- Other Room and Board

0-- General Classification

4 -- Sterile Environment

7 -- Self Care

9 -- Other

17X -- Nursery

0-- General Classification (nursery)

1 -- Newborn

2 -- Premature

5 -- Neonatal ICU

9 -- Other

18X -- Leave of Absence

Cannot be billed on MITS; bill hard-copy.

0 -- General Classification

-- Reserved (not covered)

2 -- Patient Convenience

3 -- Therapeutic Leave

4 -- ICF/MR -- Any Reason (not covered)

5 -- Nursing Home (for hospitalization) (not covered)

9 -- Other Leave of Absence

19X -- Not Assigned (Not Covered)

20X -- Intensive Care

0 -- General Classification

1 -- Surgical

2 -- Medical

3 -- Pediatric

4 -- Psychiatric

6 -- Post ICU

7 -- Burn Care

8 -- Trauma

9 -- Other Intensive Care

21X -- Coronary Care

0 -- General Classification

1 -- Myocardial Infarction

2 -- Pulmonary Care

3 -- Heart Transplant

4 -- Post CCU

9 -- Other Coronary Care

22X -- Special Charges

0 -- General Classification (not covered)

1 -- Admission Charge (not covered)

2 -- Technical Support Charge (not covered)

3 -- U.R Service Charge (not covered)

4 -- Late Discharge, Medically Necessary (not covered)

9 -- Other Special Charges. This Revenue Code is authorized only for Administrative Reports requested by branch office staff.

23X -- Incremental Nursing Charge Rate

0 -- General Classification

1 -- Nursery

2 -- OB

3 -- ICU

4 -- CCU

5 -- Hospice (not covered)

9 -- Other

24X -- All Inclusive Ancillary (Not Covered)

0 -- General Classification (not covered)

9 -- Other Inclusive Ancillary (not covered)

25X -- Pharmacy

0 -- General Classification

1 -- Generic Drugs

2 -- Non-Generic Drugs

3 -- Take Home Drugs

4 -- Drugs Incident to Diagnostic Services

5 -- Drugs Incident to Radiology

6 -- Experimental Drugs (not covered)

7 -- Non-Prescription

8 -- IV Solutions

9 -- Other Pharmacy

26X -- IV Therapy**

0 -- General Classification

1 -- Infusion Pump

9 -- Other IV Therapy

27X -- Medical/Surgical Supplies and Devices

0 -- General Classification

1 -- Non-Sterile Supplies

2 -- Sterile Supply

3 -- Take Home Supplies

4 -- Prosthetic/Orthotic Devices**

5 -- Pacemaker

6 -- Intraocular Lens**

7 -- Oxygen -- Take Home

8 -- Other Implants

9 -- Other Supplies/Devices

28X -- Oncology**

0 -- General Classification

9 -- Other Oncology

29X -- Durable Medical Equipment (Other Than Renal)**

Prior authorization of services is required for all outpatient services in this category.

0 -- General Classification

1 -- Rental

2 -- Purchase of New Durable Medical Equipment

3 -- Purchase of Used Durable Medical Equipment

4 -- Supplies/Drugs for DME Effectiveness (not covered)

9 -- Other Equipment

30X -- Laboratory**

0 -- General Classification

1 -- Chemistry

2 -- Immunology

3 -- Renal Patient (Home)

4 -- Non-Routine Dialysis

5 -- Hematology

6 -- Bacteriology and Microbiology

7 -- Urology

9 -- Other Laboratory

31X -- Laboratory -- Pathological**

0 -- General Classification

1 -- Cytology

2 -- Histology

4 -- Biopsy

9 -- Other

32X -- **Radiology -- Diagnostic****

0 -- General Classification

1 -- Angiocard Iography

2 -- Arthrography

3 -- Arteriography

4 -- Chest X-Ray

9 -- Other

33X -- **Radiology -- Therapeutic****

0 -- General

1 -- Chemotherapy -- Injected

2 -- Chemotherapy -- Oral

3 -- Radiation Therapy

5 -- Chemotherapy -- IV

9 -- Other

34X -- **Nuclear Medicine (Radioisotopes)****

0 -- General

1 -- Diagnostic

2 -- Therapeutic

9 -- Other

35X -- **CT Scan****

0 -- General

1 -- Head Scan

2 -- Body Scan

9 -- Other CT Scans

36X -- **Operating Room Services****

0 -- General Classification

1 -- Minor Surgery

2 -- Organ Transplant -- Other than kidney

7 -- Kidney Transplant

9 -- Other Operating Room Services

37X -- **Anesthesia**

0 -- General Classification

1 -- Anesthesia Incident to Radiology

2 -- Incident to Diagnostic Services

4 -- Acupuncture -- (Covered only when performed by a physician or physician'semployee-acupuncturist under a physician's supervision.)

9 -- Other Anesthesia

38X -- **Blood**

0 -- General Classification

1 -- Packed Red Cells

2 -- Whole Blood (not covered)

3 -- Plasma

4 -- Platelets

5 -- Leukocytes

6 -- Other Components

7 -- Other Derivatives (Cryoprecipitates)

9 -- Other Blood

39X -- **Blood Storage and Processing**

0 -- General Classification

1 -- Blood Administration

9 -- Other Blood Storage and Processing

40X -- **Other Imaging Services****

0 -- General

1 -- Mammography

2 -- Ultrasound

3 -- Screening Mammography

4 -- Positron Emission Tomography

9 -- Other Imaging Services

41X -- Respiratory Services**

0 -- General Classification

2 -- Inhalation Services

3 -- Hyperbaric Oxygen Therapy

9 -- Respiratory Services

42X -- Physical Therapy** Prior authorization of services is required for outpatient physical therapy services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.

0 -- General Classification

1 -- Visit Charge

2 -- Hourly Charge

3 -- Group Rate

4 -- Evaluation or Re-Evaluation

9 -- Other Physical Therapy

43X -- **Occupational Therapy**** Prior authorization of services is required for outpatient occupational therapy services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.

0 -- General Classification

1 -- Visit Charge

2 -- Hourly Charge

3 -- Group Rate

4 -- Evaluation or Re-Evaluation

9 -- Other Occupational Therapy

44X -- **Speech-Language Pathology**** Prior authorization of services is required for outpatient speech-language services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.

0 -- General Classification

1 -- Visit Charge

2 -- Hourly Charge

3 -- Group Rate

4 -- Evaluation or Re-Evaluation

9 -- Other Speech-Language Pathology

45X -- **Emergency Room****

0 -- General Classification

9 -- Other Emergency Room

46X -- **Pulmonary Function****

0 -- General Classification

9 -- Other Pulmonary Function

47X -- **Audiology**** Prior authorization of services is required for outpatient audiology services, unless Medicare Part B is the primary payer. Evaluations (471) do not require prior authorization.

0 -- General Classification

1 -- Diagnostic

2 -- Treatment

9 -- Other Audiology

48X -- **Cardiology****

0 -- General Classification

1 -- Cardiac Cath Lab

2 -- Stress Test

9 -- Other Cardiology

49X -- **Ambulatory Surgical Care****

0 -- General Classification

9 -- Other Ambulatory Surgical Care

50X -- **Outpatient Services**

0 -- General Classification

9 -- Other Outpatient Services

51X -- **Clinic****

0 -- General Classification

1 -- Chronic Pain Center (not covered)

2 -- Dental Clinic (Prior authorization of services is required for non-emergency services);

3 -- Psychiatric Clinic

4 -- OB/GYN Clinic

5 -- Pediatric Clinic

9 -- Other Clinic

52X -- **Free-Standing Clinic**

0 -- General Classification (not covered)

1 -- Rural Health -- Clinic

2 -- Rural Health -- Home (not covered)

3 -- Family Practice (not covered)

9 -- Other -- (not covered)

53X -- **Osteopathic Services**

0 -- General Classification

1 -- Osteopathic Therapy

9 -- Other Osteopathic Services

54X -- **Ambulance**

0 -- General Classification (not covered)

1 -- Supplies (not covered)

2 -- Medical Transport -- This **Revenue Code** must be used to bill for medical transportation costs incurred by an admitting hospital in the transport of patients to another facility or provider if:

(a) The other facility or provider provides a service not available at the admitting hospital; and

(b) The patient is returned to the admitting hospital within 24 hours. No other transportation services may be billed on the UB-92.

3 -- Heart Mobile (not covered)

4 -- Oxygen (not covered)

5 -- Air Ambulance (not covered)

6 -- Neonatal Ambulance Service (not covered)

7 -- Ambulance Pharmacy (not covered)

8 -- Telephonic EKG (not covered)

9 -- Other Ambulance (not covered)

55X -- **Skilled Nursing (Not Covered)**

0 -- General Classification (not covered)

1 -- Visit Charge (not covered)

2 -- Hourly Charge (not covered)

9 -- Other Skilled Nursing (not covered)

56X -- **Medical Social Services**

0 -- General Classification (not covered in outpatient setting)

1 -- Visit Charge (not covered in outpatient setting)

2 -- Hourly Charge (not covered in outpatient setting)

9 -- Other Medical Social Services** Covered in Outpatient Setting for Maternity Case Management Services Only. Use OMAP Unique Codes in Field 50 to bill these services.

57X -- **Home Health Aide (Home Health) (Not Covered)**

0 -- General Classification (not covered)

1 -- Visit Charge (not covered)

2 -- Hourly Charge (not covered)

9 -- Other Home Health Aide (not covered)

58X -- **Other Visits (Home Health) (Not Covered)**

0 -- General Classification (not covered)

1 -- Visit Charge (not covered)

2 -- Hourly Charge (not covered)

9 -- Other Home Health Visits (not covered)

59X -- **Units of Services (Home Health) (Not Covered)**

0 -- General Classification (not covered)

9 -- Home Health Other Units (not covered)

60X -- **Oxygen -- Home Health (Not Covered)**

61X -- **Magnetic Resonance Imaging (MRI)****

0 -- General Classification

1 -- Brain (including brain stem)

2 -- Spinal Cord (including spine)

9 -- Other

62X -- **Medical -- Surgical Supplies -- Extension of 27X**

1 -- Supplies Incident to Radiology

2 -- Supplies Incident to Other Diagnostic Services

63X -- **Drugs Requiring Specific Identification**

0 -- General Classification (not covered)

1 -- Single Source Drug

2 -- Multiple Source Drug

3 -- Restrictive Prescription

4 -- Epoetin, Under 10,000 Units Per Administration

5 -- Epoetin, 10,000 Units or More Per Administration

6 -- Drugs Requiring Detail Coding**

64X -- **not Assigned (Not Covered)**

65X -- **Hospice Services (Not Covered)**

0 -- General Classification (not covered)

1 -- Routine Home Care (not covered)

2 -- Continuous Home Care (not covered)

5 -- Inpatient Respite Care (not covered)

6 -- General Inpatient Care (non-respite) (not covered)

7 -- Physician Services (not covered)

9 -- Other Hospice (not covered)

66X -- **Respite Care -- Home Health (Not Covered)**

67X -- **Not Assigned (Not Covered)**

68X -- **Not Assigned (Not Covered)**

69X -- **Not Assigned (Not Covered)**

70X -- **Cast Room****

0 -- General Classification

9 -- Other Cast Room

71X -- **Recovery Room**

0 -- General Classification

9 -- Other Recovery Room

72X -- **Labor Room/Delivery**

0 -- General Classification

1 -- Labor

2 -- Delivery

3 -- Circumcision

4 -- Birthing Center

9 -- Other Labor Room/Delivery

73X -- **EKG/ECG (Electrocardiogram)****

0 -- General Classification

1 -- Holter Monitor

2 -- Telemetry, Including Fetal Monitoring

9 -- Other EKG/ECG

74X -- **EEG (Electroencephalogram)****

0 -- General Classification

9 -- Other EEG

75X -- **Gastro-Intestinal Services****

0 -- General Classification

9 -- Other Gastro-Intestinal

76X -- **Treatment or Observation Room**

0 -- General Classification

1 -- Treatment Room

2 -- Observation Room

9 -- Other Gastro-Intestinal

77X -- **Not Assigned (Not Covered)**

78X -- **Not Assigned (Not Covered)**

79X -- **Lithotripsy****

0 -- General Classification

9 -- Other

80X -- **Inpatient Renal Dialysis**

0 -- General Classification

1 -- Inpatient Hemodialysis

2 -- Inpatient Peritoneal (non-CAPD)

3 -- Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)

4 -- Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)

9 -- Other Inpatient Dialysis

81X -- **Organ Acquisition****

0 -- General Classification

1 -- Living Donor -- Kidney

2 -- Cadaver Donor -- Kidney

3 -- Unknown Donor -- Kidney

4 -- Other Kidney Acquisition

5 -- Cadaver Donor -- Heart

6 -- Other Heart Acquisition

7 -- Donor &endash;--Liver

9 -- Other Organ Acquisition

82X -- **Hemodialysis -- Outpatient or Home**

0 -- General Classification (not covered)

1 -- Hemodialysis/Composite or Other Rate

2 -- Home Supplies

3 -- Home Equipment

4 -- Maintenance/100 Percent

5 -- Support Services

9 -- Other Outpatient Hemodialysis

83X -- **Peritoneal Dialysis -- Outpatient or Home**

0 -- General Classification

1 -- Peritoneal/Composite or Other Rate

2 -- Home Supplies

3 -- Home Equipment

4 -- Maintenance/100 Percent

5 -- Support Services

9 -- Other Outpatient Peritoneal Dialysis

84X -- **Continuous Ambulatory Peritoneal Dialysis (CAPD) -- Outpatient or Home**

0 -- General Classification

1 -- CAPD/Composite or Other Rate

2 -- Home Supplies

3 -- Home Equipment

4 -- Maintenance/100 Percent

5 -- Support Services

9 -- Other Outpatient CAPD

85X -- **Continuous Cycling Peritoneal Dialysis (CCPD) -- Outpatient or Home**

0 -- General Classification

1 -- CCPD/Composite or Other Rate

2 -- Home Supplies

3 -- Home Equipment

4 -- Maintenance/100 Percent

5 -- Support Services

9 -- Other Outpatient CCPD

86X -- **Reserved for Dialysis (National Assignment)**

87X -- **Reserved for Dialysis (National Assignment)**

88X -- **Miscellaneous Dialysis**

0 -- General Classification

1 -- Ultrafiltration

9 -- Misc. Dialysis Other

89X -- **Other Donor Bank****

0 -- General Classification

1 -- Bone

2 -- Organ (other than kidney or cornea) (not covered)

3 -- Skin

9 -- Other Donor Bank

90X -- **Psychiatric/Psychological Treatments**

0 -- General Classification (not covered)

1 -- Electroconvulsive Therapy

2 -- Milieu Therapy (not covered)

3 -- Play Therapy (not covered)

9 -- Other**

(Somatotherapy services and psychiatric or psychological evaluations are the only services billable under this Revenue Code.)

91X -- **Psychiatric/Psychological Services**

0 -- General Classification (not covered)

1 -- Rehabilitation (not covered)

2 -- Day Care (not covered)

3 -- Night Care (not covered)

4 -- Individual Therapy (not covered)

5 -- Group Therapy (not covered)

6 -- Family Therapy (not covered)

7 -- Biofeedback (not covered)

8 -- Testing**

9 -- Other**

(Somatotherapy services and psychiatric or psychological evaluations are the only services billable under this Revenue Code.)

92X -- **Other Diagnostic Services****

0 -- General Classification

1 -- Peripheral Vascular Lab

2 -- Electromyogram

3 -- Pap Smear

4 -- Allergy Test

5 -- Pregnancy Test

9 -- Other Diagnostic Service

93X -- **Not Assigned (Not Covered)**

94X -- **Other Therapeutic Services**

0 -- General Classification**

1 -- Recreational Therapy (not covered)

2 -- Education/Training**

3 -- Cardiac Rehabilitation**

4 -- Drug Rehabilitation (not covered)

5 -- Alcohol Rehabilitation (not covered)

6 -- Routine Complex Equipment

7 -- Ancillary Complex Equipment**

9 -- Other Therapeutic Services**

95X -- **Not Assigned (Not Covered)**

96X -- **Professional Fees****

0 -- General Classification

1 -- Psychiatric

(Somatotherapy services and psychiatric or psychological evaluations are the only services billable under this Revenue Code.)

2 -- Ophthalmology

3 -- Anesthesiologist (MD)

4 -- Anesthetist (RN)

9 -- Other Professional Fees

97X Professional Fees

1 -- Laboratory**

2 -- Radiology* -- Diagnostic

3 -- Radiology* -- Therapeutic

4 -- Radiology* -- Nuclear Medicine

5 -- Operating Room

6 -- Respiratory Therapy

7 -- Physical Therapy (Outpatient services require prior authorization.)

8 -- Occupational Therapy (Outpatient services require prior authorization.)

9 -- Speech Pathology (Outpatient services require prior authorization.)

*Use the appropriate **HCPCS/CPT-4 Codes**.

98X -- **Professional Fees****

1 -- Emergency Room

2 -- Outpatient Services

3 -- Clinic

4 -- Medical Social Services (covered in inpatient setting only)

5 -- EKG

6 -- EEG

7 -- Hospital Visit

8 -- Consultation

9 -- Private Duty Nurse (not covered)

99X -- Patient Convenience Items (Not Covered)

0 -- General Classification

1 -- Cafeteria/Guest Tray

2 -- Private Linen Service

3 -- Telephone/Telegraph

4 -- TV/Radio

5 -- Nonpatient Room Rentals

6 -- Late Discharge Charge

7 -- Admissions Kits (covered)

8 -- Beauty Shop/Barber

9 -- Other Patient Convenience Items

** Denotes HCPCS required on outpatient claims.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: 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 33-1987(Temp), f. & ef. 7-22-87; 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 461-15-006; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-500; 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; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95

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 UB-82. 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 Remittance Advice. Documentation may be submitted to support the request. Attach a copy of the claim and Remittance Advice. Adjustment

requests must be submitted in writing to Office of Medical Assistance Programs -- (OMAP), Salem, OR 97309.

(3) How to complete an adjustment request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) Attach needed documentation;

(c) Mail the Adjustment Request to the address on the form;

(d) Enter the 13-digit Internal Control Number (ICN). This number can be found on the RA;

(e) Enter the client's eight-digit OMAP identifi-cation number in this space. This number can be found on the RA, or on the client' Medical Card;

(f) Enter the client's name as it is on the Medical Card;

(g) Enter your six-digit OMAP provider number;

(h) Enter the name of the hospital;

(i) Enter the date which is printed at the top of your RA;

(j) Description -- Possible areas you might want to change are listed. Only check those you want to change;

(k) Type of Service -- Use to correct the **HCPCS/CPT-4** modifier for laboratory and other outpatient procedures;

(l) Quantity/Unit -- Use to correct the number of services you are billing;

(m) Billed Amount -- The amount you billed OMAP;

(n) Procedure Code -- Use to correct the procedure code for laboratory and other outpatient procedures;

(o) Revenue Code -- Use to correct Revenue Codes;

(p) Insurance Payment/Patient Liability -- The payments from other sources;

(q) Other -- Use to correct **ICD-9-CM Codes** appearing on the RA. Use if none of the above address your problems;

(r) Line # -- List the line number from the original claim (UB-82) being adjusted;

(s) Service Date -- Enter the date the service was performed;

(t) Wrong Information -- Enter the incorrect information submitted on the original claim in this column;

(u) Right Information -- Enter the corrected information in this column;

(v) Remarks -- List any other information that is related to this Adjustment Request. The patient's account number may be entered here;

(w) Provider's Signature -- The provider or other authorized personnel must sign;

(x) Date -- Enter the date this form was completed.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-510; 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

410-125-1020

Filing of Cost Statement

(1) The hospital must file with Office of Medical Assistance Programs (OMAP), an annual Calculation of Reasonable Cost (OMAP 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 OMAP, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the OMAP 42 as that used for its Medicare Report;

(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 laboratory, radiology services, 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, OMAP will send the hospital a computer printout listing all transactions between the hospital and OMAP during that auditing period. The Calculation of Reasonable Cost Statement (OMAP 42) is due within 30 days of receipt by the hospital of the computer printout. Failure to file within the required period may result in a 20 percent reduction in the payment rate for a period of 90 days. After 90 days, payments may be discontinued if the cost statement has not been filed.

(3) Each Calculation of Reasonable Cost Statement submitted to OMAP must include a complete copy of the Hospital Statement of Reasonable Cost (Medicare Report) for the same fiscal period:

(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.

(4) 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.

(5) 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 OMAP. Hospitals filing false reports may also be referred to prosecution under applicable statutes.

(6) Each Calculation of Reasonable Cost Statement submitted to OMAP 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.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-121 thru 461-15-124; 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 461-15-105, 461-15-120 & 461-15-122; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-650; HR 42-1991, f. & cert. ef. 10-1-91

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 Office of Medical Assistance Programs (OMAP) personnel and Department of Health and Human Services (HHS) 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 OMAP to be eligible for Title XIX or Program 5 must be included as accruals, even those billings not yet paid.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-120(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 461-15-121; HR 21-1990, f. & cert ef. 7-9-90; Renumbered from 461-15-660; 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 Office of Medical Assistance Programs (OMAP) clients.

(2) The principal source document for the fiscal audit of Title XIX and General Assistance patient billings and payments for a given fiscal period is the OMAP data processing printout. This printout includes all transactions for the audit period. Using gross totals from this printout and applying other information from OMAP records, information received from the hospital, and other sources, OMAP will compile detailed schedules of adjustments and revise the gross totals. A revised Calculation of Reasonable Cost Statement (OMAP 42) will be prepared using revised totals and information from the Medicare report.

(3) Cost Settlements: OMAP will send the hospital a letter stating the amount of underpayment or overpayment calculated by OMAP for the fiscal year examined. Payment of the cost-settlement amount is due and payable within 30 days from the date of the letter. 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.

(4) In the event the provider chooses to appeal the decision or rate, a written request for an administrative review must be received by OMAP within 30 days of the date of the letter notifying the hospital of the settlement amount and interim rate. Upon receipt of the request; OMAP will attempt to resolve any differences informally with the provider prior to initiating a formal process.

(5) 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 under the fee schedule for laboratory and radiology 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 OMAP clients during the period the hospital was designated a Type A hospital. Settlements to Type B hospitals will be made within the legislative appropriation.

(6) Adjustments to the professional component for all hospitals will be made only to those items which are listed as professional fees (revenue codes 96X, 97X, and 98X from the Hospital Services for the Oregon Health Plan Guide) on the Hospital Claim Detail Reports and that are also carried as a line item on the Medicare Cost Report.

(7) 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 shall be finalized using the lower of cost or charges principle.

(8) 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 Ch. 409

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 461-15-120(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 461-15-122; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-670; 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

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 Office of Medical Assistance Programs (OMAP) upon request (**42 CFR 431.107**).

(2) All applicants for Title XIX or general assistance complete Form OMAP 415A or 415B authorizing the release of any records regarding his or her health. When requested by OMAP 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. OMAP may request sufficient information to evaluate the accuracy and appropriateness of **ICD-9-CM Coding** for the claim. In addition, OMAP may request an itemized billing for all services provided. OMAP will specify in its request what documentation is required

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-040; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-680

410-125-2000

Access to Records

(1) Providers must furnish requested medical documentation within 30 calendar days from the date of request. Failure to comply within 30 calendar days will result in recovery of payment made by Office of Medical Assistance Programs (OMAP) for services being reviewed.

(2) OMAP contracts with Oregon Medical Professional Review Organization (OMPRO) to conduct post payment review of admissions. OMPRO may request records from a hospital or may request access to records while at the hospital. OMPRO has the same right to medical information as OMAP.

(3) The hospital has 30 days to provide OMAP or OMPRO with copies of records. In some cases, there may be a more urgent need to review records.

(4) The Adult and Family Services Division's Third Party Resource (TPR) Unit conducts recovery activities for OMAP involving third party liability resources. TPR may request records from the hospital. This unit has the same right to medical and financial information as OMAP.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-040; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-690; HR 42-1991, f. & cert. ef. 10-1-91

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 Office of Medical Assistance Programs (OMAP) or OMPRO. 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-9 Coding**. Miscoded claims must be recoded;

(e) The appropriateness of the setting selected for service delivery;

(f) The quality of care of the services provided;

(g) The emergency nature of any service coded as an emergency;

(h) The accuracy of the billing.

(2) Medical emergency is defined as the sudden and unforeseen onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that immediate medical attention is needed to prevent:

(a) Placing the patient's health in serious jeopardy; or

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(d)Dental emergency is defined in the **Dental Services Guide**.

(3) If OMAP or OMPRO determines that a hospital admission was not medically necessary, the hospital and attending physician will be notified in writing and will have 20 days to provide additional written documentation to support the medical necessity of the admission and/or procedure(s).

(4) If the recommendation for denial is upheld by the reviewing contractor (OMPRO), the hospital and/or practitioner may request a reconsideration of the denial within 30 days of the receipt of the denial.

(5) If the reconsidered decision is to uphold the denial, payment will be recovered.

(6) The hospital and/or practicioner may appeal any finaldecisionthroughtheOMAP administrative appeals process.

(7) No payment will be made by OMAP for inpatient services determined not medically necessary by OMPRO acting on behalf of Medicare.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-090; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-700; HR 42-1991, f. & cert. ef. 10-1-91

410-125-2030

Recovery of Payments

(1) Payments made by OMAP will be recovered for:

(a) Services identified by the provider as emergent but determined, on retrospective review, not to have been emergent or urgent. Payment will also be recovered from the admitting and/or performing physician;

(b) A readmission to the same hospital if OMPRO determines that the readmission was the result of a premature discharge;

(c) Services which were billed but not provided;

(d) Services provided at an inappropriate level of care;

(e) OMAP non-covered services;

(f) Services which were covered by a third party payer or other resources;

(g) Services denied by a third party payer as not medically necessary.

(2) If review by OMAP results in a denial, the hospital may appeal any final decision through the OMAP Administrative Appeals process (see Administrative Hearings).

(3) As part of the Utilization Review Program, OMAP and/or its contractor will develop and maintain a data system profiling the patterns of practice of institutions and practitioners. As a result of these profiles, OMAP may initiate focused reviews. Any practitioner or hospital subject to a focused review will be notified in advance of the review.

(4) 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 OMAP rules or procedures, will be subject to corrective action. Actions taken will be those determined appropriate by OMAP, actions deemed appropriate by OMPRO, or sanctions established under state law or Oregon Administrative Rule and/or referral to a state or federal authority, licensing body or regulatory agency for appropriate action.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91

410-125-2040

Provider Appeals -- Administrative Review

(1) The Administrative Review process may be used by providers to request review of Office of Medical Assistance Programs (OMAP) decisions affecting the provider. See General Rules.

(2) A requests for an Administrative Review must be submitted in writing to the Medicaid Administrator, 203 Public Service Building, Salem, OR 97310.

(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 184.750, 184.770, Ch. 411 & 414

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 461-15-710; HR 42-1991, f. & cert. ef. 10-1-91

410-125-2060

Provider Appeals -- Hearing Request

If the hospital disagrees with the Office of Medical Assistance Programs (OMAP) calculation of reasonable costs for outpatient services or inpatient services, the outpatient interim rate, DRG 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 OMAP in accordance with the General Rules. 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 OMAP to consider in support of the appeal. The appeal will be conducted as described in

General Rules.

Stat. Auth.: ORS 184.750, 184.770 & Ch. 414

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 461-15-120(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 461-15-123; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-15-720; HR 42-1991, f. & cert. ef. 10-1-91

410-125-2080

Administrative Errors

(1) If a hospital has been given incorrect information by Office of Medical Assistance Programs, or by Adult and Family Services/Children's Services Division/Senior and Disabled Services Division/Mental Health and Developmental Disability Services Division 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 Remittance Advice printouts received on this claim;

(d) A copy of the original claim.

(3) Send the request: Office of Medical Assistance Programs, Provider Inquiry, Administrative Errors, Salem, OR 97310

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

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 461-15-730; HR 42-1991, f. & cert. ef. 10-1-91

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 127

HOME HEALTH CARE SERVICES

410-127-0000

Foreword

(1) The Home Health Care Services Guide is a user's manual designed to assist providers in program information and preparation of health claims for medical assistance clients. This Guide should be used in conjunction with the General Rules for Oregon Medical Assistance Programs.

(2) Administrative Rules, procedure codes, instructions on completing claim forms, and examples of forms are included in this Guide.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirement

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90

410-127-0020

Definitions

(1) "Acquisition Cost" -- The purchase price plus shipping.

(2) "Custodial Care" -- Care that is not related to a plan of care. Supervision is not required.

(3) "Division" -- The Adult and Family Services Division, Children's Services Division/State Office for Services to

Children and Families, Health Division, Mental Health and Developmental Disability Services Division, or Senior and Disabled Services Division of the Oregon Department of Human Resources.

(4) "Home" -- A place of temporary or permanent residence used as a person's home. This does not include a hospital or ICF/MR but does include assisted living facilities and adult foster care homes.

(5) "Home Health Agency" -- Any public or private agency which establishes, conducts or represents itself to the public as a home health agency or organization providing coordinated skilled home health services for compensation on a home visiting basis and licensed by the Oregon State Health Division as a Home Health Agency and certified by Medicare Title XVIII. 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.

(6) "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.

(7) "Home Health Aide Services" -- Home Health Aide Services 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 preventative 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.

(8) "Home Health Services" -- Only the services described in the OMAP Home Health Services provider guide.

(9) "Homebound" -- A client is considered homebound when:

(a) The client has a condition, due to an illness or injury which restricts his/her ability to leave his/her home, except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transitional equipment, or the assistance of another person; or

(b) The client has a condition for which is leaving home is medically contraindicated;

(c) The client has a condition for which the home is the most appropriate and cost-effective setting for the service. An individual may still be considered homebound if he or she leaves the home for short trips, e.g., an occasional trip to the barber, a walk around the block, or a drive. A lack of transportation does not qualify a client as homebound. If children (under age 21) attend day care centers or school, they are not considered homebound.

(10) "Medicaid Home Health Provider" -- A Home Health Agency licensed by the Health Division of the State of Oregon certified for Medicare and enrolled with OMAP as a Medicaid provider.

(11)"MedicalSupplies" -- Supplies prescribed by a phsician as a necessary part of the plan of care being provided by the home health agency.

(12) "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 to

675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.

(13) "Plan of Care" -- Written instructions explaining how the client is to be cared for. The plan is initiated by the Treating practitioner with assistance from Home Health Agency nurses and therapists. The plan must include but is not limited to:

(a) All pertinent diagnoses;

(b) Mental status;

(c) Types of services;

(d) Specific therapy services;

(e) Frequency of service delivery;

(f) Supplies and equipment needed;

(g) Prognosis;

(h) Rehabilitation potential;

(j) Functional limitations;

(j) Activities permitted;

(k) Nutritional requirements;

(l) Medications and treatments;

(m) Safety measures;

(n) Discharge plans;

(o) Teaching requirements;

(p) Goals;

(q) Other items as indicated.

(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 and/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.

(15) "Responsible Unit" -- The agency responsible for approving or denying payment authorization.

(16) "Skilled Nursing Services" -- The client care services pertaining to the curative, restorative or preventive aspects of nursing performed by a registered nurse or licensed practical nurse 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 others. 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.

(17) "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-LanguagePathologyand 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.

(18) "Title XVIII (Medicare)" -- Title XVIII of the Social Security Act.

(19) "Title XIX (Medicaid)" -- Title XIX of the Social Security Act.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 411-75-001; 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

410-127-0040

Coverage

(1) Home health services are made available as part of a written Plan of Care on a visiting basis to eligible clients in their homes.

(2) Home health services must be prescribed by a physician and the signed order must be on file at the Home Health Agency.

(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;

(c) Home Health aide services;

(d) Occupational therapy services;

(e) Occupational therapy evaluation;

(f) Physical therapy services;

(g) Physical therapy evaluation;

(h) Speech and language pathology services;

(i) Speech and language pathology evaluation;

(j) Medical/surgical supplies

Stat. Auth.: ORS Ch. 409

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 461-19-400 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 411-75-000; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95

410-127-0060

Reimbursement and Limitations

(1) Reimbursement. The Office of Medical Assistance Programs reimburses home health services on a per visit basis under an established fee schedule.

(2) Limitations:

(a) Limits of Covered Services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) OMAP 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;

(C) 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;

(D) Skilled nursing visits will be authorized if all other rules are met, when:

(i) Ordered services cannot be met by a private duty nurse; or

(ii) Private duty nurses are not available in the area.

(E) Medical supplies must be billed at acquisition cost and the total of all medical supplies revenue center codes may not exceed $75 per day;

(F) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not Covered Services:

(A) Medical Social Worker Services;

(B) Registered dietician counseling or Instruction;

(C) Drugs and Biologicals;

(D) Fetal Non-Stress Testing;

(E) Services not medically appropriate;

(F) Services 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);

(G) Respiratory therapist services.

Stat. Auth.: ORS Ch. 409

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 461-19-420 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 411-75-010; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95

410-127-0080

Payment Authorization

(1) Payment Authorization (PA) is approval by the Responsible Unit for services which are medically appropriate.

(2) Payment authorization is required for home health services as indicated in the Revenue Center Code section of the Home Health Care Services provider guide. 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. Authorization will be given based on medical necessity and appropriateness of services provided; authorization is not automatic. It is the provider's responsibility to obtain payment authorization.

(3) A payment authorization number must be present on all claims for home health services which require payment authorization or the claim will be denied.

(4) Where to request payment authorization:

(a) Managed health care clients -- services for clients identified on their OMAP Medical Care Identification as having an "OMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;

(b) AFS and CSD clients -- services for clients identified on their OMAP Medical Care Identification as Adult and Family Services (AFS and Childrens' Services Division (CD) will be authorized by OMAP;

(c) SDSD clients -- services for clients identified on the OMAP Medical Care Identification as Senior and Disabled Services Division (SDSD) clients will be authorized by the local branch designated on their Medical Care ID.

(5) Each payment authorization must include:

(a) Client's name;

(b) Medicaid recipient ID number;

(c) revenue center codes;

(d) Date range;

(e) Frequency of service;

(f) Performing provider number;

(g) Medical justification;

(h) Diagnosis and Primary ICD-9-CM code;

(i) Goals and Objectives;

(j) Assessment of availability of other resources to care for the client.

(6) To continue an authorization, submit the most current visit notes and justification for continuing services.

(7) Changing a payment authorization - requests to change an existing payment authorization should be mailed or FAXed to the Responsible Unit which issued the original authorization. Include the following information:

(a) Client's name;

(b) Medicaid recipient ID number;

(c) Payment authorization number;

(d) Change requested;

(e) Visit notes to support the change.

(8) Payment authorization does not guarantee eligibility. It is the provider's responsibility to verify eligibility on the date of service.

(9) Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of services.

Stat. Auth.: ORS Ch. 409

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 461-19-410 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 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 411-75-005; 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

410-127-0100

Billing Information

(1) If the client has the Basic Health Care Package, but is not enrolled in a prepaid health plan, bill with the appropriate Revenue Center Codes using the instructions on how to complete the UB-92.

(2) If the client is enrolled in the Medicare Part A, do not bill OMAP for home health services, bill Medicare. OMAP considers Medicare payment as payment in full.

(3) Submit your claim on a UB-92, electronically or on paper. Send the paper claim of the UB-92 to OMAP

(4) Do not put services that require payment authorization and services that do not require authorization on the same

claim form.

(5) Bill only one PA number per claim form.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 15-1995, f. & cert. ef. 8-1-95

410-127-0120

How to Complete the UB-92

The following fields are required to be completed. Use the Medicare Home Health Billing Manual format if optional Form Locators are include.

(1) Form Locator 1 - Provider Identification - Enter the provider name, mailing address and zip code if billing on a paper claim.

(2) Form Locator 4 - Type of Bill - enter the appropriate three-digit numeric code to identify the type of claim; codes are:

(a) First digit - Type of Facility - 3 denotes home health;

(b) Second digit - Classification - 2 denotes "in home visits";

(c) Third digit - Frequency/Definition - 1 denotes "Admit through discharge claim": used for a claim encompassing an entire home health care span of service for which the agency expects reimbursement. 2 denotes "first claim": used for the first of an expected series of payment claims for the same home health care start of care. 3 denotes "Interim-continuing claim": used when one or more payment claims for the same home health start of care have already been submitted and further claims are expected to be submitted at a later date. 4 denotes "Interim-last claim": used for a claim which is the last of a series for a home health start of care. The "through" date of this claim (Form locator 6) is the discharge date or date of death for this service span.

(3) For Locator 6 - Statement Covers Period - enter the beginning and ending dates of service covered by this claim, using MMDDYY format.

(4) Form Locator 12 - Patient's Name - enter the client's last name, first name and middle initial as it appears on the client's OMAP Medical Care Identification.

(5) Form Locators 24-30 - Condition codes - Enter A1 if EPSDT (Medicheck).

(6) Form Locator 42 - Revenue Codes - Enter the Revenue code which most accurately describes the service provided.

(7) Form Locator 46 - Service Units - Enter total units of service for each type of service. One visit equals one unit of service. One supply item equals one unit of service.

(8) Form Locator 47 - Total Charges - Enter the total charges petaining to the related code. At the bottom of Form Locator 42 enter Revenue Code 001. At the bottom of Form Locator 47, enter the total charge.

(9) Form Locator 50 - Payer Identification - Enter the names of up to three payer organizations in order. Line A for primary payer; line B for secondary payer and line C for tertiary payer. If Medicaid is primary, enter "Medicaid" one line A. If Medicaid is secondary or tertiary payer, enter the primary payer on line A and Medicaid on line B or C as

appropriate.

(10) Form Locator 51 - Provider number - Enter your six-digit OMAP provider number on the line (A, B or C) which corresponds to the line you used to identify OMAP in Locator Code 50. Your OMAP provider number is required. Do not use a Billing Provider Number. OMAP does not require that you report your provider number for other payers listed in Locator Code 50.

(11) Form Locator 54 - Prior payments - Enter the amount of any payments received from a third party resource on the same letter line as is in Form Locator 50.

(12) Form Locator 60 - Cert-SSN-HIC-ID No. - Enter the patient's Medicaid Identification number on the same letter line (A, B or C) that corresponds to the line on which Medicaid payer information is shown in Form Locator 50.

(13) Form Locator 63 - Treatment Authorization codes - Enter the nine digit prior authorization number for authorized services. The PA number will begin with the number 9.

(14) Form Locator 67 - Principal Diagnosis Codes - Enter the ICD-9-CM codes describing the principal diagnosis (i.e., the condition for which the plan of treatment was established and the patient taken into service). The ICD-9-CM must be carried out to its highest degree of specificity, (see OMAP General Rules for details). Do not enter decimal points or unnecessary characters.

(15) Form Locator 84 - Remarks - Use this space for the appropriate Third Party Resource (TPR) Explanation Codes:

(a) Third Party Resource (TPR) Explanation Codes - Single Insurance Coverage - (Use a single insurance code when the client has only one insurance policy in addition to Medicaid):

(A)UD -- Service Under Deductible;

(B)NC -- Service not Covered by Insurance Policy;

(C)PN -- Patient not Covered by Insurance Policy;

(D)IC -- Insurance Coverage Cancelled/ Terminated;

(E)IL -- Insurance Lapsed or not in Effect on Date of Service;

(F)IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H)NA -- Service not Authorized or Prior Authorized by Insurance;

(I) NE -- Service not Considered Emergency by Insurance;

(J) NP -- Service not Provided by Primary Care Provider/ Facility;

(K)MB -- Maximum Benefits Used for Diagnosis/Condition;

(L)RI-- Requested Information not Received by Insurance from Patient;

(M) RP -- Requested Information not Received by Insurance from Policyholder;

(N)MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O)OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made);

(P) AP -- Insurance mandated under administrative/court order through an absent parent - not paid within 30 days.

(b) Third Party Resource (TPR) Codes - Multiple Insurance Coverage -- (Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid:

(A)MP -- Primary Insurance Paid -- Secondary Paid;

(B)SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C)MU Primary and Secondary Under Deductible;

(D)PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Cancelled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K)SA -- Primary Paid -- Secondary Denied -- Service not Authorized or Prior Authorized;

(L)SE -- Primary Paid -- Secondary Denied -- Service not Considered Emergency;

(M)SF -- Primary Paid -- Secondary Denied -- Service not Provided by Primary Care Provider/ Facility;

(N)SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/ Condition;

(O)SI -- Primary Paid -- Secondary Denied -- Requested Information not Received from Policyholder;

(P)SR -- Primary Paid -- Secondary Denied -- Requested Information not received from Patient;

(Q)MC -- Service not Covered by Primary or Secondary Insurance;

(R)MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made)

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 12-1992, f. & cert. ef. 4-1-92; HR 15-1995, f. & cert. ef. 8-1-95

410-127-0160

Instructions on How to Complete the OMAP 505

(1) The following information must be entered on the OMAP 505:

(a) Patient's Name: The name as it appears on the Medical Card;

(b) Insured's Medicaid Number: The eight-digit number from the Medical Card;

(c) Insured's Group Number: The medicare number as it appears on the client's Medical Card. (Example: 123456789A or 234567890C1);

(d) Other Health Insurance Coverage: If no payment was received from Medicare, you must use this space to explain why no payment was made. Select a two-digit "Reason" code from the Third Party Resource (TPR) Codes that are found in the Billing Section of this Guide. Be sure that this "Reason" code is the first entry in Field 9, followed by the name of the Third Party Resource (Medicare). Example: Medicare paid nothing ("Reason" code -- NC, Not Covered). Enter: NC -- Medicare. Do not mail the Medicare EOB in with your claims;

(e) Date of Service: Must be numeric (10/10/90). If you use a "From -- To" date range, all services you provided for the month (that are billable on the OMAP 505) must be identified and billed on the same claim;

(f) Place of Service: Where service is provided:

(A) 4 = Patient's home;

(B) 7 = Nursing Facility Intermediate Care;

(g) Procedure Code: Enter only the OMAP Unique Procedure Codes listed in the Guide;

(h) Diagnosis Code: The single digit indicator for the diagnosis code from Field 23A that corresponds to the diagnosis for which service is rendered. Enter 1 when referring to the primary diagnosis; enter 2, 3, or 4 when referring to other diagnoses;

(i) Days or Units: Enter the number of services or units billed;

(j) Type of Service Codes (TOS): Use Type of Service "S";

(k) Charges Billed Medicare: Enter the total dollar amount you billed to Medicare for each service;

(l) Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare for each service;

(m) Provider Number: Enter your OMAP provider number here unless it is used in Field 34;

(n) Total Charge: Add the charges in Field 24G and enter the total dollar amount you billed Medicare;

(o) Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services;

(p) Balance Due: Subtract the amounts in Fields 28 and 30 from Field 27 and enter the balance in this field. You must put an amount in this field;

(q) Physician's or Supplier's Name, Address, Zip Code and Phone Number: Only your OMAP provider number is required.

(2) The following information must be entered on the OMAP 505 when appropriate:

(a) Was Condition Related To: Complete if service is related to an injury/accident;

(b) If an Emergency Check Here: If the service was performed as an emergency;

(c) Name of Referring Physician or Other Source: If this service is the result of a referral, enter the OMAP provider number of the referring (requesting) practitioner. If this service is the result of an HMO or PCO referral, the OMAP

provider number of the HMO or PCO Plan (not the practitioner) must be entered here. Enter the doctor's provider number if a client has a Medical Card showing doctor restrictions;

(d) Prior Authorization: Enter the prior authorization number here;

(e) Insurance Other than Medicaid/Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "0".

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90

410-127-0180

Individual Adjustment Request

(1) Overpayments, underpayments and payments received after OMAP has paid a claim can be resolved through the adjustment process.

(2) Obtain Individual Adjustment Request Forms from the AFS Forms Distribution Center.

(3) Note: Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation may be submitted to support your request. Adjustment Requests must be submitted in writing to: Office of Medical Assistance Programs.

(4) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) This is a reminder to attach needed documentation;

(c) Mail your Adjustment Request to this address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space;

(e) Enter the client's Medicaid identification number in this space. This number can be found on the RA or on the client's Medical Care Identification;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Care Identification;

(g) Enter your six-digit provider number in this space;

(h) This space is for your provider name;

(i) Enter the date printed at the top of your RA;

(j) Description: This column contains possible areas you might want to correct. Only check the box you want to change:

(A) Place of Service -- Leave blank:

(B) Type of Service -- Leave blank;

(C) Quantity/Unit -- Use to correct the number of services being billed;

(D) Revenue Center Code -- Use to correct Revenue Center Codes;

(E) Insurance Payment/Patient Liability -- Use to correct the payments from other sources;

(F) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(G) Billed Amount -- Use to correct the amount billed OMAP;

(H) Other -- Use this box to correct ICD-9-CM codes appearing on the Remittance Advice or use if none of the above address your problems;

(I) NDC/Procedure Code - Leave Blank.

(k) Line # -- Use the form locator number from the original claim UB-92 you are now adjusting;

(l) Service Date -- Enter the date you per-formed the service;

(m) Wrong Information -- Enter the incorrect information submitted on your original claim in this column;

(n) Right Information -- Enter the corrected information in this column;

(o) Remarks -- This is the area for you to give additional information or explain your request;

(p) Provider's Signature -- The signature of the provider or other authorized personnel must be in this space;

(q) Date -- Enter the date you completed this form.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 12-1992, f. & cert. ef. 4-1-92; HR 15-1995, f. & cert. ef. 8-1-95

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 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 or re-evaluation.

(5) Skilled nursing:

(a) 551 - Visit charge - PA;

(b) 559 - Other skilled nursing - evaluation.

(6) Home health aid -- 571 - Visit charge - PA

(7) Total charge -- 001 - Total Charge.

Stat. Auth.: ORS Ch. 409

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

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 128

FEDERALLY QUALIFIED HEALTH CENTER SERVICES

410-128-0000

Purpose

(1) The **Federally Qualified Health Centers Services Billing and Procedures Guide** is a manual designed to assist medical providers prepare health claims for medical assistance patients. The **Guide** must be used in conjunction with the "General Rules for Oregon Medical Assistance Programs".

(2) Instructions on completing claim forms, Administrative Rules, and examples of some completed forms are included in this edition. A section listing procedure and diagnosis code information is also included.

(3) The last section includes forms most commonly used in billing for Medicaid patients. Providers may duplicate these forms for their use.

(4) The Office of Medical Assistance Programs endeavors to furnish medical providers with up-to-date billing and procedural information along with guidelines to keep pace with program changes and governmental requirements.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 409.010

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91

410-128-0010

OregonMedicalAssistancePrograms Requirements for Federally Qualified Health Centers

(1) Federally Qualified Health Centers (FQHCs) are eligible for participation in the Oregon Medical Assistance Programs if they meet the following criteria:

(a) For those centers receiving Public Health Services (PHS) grant funds under authority of Section 329 -- Migrant Health Centers, Section 330 -- Community Health Centers, or Section 340 -- Services to Homeless Individuals, the provider must submit a copy of the notice of grant award with the Provider Application Form (OMAP 739) and the required documents;

(b) For those non-federally funded health centers that Public Health Services recommends, and the Health Care Financing Administration (HCFA) determines, should be designated as FQHCs (i.e., *Look Alikes*), the provider must submit a copy of the letter from HFCA designating the facility as a "*Look Alike*" or designating the facility as a non-federally funded health center with the Provider Application Form and the required documents;

(c) For those non-federally funded health centers that the Health Care Financing Adminis-tration (HCFA) determines may, for good cause, qualify through waivers of the HFCA requirements, the provider must submit a copy of the letter from HFCA designating the facility as a "*Look Alike*" with the Provider Application Form and the required documents as defined in OAR 410-128-0120. Waivers may be granted for up to two years;

(d) For those outpatient health programs or facilities operated by Indian tribes under the Indian Self-Determination Act and for certain facilities serving urban Indians, the provider must submit a copy of the award/contract from the Indian Health Service with the Provider Application Form and the required documents;

(e) The Provider Application Form and the required documents as defined in OAR 410-128-0120 will be reviewed by the Office of Medical Assistance Programs for compliance with program rules.

(2) Submit your completed Provider Application Form to the OMAP HPPU Unit. Submit your completed Federally Qualified Health Center Cost Statement, Federally Qualified Health Center Worksheet (OMAP 3032) and the required documents as defined in OAR 410-128-0120 to: The Office of Medical Assistance Programs, Quality Assurance Unit.

(3) The term "required documents" in this rule refers to documents defined in OAR 410-128-0120.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.085

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93

410-128-0020

Procedure Code, Prior Authorization, and Diagnosis Codes

(1) Procedure Code:

(a) Bill all Federally Qualified Health Center (FQHC) services on a HCFA-1500;

(b) Bill services for each encounter under the unique Office of Medical Assistance Programs (OMAP) procedure code 9600M except for diagnostic procedures for diagnoses that are below the funded line on the Health Service Commission's Prioritized List of Health Services. Bill such diagnostic services using procedure code FQ600.

(2) Prior Authorization: Prior authorization is not applicable to Federally Qualified Health Center services.

(3) Diagnosis Codes:

(a) Federally Qualified Health Centers must use diagnosis codes from the **ICD-9-CM Codebook**;

(b) Always enter the primary diagnosis code in Field 21 on the HCFA-1500;

(c) OMAP will accept up to three additional diagnosis codes only if the claim includes charges for services related to other diagnoses.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-128-0030

Health Insurance Claim Form (HCFA-1500)

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another or attach itemized billings. HCFA-1500 forms are not provided by OMAP. HCFA-1500 forms can be obtained through local forms suppliers. Completed HCFA-1500 forms must be sent to the Office of Medical Assistance Programs.

(2) The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight-digit number found on the OMAP Medical Care ID;

(b) Patient's Name: The name as it appears on the OMAP Medical Care ID;

(c) Diagnosis or Nature of Illness or Injury: Enter the primary diagnosis code first and subsequent Dx as needed. Only use diagnosis codes from **ICD-9**;

(d) Date of Service: Must be numeric (05/03/92). If "From -- To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(e) Place of Service: Where service is provided:

(A)1 = Inpatient hospital;

(B)2 = Outpatient hospital/OP Department;

(C)3 = Practitioner's office;

(D)4 = Patient's home;

(E)5 = Day care facility;

(F)6 = Night care facility;

(G)7 = Intermediate care facility;

(H)8 = Skilled nursing facility;

(I)A = Independent lab.;

(J) B = Other medical/surgical facility;

(K)C = Residential treatment center;

(L)D = Specialized treatment center.

(f) Type of Service Codes (TOS): Enter "1" in this field;

(g) Procedures, Services or Supplies: Enter 9600M or FQ600 in this field;

(h) Diagnosis Code: Use the one-digit line reference number from the Diagnosis or Nature of Illness or Injury Field;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service Field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge Field minus the information in the Amount Paid Field);

(m) Provider Number: Enter the OMAP billing or provider number here.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Care ID. When appropriate, use the Third Party Resource (TPR) Codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related To: Complete as appropriate when an injury is involved;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, FCHP/PCO (if the client is in a prepaid health plan);

(d) I.D. Number of Referring Physician: Enter the OMAP provider number of the referring provider, FCHP/PCO (if the client is in a prepaid health plan);

(e) EPSDT (Medicheck): This field is used only for Family Planning information: Family Planning: Put a "Y" in this box if treatment is related to family planning;

(f) Reserved for Local Use -- (Field 10d): Put a "Y" in this field if service was an emergency;

(g) Amount Paid: Enter the total amount paid from other resources.

(4) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service not Covered by Insurance Policy;

(C) PN -- Patient not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Cancelled/ Terminated;

(E) IL -- Insurance Lapsed or not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service not Authorized or Prior Authorized by Insurance;

(I) NE -- Service not Considered Emergency by Insurance;

(J) NP -- Service not Provided by Primary Care Provider/ Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/ Condition;

(L) RI -- Requested Information not Received by Insurance from Patient;

(M) RP -- Requested Information not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under adminis-trative/court order through an absent parent -- Not paid within 30 days (effective November 1, 1991);

(P) OT -- Other (if above codes do not apply, include detained information of why no TPR payment was made);

(Q) MD -- Medicare billed -- disposition delayed

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service not Provided by Primary Care Provider/ Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/ Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information not Received from Patient;

(Q) MC -- Service not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made)

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95

410-128-0040

Medicare/Medicaid Claims

(1) When a patient has both Medicare and Medicaid coverage, providers *must* bill Medicare first.

(2) Medicare will automatically forward all claims to OMAP for processing. However, since Federally Qualified Health Centers must bill OMAP using a *single* unique procedure code, these claims cannot be processed and paid automatically. A Remittance Advice instructing you to rebill OMAP on the HCFA-1500 claim form will be sent to you.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill OMAP using a HCFA-1500 claim form, but only after that carrier has made payment determination.

(4) When rebilling on the HCFA-1500, bill all services for each encounter under the unique OMAP procedure code 9600M or FQ600. Enter any Medicare payment received in the "Amount Paid" Field or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" portion of the HCFA-1500 claim form. Refer to OAR 410-128-0030 for detailed billing instructions.

(5) OMAP payment will be based on the allowable cost per encounter, less the actual Medicare payment amount.

Stat. Auth.: ORS Ch. 409

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

410-128-0060

Adjustment Requests

(1) Overpayments and under-payments received after OMAP has paid a claim can be resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a HCFA-1500.

(2) Documentation may be submitted to support your request. Adjustment Requests must be submitted in writing to the Office of Medical Assistance Programs (OMAP), P.O. Box 14952, Salem, OR 97309.

(3) How to Complete an Adjustment Request:

(a) Check the appropriate box for under-payments (OMAP paid too little) or overpayments (OMAP paid too much);

(b) This is a remainder to attach needed documentation;

(c) Mail the Adjustment Request to the address above;

(d) Enter the 13-digit Internal Control Number (ICN) printed on the Remittance Advice in Field 7;

(e) Enter the client's identification number. (Field 6 on the RA, or on the client's Medial Card);

(f) Enter the client's name. Use the same name as is shown on the Medical Card;

(g) Enter your six-digit Federally Qualified Health Center provider number;

(h) Enter your provider name;

(i) Enter the date printed at the top of your RA;

(j) Description -- This area contains areas you may want to change. Only check the box you want to change:

(A) Place of Service = Enter place where service is provided:

(i) 1 = Inpatient hospital;

(ii) 2 = Outpatient hospital;

(iii) 3 = Practitioner's office;

(iv) 4 = Patient's home;

(v) 5 = Day-care facility;

(vi) 6 = Night-care facility;

(vii) 7 = Intermediate care facility;

(viii) 8 = Skilled nursing facility;

(ix) A = Independent lab;

(x) B = Other medical/ surgical facility;

(xi) C = Residential treatment center;

(xii) D = Specialized treatment center.

(B) Type of Service -- Use only type of service "1";

(C) Quantity/Unit -- The number of services billed;

(D) Procedure Code -- Your must use 9600M;

(E) Revenue Center Code (Hospital only) -- Do not check this box. This is for hospital billing only;

(F) Insurance Payment/Patient Liability -- Payments from other sources or any payments received after your claim was submitted;

(G) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(H) Billed Amount -- The amount you billed OMAP;

(I) Other -- Use this box if none of the above address your problems.

(k) Line # -- List the line number from the original claim (HCFA-1500) you are now adjusting;

(l) Service Date -- Enter the date you performed the service;

(m) Wrong Information -- Enter the incorrect information submitted on your original claim in this column;

(n) Right Information -- Enter the corrected information in this column;

(o) Remarks -- Use this area to provide additional information regarding this request;

(p) Provider's Signature -- The provider or other authorized personnel must sign in this space;

(q) Date -- Enter the date you completed this form.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 12-1992, f. & cert. ef. 4-1-92

410-128-070

General Requirements

(1) The following rules and regulations apply to providers reimbursed under the Federally Qualified Health Center (FQHC) Program. In cases of conflict between the rules contained in subsections (a) and (b) of this section, subsection (a) of this section will prevail over subsection (b) of this section. The cost principles contained in **OMB Circular A-87** or **A-122** must be used by FQHC's. Use the circular appropriate to your clinic.

(a) Rules and Regulations:

(A) FQHC Administrative Rules;

(B) Oregon Medical Assistance Program General Rules;

(C) All other applicable Oregon Medical Assistance **Program Guides**.

(b) Cost Principles for State and Local Governments, **OMB Circular A-87** and **OMB Circular A-122**.

(2) Each FQHC shall:

(a) Maintain internal control over and accountability for all funds, property and other assets;

(b) Adequately safeguard all such assets and assure that they are used solely for authorized purposes

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-128-0080

Accounting and Record Keeping

(1) Federally Qualified Health Center (FQHC) Cost Statements (OMAP 3027) and the FQHC Cost Statement Work Sheet (OMAP 3032) must be completed by each FQHC operating a clinic in the State of Oregon and seeking payment as a FQHC. If a FQHC has several clinic sites, it must file individual cost statements for each clinic site operated by the FQHC unless specifically exempted by OMAP. To request an exemption write to OMAP. Include an explanation why the FQHC should be exempt. Unless an exemption is approved by OMAP, individual cost statements must be completed by each clinic site for all cost statements filed after July 1, 1994.

(2) Federally Qualified Health Center (FQHC) Cost Statements must be prepared in conformance with generally accepted accounting principles, the provisions of the Federally Qualified Health Center Administrative Rules, and all other applicable rules listed in OAR 410-128-0070.

(3) The provider must maintain, for a period of not less than five years from the end of the fiscal year the FQHC Cost Statement, Cost Statement Worksheet, a copy of its trial balance, audited financial statements, depreciation schedules, overhead cost allocation schedules, financial and clinical records for the period covered by such cost statement. The provider must maintain adequate records to thoroughly explain how the amounts reported on the FQHC Cost Statement were determined. If there are unresolved audit questions at the end of this five-year period, the records must be maintained until the questions are resolved. The records must be accurate and in sufficient detail to substantiate the data reported.

(4) Expenses reported as allowable costs must be adequately documented in the records of the provider or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee which states the purpose of the trip or activity, the date(s), the name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over $25.

(5) OMAP may require the FQHC to prepare special work papers or reports to support or explain data reported on the cost statement for current or previous periods. These work papers/reports must be completed by the FQHC within 30 days of OMAP's request. The FQHC may request up to 30 days extension if the request is made before the end of the original 30-day period. Any request for an extension must be in writing.

(6) The FQHC Cost Statement must be reconcilable to the audited financial records and encounters must be reconcilable to the Bureau's Common Reporting Requirements Report (BCRR) for those clinics where applicable. If the FQOC Cost Statement cannot be reconciled to the BCRR, the BCRR number will be used.

Stat. Auth.: ORS Ch. 409

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

410-128-0120

Filing Cost Statements

(1) Annually, each FQHC must file with the Quality Assurance Unit in OMAP the FQHC Cost Statement (OMAP 3027) and FQHC Cost Statement Worksheet (OMAP 3032), a copy of its trial balance, audited financial statements, depreciation schedules, and overhead cost allocation schedules. The FQHC Cost Statement is due 12 months (original submission period) after the end of the normal fiscal period, change of ownership, or withdrawal from the program. A 30-day extension may be granted for good cause if a written request is received and approved in writing by OMAP prior to the expiration of the original 12 months. No revisions may be made to the FQHC Cost Statement after the original submission period without prior approval from OMAP.

(2) The FQHC Cost Statement may be filed for less than a 12 month period only when necessitated by the FQHC terminating their agreement with OMAP, or by a change in ownership, or by a change in fiscal period. Cost statements containing up to 15 months of financial data will be accepted in conjunction with a change in fiscal year end.

(3) An improperly completed or incomplete FQHC Cost Statement will be returned to the facility for proper completion. Corrected cost statements must be returned to OMAP within 30 days of receipt. The cost statement will be considered incomplete if all the required documents are not provided when the cost statement is submitted.

(4) Each required FQHC Cost Statement must be signed by the authorized individual who normally signs the FQHC's federal income tax return or similar report. If the FQHC Cost Statement is prepared by someone other than an employee of the provider, the individual preparing the FQHC Cost Statement must also sign and indicate his or her status with the provider.

Stat. Auth.: ORS Ch. 409

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

410-128-0140

Encounter Rate Setting

(1) Existing provider -- The rate per encounter will be established from actual costs for the FQHC's preceding fiscal period as provided in the FQHC Cost Statement (OMAP 3027) and the audited financial statement within 30 days after the settlement is completed. Services provided on or after the effective date of the new rate will be paid at the new rate;

(2) New provider -- The rate per encounter, where no previous cost expense exists, will be established from estimated provider costs on the FQHC Cost Statement. The encounter rate will be limited to the lesser of estimated cost or the maximum payment as specified in OAR 410-128-0370 until a FQHC Cost Statement, based on actual costs, has been filed, reviewed, and accepted.

(3) The encounter rate will be the lesser of the all-inclusive encounter rate established by section (1) and (2) of this rule or the maximum payment per encounter established by OAR 410-128-0370.

Stat. Auth.: ORS Ch. 409

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

410-128-0150

Settlement

(1) Settlement will be based on the FQHC Cost Statement (OMAP 3027) information required under OAR 410-128-0120. Settlement is determined by dividing total allowable cost by total encounters times the number of Medicaid encounters as defined by OAR 410-128-0390 less the amounts already paid by OMAP and other third parties:

(a) Total encounters are defined in OAR 410-128-0380. All encounters that meet the definition in this rule must be included in total encounters;

(b) Allowable cost will be determined by the application of these FQHC rules to provider costs on the FQHC Cost Statement. Allowable costs are the necessary costs incurred for the customary and normal operation of a provider, to the extent that they are reasonable and related to providing services as defined in OAR 410-128-0380;

(c) OMAP Medicaid encounters are those encounters which meet the definition in OAR 410-128-0390.

(2) OMAP will determine a settlement within 12 months after the completed cost statement and all documents listed in OAR 410-128-0120 have been received.

(3) If OMAP elects to perform an on-site audit of the FQHC or a desk review, the settlement may be adjusted based on the audit or desk review.

(4) In no instance will the total amount paid to a clinic exceed the amount determined by the cap times Medicaid encounters plus the out-station expense.

Stat. Auth.: ORS Ch. 409

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

410-128-0155

Managed Care

Medicaid clients enrolled in managed health care plans require authorization from the plan before receiving plan covered and case managed services outside the plan. FQHCs should request an authorization or referral before providing services to Medicare clients enrolled in a health plan. Payment for these services is a matter between the FQHC and the plan authorizing the services.

Stat. Auth.: ORS Ch. 409

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

410-128-0260

Depreciation

OMB Circular A-87, 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 provider 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 provider are subject to approval by OMAP. Depreciation and amortization schedules must be maintained.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

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

410-128-0280

Related Party Transactions

(1) Costs of services, facilities, and supplies furnished to a provider by individuals or organizations related to the provider by common ownership or control are allowable at the lower of cost excluding profits and markups to the related party or charge to the provider. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. Documentation of costs to related parties shall be made available at time of audit. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(2) Rental expense paid to related individuals or organizations for facilities or equipment shall be allowable 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 Administrative Rules.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

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

410-128-0330

Compensation for Outstationed Eligibility Workers

To determine which part of the Outstationed Eligibility Worker's Expense (OSEW) should be charged to OMAP, calculate the percentage of the OSEW's total time spent performing eligibility services and multiply it by the total expense of the outstationed eligibility worker. This portion of the wages and benefits may be charged to OMAP on the FQHC Cost Statement.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 71-1-93

410-128-0350

Productivity Guidelines

(1) FQHCs are required to meet the Medicare FQHC productivity screening guidelines, however, BCRR encounters, rather than Medicare "visits" will be used in applying the screening guidelines. Current Medicare FQHC productivity screening guidelines are outlined in the **Federal Register, Volume 57, No. 114, dated June 12, 1992**. FQHCs are also

required to comply with any changes to this productivity standard upon publication of the standard as a final rule.

(2) If these measures are not met, the total number of encounters will be increased to the minimum productivity level to determine the settlement amount and the encounter rate

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-128-0370

Maximum Payment Per Encounter (FOHC "CAP")

(1) Medicaid reimburses FQHCs based on the providers' reasonable cost incurred in furnishing FQHC services to Medicaid clients. OMAP will impose a limit on the per encounter rate for encounters that take place between 1-1-94 and 12-31-94; and that limit shall be no less than the total of:

(a) The $88 reimbursement rate established for outpatient medical care in facilities operated by the Indian Health Service for calendar year 1993 as published in 58 **Federal Register** 17422 (4-2-93) plus the 1994 percentage increase in the Medicare Economic Index ("MEI") applicable to primary care physician services, as published in the **Federal Register**; and

(b) 75 percent of the difference (if any) between the total of term and condition (a) and the FQHC's actual per encounter rate.

(2) OMAP will impose a limit on the per encounter rate for encounters that take place between 1-1-95 and 12-31-95 and that limit shall be no less than the total of:

(a) The figure calculated in (1)(a) plus the 1995 percentage increase in the MEI applicable to primary care physician services; and

(b) 50 percent of the difference (if any) between the total of term and condition (2)(a) and the FQHC's actual per encounter rate.

(3) OMAP will impose a limit on the per encounter rate for encounters that take place between 1-1-96 and 12-31-96 and that limit shall be no less than the total of:

(a) The figure calculated in (2)(a) plus the 1996 percentage increase in the MEI applicable to primary care physician services; and

(b) 25 percent of the difference (if any) between the total of (3)(a) and the FQHC's actual per encounter reimbursement.

(4) OMAP will impose a limit on the per encounter rate for encounters that take place after 12-31-96 and that limit shall be no less than the figure calculated in (3)(a) plus the annual percentage increase in the MEI, and that limit shall be increased each year thereafter on January 1 by the MEI.

(5) The following example illustrates how the provisions of (1) through (4) would apply, assuming that an FQHC's actual per encounter rate remained at $140 per encounter between 1-1-93 and 12-31-98 and assuming that the MEI increased by 5 percent in 1993 and each year thereafter:

(a) The FQHC would be reimbursed $140 per encounter for encounters taking place between 7-1-93 and 12-31-93;

(b) The FQHC's per encounter reimbursement limit in 1994 would be $128.10 ($88 + $4.40 (MEI of 5% of $88) = $92.40; $140 - $92.40 = $47.60 x 75% = $35.70; $92.40 + $35.70 = $128.10);

(c) The FQHC's per encounter reimbursement limit in 1995 would be $118.51 ($92.40 + $4.62 (5% of $92.40) = $97.02; $140 - $97.02 + $42.98 x 50% = $21.49; $97.02 + $21.49 = $118.51);

(d) The FQHC's per encounter reimbursement limit in 1996 would be $111.40 ($97.02 + $4.85 (5% of $97.02)) = $101.87; $140 - $101.87 = $38.13 x 25% = $9.53; $101.87 + $9.53 = $111.40);

(e) The FQHC's per encounter reimbursement limit for 1997 would be $106.96 ($101.87 + $5.09 (5% of $101.87) = $106.96);

(f) The FQHC's per encounter reimbursement limit in 1998 would be $112.30 ($106.96 + $5.35 (5% of $106.96) = $112.31).

(6) For purposes of interim per encounter payment due an FQHC, the interim per encounter payment shall be based on the lessor of final per encounter rate determined in or as a result of the FQHC's most recent final cost report, or the encounter rate cap in effect during that period.

(7) For the period July 1, 1996 through June 30, 1997, the interim per encounter payment shall be based on the lesser of 95 percent of the final per encounter rate determined in or as a result of the FQHC's most recent final cost report, or 95 percent of the encounter cap rates in effect during this period of time.

(8) All providers have 12 months from the date a service is provided to submit a claim for payment to OMAP. In order to properly account for all claims and reconcile a settlement amount on the FQHC cost statement, all claims must be submitted to OMAP per OAR 410-128-0020 thru 410-128-0060.

(9) This payment limit does not apply to outstationed worker expense.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the office of the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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; HR 12-1996(Temp), f. & cert. ef. 7-1-96; HR 23-1996, f. 11-29-96, cert. ef. 12-1-96

410-128-0380

Total Encounters

(1) Each FQHC is required to report total encounters as defined in the **U.S. Department of Health and Human Service Bureau's Common Reporting Requirements (BCRR) Manual, Chapter III, A, 2, Definitions**. All encounters which meet this definition, except for section (2) of this rule, must be included in total encounters as reported on the FQHC Cost Statement (OMAP 3027).

(2) WIC encounters and all costs approved under the WIC contract must be excluded from the cost statement. All encounters generated by patient advocates/ombudsmen and outreach workers employed by or under contract with the FQHC and salary and fringe benefits or contract cost attributable to such workers must be excluded from the FQHC cost statements or reports. Cost allocation methods must be clearly documented.

(3) All documents, including original tally sheets and summary sheets used to calculate total encounters, must be maintained for five years. The original tally sheets must contain the following information:

(a) Patient's name;

(b) Date of service;

(c) Chart number and/or the patient number.

(4) The tally sheets must agree with the summary sheets and the summary sheets total must be the same as the amount reported on the FQHC Cost Statement.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-128-0390

Office of Medical Assistance Programs -- Federally Qualified Health Center Encounters

(1) FQHC encounters billed to OMAP must meet the definition in OAR 410-128-0380 and are limited to services which are part of the core services which are normally covered by Oregon Medicaid and other ambulatory services included in the State Plan under Title XIX of the Social Security Act. These services include:

(a) Physician services;

(b) Services and supplies furnished as an incident to a physician's professional services;

(c) Physician assistant, nurse practitioner, clinical psychologist or clinical social worker services;

(d) Services and supplies furnished as an incident to a physician assistant's, nurse practitioner's, clinical psychologist's or clinical social worker's services that would otherwise be covered if furnished by a physician or as incident to a physician's services;

(e) Registered professional nurse or licensed practical nurse services and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies); and

(f) Any other ambulatory services covered by Oregon's Medicaid Program.

(2) FQHC ambulatory services are any other ambulatory service included in the State Plan under Title XIX of the Social Security Act, Medical Assistance Program. Program limitations which are included in the State Plan also apply to "other ambulatory services" provided by an FQHC. In other words, services provided by an FQHC which meet the definition of "other ambulatory services" are covered using the same criteria as approved in the State Plan. Services provided by the FQHC which are not listed above and are not covered by the State Plan are not eligible for Medicaid reimbursement. See appropriate OMAP **Provider Guides** and OARs for additional clarification of billable services, limitations of coverage, and non-covered procedures. OMAP prior authorization does not apply to FQHCs.

(3) Excluded from the definition of OMAP FQHC encounters are all services provided to Medicaid clients for which a managed health care plan has entered into contract with OMAP to provide those services in return for capitation

payments.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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

410-128-0395

Sanctions

In addition to the Sanctions in General Rules for the Office of Medical Assistance Programs, the following apply to FQHCs:

(1) Failure to comply with OMAP rules and timelines specified in OAR 410-128-0010 through 410-128-0400 is considered noncompliance. This may result in reduction of the current encounter rate by 50 percent or to $40 per encounter, whichever is less.

(2) Continued noncompliance after an additional 60-day period has elapsed, beginning with the date the encounter rate was reduced as described in section (1) of this rule, may result in the loss of cost based reimbursement for the period of noncompliance. In this instance, cost settlement will be based on the reduced encounter rate as specified in section (1) of this rule.

(3) Continued noncompliance of more than 120 days after the encounter rate is reduced, as described in section (1) of this rule, may result in loss of cost based settlement and in disenrollment from the Oregon Medical Assistance Programs. The FQHC will not be permitted to re-enroll without first demonstrating to OMAP's satisfaction that it is complying with and will continue to comply with all OMAP rules.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 71-1-93

410-128-0400

Federally Qualified Health Center Cost Statement (OMAP 3027) Instructions

(1) The OMAP 3027 is a required form for Federally Qualified Health Center (FQHC) reimbursement. It must be completed each fiscal year. Reimbursement is based upon the actual allowable cost per encounter as defined in the **"Federally Qualified Health Centers Billing and Procedures Guide"**. The six page form must be submitted to the Office of Medical Assistance Programs (OMAP) within 120 days of the end of the FQHC's normal fiscal period, change of ownership, or withdrawal as a provider with OMAP. The FQHC Cost Statement must include all documents required by OAR 410-128-0120.

(2) Each section must be completed if applicable.

(3) (Page 1) Statistical Information:

(a) Enter the full name of the FQHC, the address and telephone number, the fiscal reporting period, the OMAP provider

number, and the name of the person(s) or organization(s) having legal ownership of the FQHC;

(b) List all other Federally Qualified Health Centers, medical providers, and suppliers, or entities owned by the FQHC by the OMAP provider number;

(c) List all physicians and health care providers furnishing services to the FQHC by the OMAP provider number;

(d) The FQHC Cost Statement must be pre-pared and signed by the FQHC accountant and an authorized responsible officer.

(4) (Page 2) Part A -- FQHC Provider Staff and Visits:

(a) FTE Personnel: List the total number of staff by position and enter a total on line 20;

(b) Encounters: List the number of on-site and off-site encounters by staff and enter a total on line 20.

(5) Part B -- Minimum Medical Team Productivity:

(a) Calculate the productivity level for physicians to determine if the productive screen was met;

(b) Calculate the productivity level for midlevel practitioners and visiting nurses, to determine if the required productivity screen was met.

(6) (Pages 3 - 4) -- Reclassification and Adjust-ment of Trial Balance of Expenses:

(a) Covered Health Care Costs, Non-Reimbursable Program Costs, Allowable Overhead Costs, and Non-Reimbursable Overhead Costs:

(A) Record the expenses for covered medical costs, non-reimbursable program costs, allowable overhead costs and non-reimbursable overhead costs provided by costs centers in columns 1 - 5 and enter the totals in column 6. (Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used.);

(B) Enter any reclassified expenses, adjustments (increase/ decrease) of actual expenses in accordance with the FQHC rules on allowable costs in column 7. (Attach documentation/explanation.);

(C) Enter the combined reclassified trial balance with the amount of adjustment in column 8;

(D) Enter the totals from each column under Covered Medical Costs on line 21;

(E) Enter the totals from each column under Non-Reimbursable Program Costs on line 29;

(F) Enter the totals from each column under Allowable Overhead Costs on line 48;

(G) Enter the totals from each column under Non-Reimbursable Overhead Costs on line 61.

(H) Enter the combined totals from lines 21, 29, 48 and 61 on line 62.

(7)(a) (Page 5) Determinations:

(b) Determination of Overhead Applicable to FQHC Services:

(A) Part A and B: Enter all totals from the previous pages of the FQHC Cost Statement as requested under overhead applicable to FQHC services and FQHC rate;

(B) Part C: If applicable, complete by entering the wages for your outstation workers on line C1, divide the wages by

the number of billable Medicaid encounters to determine the rate per encounter;

(C) Part D: Complete to determine the amount due to (or from) OMAP.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

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

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

410-129-0000

Foreword

(1) The **Speech-Language Pathology, Audiology and Hearing Aid Services Billing and Procedures Guide** is a user's manual designed to assist providers in preparing health claims for medical assistance clients. This **Guide** is used in conjunction with the General Rules for Oregon Medical Assistance Programs.

(2) Instructions on completing claim forms, Administrative Rules and examples of some completed forms are included in this **Guide**. A section listing procedure codes and their definitions, restrictions and limitations is also included.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91

410-129-0010

Purpose

In conjunction with the General Rules for Oregon Medical Assistance Programs, these rules are hereby established by the Office of Medical Assistance Programs (OMAP) for the purpose of supervising and controlling payments for speech-language pathology, audiology and hearing aid services provided to those Office of Medical Assistance Programs clients eligible to receive such services under the provisions of Oregon State Statutes. OMAP will reimburse for the lowest level of service that meets the medical need.

Stat. Auth.: ORS 184.750, 184.770 & Ch. 414

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 67-1985, f. 11-19-85, ef. 12-1-85; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; Renumbered from 461-21-300

410-129-0020

Therapy Goals/Outcome

(1) Therapy will be based on a plan of treatment with goals and objectives developed from an evaluation/assessment or re-evaluation.

(2) The therapy regimen will be taught to the patient, family, foster parents, and/or caregiver to assist in the achievement of the goals and objectives.

Stat. Auth.: ORS Ch. 409

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

410-129-0040

Maintenance

Therapy becomes maintenance when any one of the following occur:

(1) The therapy treatment plan goals and objectives are reached; or

(2) There is no progress toward the therapy treatment plan goals and objectives; or

(3) The therapy treatment plan does not require the skills of a therapist; or

(4) The patient, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are responsible for the maintenance therapy.

Stat. Auth.: ORS Ch. 409

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93

410-129-0060

Prescription Required

(1) Authorization of payment of speech-language pathology must be supported by written order of a physician (i.e., by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy) and a therapy treatment plan. The therapy treatment plan must be signed by a physician. The order and the therapy treatment plan will be reviewed and signed by the physician every six months. The physician's order must specify the services required.

(2) 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, preferably, 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 is an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS Ch. 409

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 461-21-301; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95

410-129-0065

Licensing Requirements

(1) Speech Pathologists:

(a) ORS Chapter 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology, OAR Chapter 335, will govern the practice of licensed speech pathologists. Licensed speech pathologists may enroll as providers and be reimbursed for services;

(b) Services of graduate speech pathologists under supervision of a licensed Speech Pathologist during the Clinical Fellowship Year are reimbursable to the licensed supervisor;

(c) Services of a licensed speech pathologist while teaching or supervising students in speech pathology will not be reimbursed.

(2) Audiologists. ORS Chapter 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology, OAR Chapter 335, will govern the practice of licensed audiologists. Licensed audiologists may enroll as providers and be reimbursed for services.

(3) Hearing Aid Dealers. ORS 694.015 through 694.199, Board of Hearing Aid Dealers licensing program, OAR Chapter 333, will govern the services by licensed hearing aid dealers. Licensed hearing aid dealers may enroll as providers and be reimbursed for services.

Stat. Auth.: ORS Ch. 409

Hist.: HR 27-1993, f. & cert. ef. 10-1-93

410-129-0070

Limitations

(1) Speech Pathology:

(a) All speech pathology services will be performed by a licensed speech pathologist or a graduate speech pathologist in the clinical fellowship year being supervised by a licensed speech pathologist;

(b) The rules contained in OAR 410-129-0010 to 410-129-0080 and 410-129-0220 also apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. They do no apply to services provided to hospital inpatients. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments is to be in accordance with the rules in their respective provider guides;

(c) Speech pathology therapy treatments may not exceed one hour per day, either group or individual. Treatment must be either group or individual, and cannot be combined in the autho-rization period;

(d) Therapy records must include:

(A) Documentation of each session;

(B) Therapy provided and amount of time spent; and

(C) Signature of the therapist.

(e) Documentation (progress notes, etc.) must be retained in the provider's records. All notes of graduate speech pathologists in the clinical fellowship year must be countersigned by the supervising licensed speech pathologist;

(f) Service of a graduate speech pathologist under direct supervision of a licensed speech pathologist during the Clinical Fellowship Year are reimbursable to the licensed supervisor under the following conditions:

(A) Supervision must occur on the same premises and the supervisor must be readily accessible to the resident performing the actual service;

(B) Documentation of the supervisor must clearly indicate her/his level of involvement in the delivery of each service in order to assure quality of care to the client;

(C) Documentation of the Clinical Fellow must show to the satisfaction of the agency that services are medically necessary in continuing the plan and treatment for the client in clear, legible notation.

(g) Services Which Do not Require Payment Authorization:

(A) One communications (speech/language) screening will be reimbursed per calendar year;

(B) Two assessments for speech/language will be reimbursed per calendar year;

(C) Two assessments for dysphagia will be reimbursed per calendar year;

(D) One assessment for augmentative communication system or device will be reimbursed per recipient per calendar year;

(E) One assessment for voice prosthesis or artificial larynx will be reimbursed per calendar year;

(F) Purchase, repair or modification of electrolarynx;

(G) Supplies for speech therapy will be reimbursed up to two times per calendar year, not to exceed $5 each.

(h) Services Which Require Payment Authorization:

(A) All speech pathology therapy treatments ;

(B) Augmentative communication system or device, purchase or rental. Rental of each device limited to one month. All rentals to apply to purchase price;

(C) Repair/modification of augmentative communication system or device.

(i) Services not Covered:

(A) Services of a licensed speech pathologist while teaching or supervising students of speech pathology will not be reimbursed;

(B) Maintenance therapy is not reimbursable as described in OAR 410-129-0040;

(2) Audiology and Hearing Aid Dealer Services:

(a) All hearing services will be performed by licensed audiologists or hearing aid dealers;

(b) One (monaural) hearing aid may be reimbursed every five years for adults who meet the following criteria (or more frequently if hearing thresholds have decreased significantly, as determined during at the authorized process):

(A) Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1,000, 2,000, and 3,000 Hertz (Hz) in the better ear. Submit the following information with the payment authorization request:

(i) History of hearing aid use;

(ii) Audiogram;

(iii) Physician's prescription indicating medical clearance for hearing aid use (see OAR 410-129-0060);

(iv) Pertinent medical history;

(v) Specific brand and model of hearing aid being requested.

(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. Submit a vision evaluation with the payment authorization request;

(d) If two hearing aids are being requested for an adult with low vision, there must be a statement of the need for two aids;

(e) Two (binaural) hearing aids will be reimbursed every three years for children. Please submit the following with the payment authorization request:

(A) History of hearing aid use;

(B) Audiometry;

(C) Physician's prescription (see OAR 410-129-0060);

(D) Pertinent medical history;

(E) Specific brand and model of hearing aid being requested.

(f) 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;

(g) Services Which Do not Require Payment Authorization:

(A) One basic audiologic assessment in a calendar year;

(B) One basic comprehensive audiometry (audiologic evaluation) -- per calendar year;

(C) One hearing aid evaluation/tests/selection -- per calendar year;

(D) One electroacoustic evaluation for hearing aid; monaural -- per calendar year;

(E) One electroacoustic evaluation for hearing aid; binaural -- per calendar year;

(F) Hearing aid batteries -- up to 6 per calendar year.

(h) Services Which Require Payment Authorization:

(A) Hearing aids;

(B) Repair of hearing aids, including earmold replacement. Maximum allowable for earmold replacement is $30; maximum allowable for repair of hearing aid is $100;

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices.

(i) 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 reimbursal separately;

(D) Aural rehabilitation therapy is included in the fitting and dispensing fee, and is not reimbursable separately;

(E) Cochlear implant supplies are not covered in this OMAP program. See the OMAP **Hospital Services Provider Guide**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Hist.: HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95

410-129-0080

Prior Authorization of Payment

(1) Prior authorization (PA) is approval by the OMAP Medical Group or Senior and Disabled Services Division branch office for services which are medically necessary. Prior authorization is required for Speech-Language Pathology, Audiology and Hearing Aid Services indicated in the procedure code section of the **Provider Guide** before the services are provided. Obtaining PA is the responsibility of the provider.

(2) The contact for prior authorization of payment is:

(a) Services for clients identified on the Medical Care Identification as Adult and Family Services (AFS) and Children's Services Division (CSD) clients will be prior authorized by the Office of Medical Assistance Programs. All required documentation shall be mailed to the address shown in the **Provider Guide**. Requests may also be faxed to OMAP. Indicate the OMAP Medical Group on the cover page;

(b) Services for clients identified on the Medical Care Identification as Senior and Disabled Services Division (SDSD) clients (except requests for augmentative communications systems or devices) will be prior authorized by the local branch designated on the Medical Care Identification.

(3) A copy of the written prescription or the OMAP 3071 (Prior Authorization and Status Report for Physical, Occupational and Speech Therapy Form, see Forms section) and a copy of the therapy treatment plan must be submitted

with each request. The request must document medical necessity (including diagnosis) and specify services requested (e.g., 30 minutes of speech therapy three times a week for two months). Include the following information on the OMAP 3071:

(a) Client's name;

(b) Procedure codes;

(c) Therapist's name;

(d) Date(s) of service;

(e) Usual and customary charge;

(f) Medicaid ID number;

(g) Provider number;

(h) Medical justification;

(i) Frequency, duration, length of service.

(4) Verbal authorization will be given for up to 30 days for urgent or emergent requests only. A 1072C will be sent to confirm the verbal authorization. The provider must send written medical justification within the first 15 days to obtain authorization for further services. If written justification is not received, no further services will be authorized.

(5) If services which require prior authorization are provided on an emergency basis, providers must contact the appropriate agency on the first work day following the emergency service to obtain necessary authorization.

(6) A Prior Authorization Number *mus*t be present on all speech-language pathology, audiology and hearing aid claims for procedure codes which require prior authorization or the claim will be denied for payment.

(7) A valid prescription of a physician is required for:

(a) A speech-language pathology services performed by a provider other than a physician;

(b) All hearing aids provided by an audiologist or hearing aid dealer.

(8) Requests to change an existing prior authorization should be mailed or faxed. Include the following information:

(a) Client name;

(b) Medicaid ID number;

(c) Prior authorization number;

(d) Documentation to support the requested change.

(9) Prior authorization does not guarantee eligibility; providers must check for eligibility on the date of service.

(10) Prior authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of services.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

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 461-21-310; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93

410-129-0100

Medicare/Medicaid Claims

(1) When an individual has both Medicare and Medicaid coverage audiologists must bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Payment will be made at OMAP rates. Payment will be based on either Medicare's maximum allowable rate or OMAP's maximum allowable rate, whichever is the lesser.

(2) Audiologists must bill all hearing aids and related services directly to OMAP on an OMAP 505. Prior authorization is required on most of these services. (See **Procedure Code Section** of this **Guide**.)

(3) If Medicare transmits incorrect information to OMAP, or if an out-of-state Medicare carrier or intermediary was billed, providers must bill OMAP using an OMAP 505 form. If any payment is made by OMAP, an Adjustment Request must be sub-mitted to correct payment, if necessary. Send all completed OMAP 505 forms to: Office of Medical Assistance Programs.

(4) Hearing Aid Dealers bill all services directly to OMAP on a HCFA-1500. Prior authorization must be requested where appropriate. (**See Procedure Code Section** of this **Guide**.)

(5) Speech Pathologists bill all services directly to OMAP on a HCFA-1500. Prior authorization must be requested where appropriate. (**See Procedure Code Section** of this **Guide**.)

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92

410-129-0120

How to Complete a HCFA-1500

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another. Completed HCFA-1500 forms must be sent to: Office of Medical Assistance Programs (OMAP). Unit further notice from OMAP, providers may bill using either the HCFA-1500 claim form dated 1/84 or the newly revised HCFA-1500, dated 12/90. If providers choose to use the 12/90 form, they must follow these instructions. If the unrevised HCFA-1500 billing form is used, providers must continue to use the instructions as they are currently shown in the **Provider Guide**.

(2) The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight-digit number found on the OMAP Medical Card;

(b) Patient's Name: The name as it appears on the OMAP Medical Card;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(e) Date of Service: Must be numeric (05/03/92). If "From -- To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(f)Place of Service: Where service is provided:

(A) 2 &endash; Outpatient hospital/OP department;

(B) 3 &endash; Practitioner's office;

(C) 4 &endash; Patient's home;

(D) 7 &endash; Intermediate care facility;

(E) 8 &endash; Skilled nursing facility;

(F) C &endash; Residential treatment center.

(g) Type of Service Codes (TOS): Use Type of Service "J" in this field;

(h)Procedures, Services or Supplies: Use only the CPT Codes, HCPCS Codes or OMAP Unique Codes listed in the **Speech-Pathology Guide**;

(i)Charges: Enter a charge for each line item;

(j)Days or Units: This number must match the number of days in the Date of Service Field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge Field minus the information in the Amount Paid Field);

(m) Provider Number: Enter the OMAP billing or provider number here.

NOTE: Only one number may be entered in this field.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Card. Use the Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related To: Complete as appropriate when an injury is involved;

(c) Reserved for Local Use (Field 10d): Put a "Y" in this field if the service was an emergency;

(d) Prior Authorization Number: If required, enter the Prior Authorization number here;

(e) Reserved for Local Use -- (Field 24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(f) Amount Paid: Enter the total amount paid from other resources.

(4)Third Party Resource (TPR) Code:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b)Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A)UD -- Service Under Deductible;

(B)NC -- Service not Covered by Insurance Policy;

(C)PN -- Patient not Covered by Insurance Policy;

(D)IC -- Insurance Coverage Canceled/ Terminated;

(E)IL -- Insurance Lapsed or not in Effect on Date of Service;

(F)IP -- Insurance Payment Went to Policyholder;

(G)PP -- Insurance Payment Went to Patient;

(H)NA -- Service not Authorized or Prior Authorized by Insurance;

(I)NE -- Service not Considered Emergency by Insurance;

(J)NP -- Service not Provided by Primary Care Provider/ Facility;

(K)MB--MaximumBenefitsUsedfor Diagnosis/ Condition;

(L)RI -- Requested Information not Received by Insurance from Patient;

(M)RP -- Requested Information not Received by Insurance from Policyholder;

(N)MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days (effective November 1, 1991);

(P)OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c)Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A)MP -- Primary Insurance Paid -- Secondary Paid;

(B)SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C)MU -- Primary and Secondary Under Deductible;

(D)PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E)SS -- Primary Insurance Paid -- Secondary Service not Covered;

(F)SC -- Primary Insurance Paid -- Secondary Patient not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or not in Effect;

(I)SP -- Primary Paid -- Secondary Payment Went to Patient;

(J)SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service not Provided by Primary Care Provider/ Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/ Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information not Received from Policy- holder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information not Received from Patient;

(Q) MC -- Service not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92

410-129-0140

Instructions on How to Complete the OMAP 505

(1) *Patient's Name: Enter the name as it appears on the Medical Card.

(2) *Insured's Medicaid Number: Enter the eight digit number from the Medical Card.

(3) *Insured's Group Number: The Medicare number as it appears on the client's Medicare Identification Card. (Example: 123456789A or 234567890C1).

(4) *Other Health Insurance Coverage: If no payment was received from Medicare, this space *must* be used to explain why no payment was made. Select a two-digit "Reason" code from the Third Party Resource (TPR) codes that are found in the billing section of this **Guide**. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the Third party Resource (Medicare). Example: Medicare paid nothing ("Reason" code NC, Not Covered). Enter: NC -- Medicare. Do not mail the Medicare EOB in with your claims.

(5) ** Was Condition Related To: Complete if service is related to an injury/accident.

(6) **If an Emergency Check Here: Check here if the service was performed as an emergency.

(7)*Name of Referring Physician or Other Source: Enter the OMAP provider number of the referring provider, HMO/PCO referrals, restricted patient referrals. If this service is the result of an HMO or PCO referral, the OMAP

provider number of the HMO or PCO Plan *must* be entered here.

(8)**Prior Authorization: If required, enter the prior authorization number here.

(9)*Date of Service: Use a six digit numeric date. If a "From --To" date range is used, all services must be on consecutive days.

(10)*Place of Service: Where service is provided:

(a) 1 = Inpatient hospital;

(b) 2 = Outpatient hospital/OP department/ER;

(c) 3 = Practitioner's office;

(d) 4 = Patient's home;

(e) 7 = Intermediate care facility;

(f) 8 = Skilled nursing facility;

(g) C = Residential treatment center.

(11)*Procedure Code: Enter the CPT Codes, HCPCS Codes or OMAP Unique Procedure Codes listed in this **Guide**.

(12)*Days or Units: Enter the number of services or units billed.

(13)*Type of Service Codes (TOS): Use Type of Service "J".

(14)*Charges Billed Medicare: Enter the total dollar amount you billed to Medicare for each service.

(15)*Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare for each service.

(16)**Provider Number: Enter the OMAP provider number here unless it is used in Field 34.

(17)*Total Charge: Add the charges in Field 24G and enter the total dollar amount billed Medicare.

(18)*Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services.

(19)**Insurance Other than Medicaid/ Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "0".

(20)*Balance Due: Subtract the amounts in Fields 28 and 30 from Field 27 and enter the balance in this field. An amount *must* be put in this field.

(21)Your Patient's Account Number: If the patient account number is entered here, OMAP will print that number on the Remittance Advice.

(22)*Physician's or Supplier's name, Address, Zip Code and Phone Number: Only the OMAP provider number is required.

* = Required Field ** = Required When Applicable

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91

410-129-0160

Individual Adjustment Request

(1) Overpayments, underpayments and payments received after OMAP has paid a claim can be resolved through the adjustment process. Obtain Individual Adjustment Request forms from the AFS Provider Forms Distribution Center. Much of the information required on the AdjustmentRequestformisprinted onthe Remittance Advice. Documentation may be submitted to support your request. Adjustment Requests must be submitted in writing to: Office of Medical Assistance Programs.

(2) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) This is a reminder to attach needed documentation;

(c) MailyourAdjustmentRequesttothis address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**.);

(e) Enter the client's identification number in this space. This number can be found on the RA in Field 6, or on the client's Medical Card;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Card;

(g) Enter the six-digit provider number in this space;

(h) This space is for the provider name;

(i) Enter the date printed at the top of the RA;

(j) Description: This column contains possible areas you might want to correct. Only check the box you want to change:

(A) Place of Service -- Enter place where service is provided. Use Place of Service from the HCFA-1500 or OMAP 505;

(B) Type of Service -- Use only Type of Service "J";

(C) Quantity/Unit -- The number of services being billed;

(D) NDC/Procedure -- You must use the codes from this **Guide**;

(E) Revenue Center Code (Hospital only) -- Do not check this box. This is for hospital billing only;

(F) Insurance Payment/Patient Liability -- The payments from other sources;

(G) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(H) Billed Amount -- The amount you billed OMAP;

(I) Other -- Use this box if none of the above address your problems.

(k) Line # -- List the line number from the original claim (HCFA-1500 or OMAP 505) you are now adjusting;

(l) Service Date -- Enter the date you performed the service;

(m) Wrong Information -- Enter the incorrect information submitted on your original claim in this column;

(n) Right Information -- Enter the corrected information in this column;

(o) Remarks -- Use this area to give OMAP additional information or explain the request;

(p) Provider's Signature -- The signature of the provider or other authorized personnel must be in this space;

(q) Date -- Enter the date this form was completed.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92

410-129-0180

Procedure Codes

(1) Procedure codes listed in the **Speech-Language Pathology, Audiology and Hearing Aid Services Provider Guide** 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 OMAP's **Medical-Surgical Services Provider Guide** and must bill OMAP using the processes and procedure codes identified in that **Guide**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93

410-129-0200

Speech-Language Pathology Procedure Codes

(1) Speech Therapy Services:

(a) 5009K -- Communication (speech/language) screening -- Limited to one per calendar year.

(b) 5010K -- Assessment of speech, voice, language systems, oral/pharyngeal sensori-motor competencies and/or communication abilities -- Limited to one per calendar year;

(c) 5011K -- Assessment for dysphagia -- Limited to two per calendar year;

(d) 5030K -- Speech therapy -- Adult -- Individual sessions 15 minutes -- PA -- When requesting payment authorization, please indicate total number of sessions and total number of 15-minute units. Bill in 15-minute units;

(e) 5031K -- Speech therapy -- Adult -- Group session -- 15 minutes -- PA -- When requesting payment authorization,

please indicate total number of sessions and total number of 15-minute units. Bill in 15-minute units;

(f) 5044K -- Speech therapy -- Child under 21 -- Individual session -- 15 minutes -- PA -- When requesting payment authorization, please indicate total number of sessions and total number of 15-minute units. Bill in 15-minute units;

(g) 5049K -- Speech therapy -- Child under 21 -- Group session -- 15 minutes -- PA -- When requesting payment authorization, please indicate total number of sessions and total number of 15-minute units. Bill in 15-minute units.

(2) Other Speech Services:

(a) 5012K -- Assessment for oral or laryngeal prosthesis or artificial larynx -- Limited to one per calendar year;

(b) 5013K -- Assessment for augmentative communication system or device -- Limited to one per calendar year (see criteria in OAR 410-129-220);

(c) 5055K -- Repair/Modification of oral/ pharyngeal or artificial larynx;

(d) 5056K -- Laryngectomy supplies (e.g., batteries stoma caps);

(e) 5065K -- Repair/Modification of augmentative communication system or device (excludes adaptive hearing aid) -- PA -- Authorization must be obtained prior to provision of services;

(f) L8500 -- Artificial larynx any type;

(g) 5060K -- Augmentative communication system or device -- Purchase -- PA -- Authorization must be obtained prior to provision of services. (Please see criteria in OAR 410-129-0220);

(h) 5051K -- Supplies for speech therapy -- Limited to two per calendar year, not to exceed $5 each;

(i) 5061K -- Augmentative communication system or device -- Rental -- Limited to one month per device, no more than two months total -- PA.

PA = Payment Authorization Required

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 409

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

410-129-0220

Augmentative Communications System or Device

(1)TheOfficeofMedical Assistance Programs will cover dedicated communication systems or devices and necessary attachments (i.e., to bed or wheelchair).

(2) All requests for these systems, devices and necessary attachments will be reviewed for medical necessity.

(3) All required supporting documentation must be submitted prior to review. A form has been developed that outlines the necessary information required for review. A written narrative should be attached to provide a sufficient level of detail.

(4) If, in the opinion of OMAP, the clinical documentation furnished does not support the services requested, the request will be denied.

(5) Criteria. The following criteria must be met before any request for an augmentative communication system or device will be considered:

(a) A physician's statement of diagnosis and medical prognosis including the necessity to communicate medical needs must be submitted;

(b) A reliable and consistent motor response which can be used to communicate must be identified;

(c) As measured by standardized or observational tools, the individual must have the cognitive ability of:

(A) Object permanence -- Ability to remember objects and realize they exist when they are not seen;

(B) Means end -- Ability to anticipate events independent of those currently in progress. The ability to associate certain behaviors with actions that will follow.

(d) The client must be assessed by a team consisting of a Speech Pathologist and when appropriate an Occupational Therapist and/or Physical Therapist. Formal evaluation reports should be included;

(e) Devices evaluated must be documented with an explanation of why this particular device is best suited for this individual and why the device is the lowest level which will meet basic functional communication needs;

(f) There must be a documented trial of the selected device and a report on the success in using this device;

(g) A therapy treatment plan must be developed stating who will program the device, monitor and re-evaluate the user on a periodic basis. Indicate the individual who will be responsible for carrying out the plan;

(h) Requests for Augmentative Communications Systems or Devices are sent to Office of Medical Assistance Programs;

(i) A vendor's price quotation for the device must accompany each request including where the device is to be shipped;

(j) Submit with the request for authorization for an augumentative communication system or device:

(A) A formal augmentative communication assessment report -- required elements are listed on the the reverse of the OMAP 3047 form;

(B) A physician's prescription of diagnosis and prognosis (not a prescription for an augmentative device).

(k) Augmentative Communication Device Selection Report:

(A) Client Information

Name:

Medicaid ID #:

DOB:

Medical Diagnosis:

Medical Prognosis:

Speech-Language Diagnosis:

(B) Evaluation Information

Name Speech Pathologist:

Name OT:

Name PT:

Contact Person:

Telephone #:

Physician:

(C) Device Information

Item:

Cost Estimate:

Manufacturer:

Distributor/Dealer:

(D) Physical Status

General Medical:

Respiratory:

Hearing:

Vision:

Head Control:

Trunk Stability:

Arm Movement:

Ambulation:

Seating/Position for Use of Device:

Ability to Access the Device:

Social/Emotional:

(E) Communication Abilities

Attempts to communicate with consistent response:

Ability to make choices:

Understand that communication will cause an action to occur:

Understand that symbols stand for verbal communication:

Prognosis to develop intelligible speech:

(F) Selection of Device

Patient's current means of communication:

All devices considered and rational for elimination:

Rationale for selection of specific device:

Indications for success with selected device:

(G) Prognosis

Communication Ability:

Duration of Need:

Support necessary to be successful (i.e., care giver, family, necessary professionals:

Please use additional pages if necessary.

Stat. Auth.: ORS Ch. 409

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

410-129-0240

Audiologist and Hearing Aid Procedure Codes

(1) 92553 -- Basic audiologic assessment -- Includes the measuring of hearing acuity and tests relating to air conduction, bone conduction.

NOTE: Only one audiologic assessment may be paid per calendar year.

(2) 92557 -- Basic comprehensive audiometry (audiological evaluation) -- Includes pure tone, air and bone, and speech, threshold and discrimination. Also includes testing necessary to determine feasibility of amplification.

(3) V5010 -- Hearing aid evaluation/tests/ selection -- May include sound field speech reception tests, speech discrimination tests, determination of appropriate style of hearing aid, and which ear should receive amplification

(4) V5090 -- Hearing aid dispensing/fitting -- PA -- Includes adjusting aid to the wearer, preparation and sizing of earmolds, ear impressions, instructions to wearer, and follow-up care.

PA = Prior Authorization Required

Stat. Auth.: ORS Ch. 409

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

410-129-0260

Hearing Aids and Hearing Aid Technical Service and Repair

(1) 92594 -- Electroacoustic evaluation for hearing aid -- Monaural.

(2) 92595 -- Electroacoustic evaluation for hearing aid -- Binaural.

(3) 9911K -- Repair of hearing aid/replacement ear molds -- PA.

(4) 9912K -- Adjustment of hearing aid.

(5) 9922K -- Hearing aid batteries.

(6) 9924K -- Assistive listening device -- PA.

(7) V5050 -- Hearing aid -- Monaural -- Child under 21 -- PA.

(8) V5130 -- Hearing aid -- Binaural -- Child under 21 -- PA.

(9) V5140 -- Hearing aid -- Binaural -- Adult with low vision -- PA.

(10) V5170 -- Hearing aid -- Monaural -- Adult -- PA.

NOTE: Submit hearing aid user's history and results of an audiometry when requesting PA for above codes.

PA = Prior Authorization Required.

Stat. Auth.: ORS Ch. 409

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

410-129-0280

Hearing Testing for Diagnostic Purposes (On Physician's Referral Only)

(1)92541--Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording.

(2) 92542 -- Positional nystagmus test, minimum of four positions, with recording.

(3) 92543 -- Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) with recording.

(4) 92544 -- Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording.

(5) 92545 -- Oscillating tracking test, with recording.

(6) 92546 -- Torsion swing test, with recording.

(7) 92547 -- Use of vertical electrodes in any or all of above tests counts as one additional test.

(8) 92551 -- Screening test, pure tone, air only.

(9) 92552 -- Pure tone audiometry (threshold); air only.

(10) 92555 -- Speech audiometry; threshold only.

(11) 92556 -- Threshold and discrimination.

(12) 92562 -- Loudness balance test, alternate binaural or monaural.

(13) 92563 -- Tone decay test.

(14) 92564 -- Short increment sensitivity index (SISI).

(15) 92565 -- Stenger test, pure tone.

(16) 92567-- Tympanometry.

(17) 92568-- Acoustic reflex testing.

(18) 92569-- Acoustic reflex decay test.

(19) 92571-- Filtered speech tests.

(20) 92572-- Staggered spondaic word test.

(21)92576-- Synthetic sentence identification test.

(22) 92577-- Stenger test, speech.

(23) 92582-- Conditioning play audiometry.

(24) 92583-- Select picture audiometry.

(25)92585--Brainstem evoked response recording.

(26) 92589 -- Central auditory function test(s) (specify tests).

NOTE: These tests may only be performed and billed by a licensed audiologist or a licensed physician.

Stat. Auth.: ORS Ch. 409

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

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1998 Compilation

DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 130

MEDICAL-SURGICAL SERVICES

410-130-0000

Foreword

(1) The OMAP Medical-Surgical Services guide is designed to assist:

(a) Medical-surgical providers (doctors of medicine, osteopathy and naturopathy;

(b) Podiatrists;

(c) Acupuncturists;

(d) Physician's assistants;

(e) Nurse practitioners;

(f) Laboratories;

(g) Family planning clinics;

(h) Social workers (only administrative exams and maternity management);

(i) Psychologists (administrative exams);

(j) Direct entry midwives;

(k) Portable x-ray providers;

(l) Ambulatory surgical centers;

(m) Acupuncturists.

(2) The OMAP Medical-Surgical Services guide is designed to assist providers to deliver medical services and prepare health claims for patients with Medicaid coverage. For patients enrolled in a managed care plan, contact the patient's plan for coverage and billing information.

(3) This guide contains information on policy, special programs, prior authorization, and criteria for some procedures. OMAP's HCFA-1500 Billing Guide is designed for personnel who actually bill OMAP and contains code lists and detailed instructions for filling out forms. All OMAP guides are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Administrative Rules.

(4) The Prioritized List of Health Services, OHP Administrative Rule 410-141-0520, defines the covered services under Oregon Medicaid. The list is found in the OHP Administrative Rules.

(5) The main part of the guide, containing detailed lists of services which require prior authorization, is arranges in alphabetical order.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-14-001 and 461-14-500; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 6-1994, f. & cert. ef. 2-1-94; HR 23-1997, f. & cert. ef. 10-1-97

410-130-0010

Health Insurance Claim Form (HCFA-1500)

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another or attach itemized billings. Completed HCFA-1500 Forms must be sent to the Office of Medical Assistance Programs.

(2) The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight-digit number found on the OMAP Medical Care Identification;

(b) Patient's Name: The name as it appears on the OMAP Medical Care Identification;

(c) Diagnosis or Nature of Illness or Injury: Enter the primary diagnosis code first and subsequent Dx as needed. Only use diagnosis codes from **ICD-9**. Enter up to four codes in priority order. Carry out the codes to their highest degree of specificity (4th or 5th digit);

(d) Date of Service: Must be numeric. If "From -- To" dates are used, a service must have been provided on each consecutive day;

(e) Place of Service: Where service is provided:

(A) 1 = Inpatient hospital;

(B) 2 = Outpatient hospital/OP department;

(C) 3 = Practitioner's office;

(D) 4 = Patient's home;

(E) 5 = Day care facility;

(F) 6 = Night care facility;

(G) 7 = Nursing home;

(H)8 = Skilled nursing facility;

(I) 9 = Surgical procedures -- emergent;

(J) A= Independent lab;

(K) B = Other medical/surgical facility;

(L) C = Residential treatment center;

(M) D = Specialized treatment center;

(f) Type of Service Codes (TOS):

(A) 1= Medical Care -- 90000 series (MDs, DOs and Naturopaths) and Administrative Medical Examinations and Reports;

(B) 2 = Primary Surgeon -- 10000 - 60000 series (MD/DO's and Naturopaths only);

(C) 7 = Anesthesia -- (MD/DO's and CRNA's only);

(D) 8 = Assistant Surgeon -- 10000 - 60000 series;

(E) K = Lab/X-Ray (prof/tech) -- 70000 - 80000 series; Radiology and laboratory HCPCS;

(F) L = Podiatrist;

(G) N = Nurse Practitioner;

(H) W = Registered Physician Assistant;

(I) P = Lab/X-Ray (prof only) -- Professional fee charge only for laboratory or x-ray service -- 70000 - 80000 series;

(J) S = RN, Dieticians and PCO/FCHP (may bill for maternity management services only); Social Workers (may bill for maternity management services and Administrative Medical Examinations and Reports only); Psychologists (may bill for Administrative Medical Examinations and Reports only);

(K) T = Lab/X-Ray (tech only) -- Technical fee charge for laboratory or x-ray service -- 70000 - 80000 series;

(L) V = Family planning clinics;

(M) H = Ambulatory Surgical Centers.

(g) Procedures, Services or Supplies: Use only CPT-4, HCPCS or OMAP uniques. When appropriate, also enter no more than one two-digit modifier;

(h) Diagnosis Code: Use the one-digit line reference number from the Diagnosis or Nature of Illness or Injury Field;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service Field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge Field minus the information in the Amount Paid Field);

(m) Provider Number: Enter the OMAP billing or provider number here.

NOTE: Only one number may be entered in this field.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Care Identification. When appropriate, use the Third Party Resource (TPR) Codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related To: Complete as appropriate when an injury is involved;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, FCHP/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(d) I.D. Number of Referring Physician: Enter the OMAP provider number of the referring provider, FCHP/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(e) Prior Authorization Number: If required, enter the Prior Authorization Number here;

(f) EPSDT (Medicheck): This box is to be used for Family Planning services only. Family Planning: Put a "Y" in this box if treatment was an emergency;

(g) Reserved for Local Use (Field 10d): Put a "Y" in this box if treatment was an emergency;

(h) Reserved for Local Use -- (24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(i) Amount Paid: Enter the total amount paid from other resources. Do not show any payment from OMAP on this line.

(4) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage -- Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service not Covered by Insurance Policy;

(C) PN -- Patient not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Cancelled/ Terminated;

(E) IL -- Insurance Lapsed or not in Effect on Date of Service;

(F) IP -- Insurance Payment went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service not Authorized or Prior Authorized by Insurance;

(I) NE -- Service not Considered Emergency by Insurance;

(J) NP -- Service not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/ Condition;

(L) RI -- Requested Information not Received by Insurance from Patient;

(M) RP -- Requested Information not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days (Effective November 1, 1991);

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c) Multiple Insurance Coverage -- Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary Paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service not Provided by Primary Care Provider/ Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/ Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information not Received from Patient;

(Q) MC -- Service not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

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 461-14-530; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 48-1991, f. 10-16-91, cert. ef. 11-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94

410-130-0020

Medicare/Medicaid Claims

(1) If a patient has both Medicare and Medicaid coverage, providers must bill Medicare first. Medicare will automatically forward all claims to OMAP for processing.

(2) If Medicare transmits incorrect information to OMAP or if an out-of-state Medicare carrier or intermediary was billed, providers must bill OMAP using an OMAP 505 Form. Enter any Medicare payment received in the "Amount Paid" Field or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" portion of the OMAP 505 form.

(3) If any payment is made by OMAP, an Adjustment Request must be submitted to correct payment, if necessary.

(4) OMAP payment will be based on the lesser of Medicare's maximum allowable rate, or OMAP's maximum allowable rate.

(5) Send all completed OMAP 505 Forms to Office of Medical Assistance Programs, Salem, OR 97309.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS

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 461-14-540; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91

410-130-0040

How to Complete the OMAP 505

(1) The OMAP 505 is a required billing form for Medicare/Medicaid claims. The following information *mus*t be entered on the OMAP 505:

(a) Patient Name: Enter the name listed on the Medical Care Identification;

(b) Insured's Medicaid Number: Enter the eight-digit number from the Medical Care Identification;

(c) Insured's Group Number: The Medicare number as it appears on the client's Medicare Identification Card;

(d) Other Health Insurance: If no payment was received from Medicare, a Third Party Reason Code must be used. Select and enter a two-digit "Reason" code from the Third Party Resource (TPR) Codes following the HCFA-1500 instructions. Be sure that this "Reason" code is the first entry in Field 9, followed by Third Party Resource name. Example: Medicare paid nothing (Enter: NC -- Medicare). Do not mail your Medicare EOB with your claim;

(e) Diagnosis (DX: Enter primary diagnosis/ condition of the client indicated by current **ICD-9** code number. Enter up to four codes in priority order. Carry the codes out to their highest degree of specificity;

(f) Date of Service: Must be numeric. If "From -- To" dates are used, a service must be on consecutive days and the quantity in the "Days" or "Units" field must equal the number of days;

(g) Place of Service: Where service is provided:

(A) 1 = Inpatient hospital;

(B) 2 = Outpatient hospital/OP Department/ER;

(C) 3 = Practitioner's office;

(D) 4 = Patient's home;

(E) 5 = Day care facility;

(F) 6 = Night care facility;

(G) 7 = Nursing home;

(H) 8 = Skilled nursing facility;

(I) 9 = Surgical procedures -- emergent;

(J) A = Independent laboratory;

(K) B = Other medical/surgical facility;

(L) C = Residential treatment center;

(M) D = Specialized treatment center.

(h) Procedure Codes: Use only CPT-4, HCPCS, or OMAP uniques. Enter the appropriate procedure code plus any appropriate two-digit modifier.

(i) Diagnosis Code: Must be a one-digit number only referenced from 23A;

(j) Days or Units: This number must match the number of days/units in services provided;

(k) Type of Service Codes (TOS):

(A) 1 = Medical Care -- 90000 series and Administrative Medical Examinations and Reports;

(B) 2 = Primary Surgeon -- 10000 - 60000 series (MD/DO's only);

(C) 7 = Anesthesia (MD/DO's and CRNA's only);

(D) 8 = Assistant Surgeon -- 10000 - 60000 series;

(E) W = Registered PA;

(F) L = Podiatrist;

(G) N = Nurse Practitioner;

(H) K = Lab/X-Ray (professional and technical) -- 70000 - 80000 series;

(I) P = Lab/X-Ray (professional only) -- Professional fee charge only for laboratory or x-ray service;

(J) T = Lab/X-Ray (technical only) -- Technical fee charge only for laboratory or x-ray service;

(K) V = Family Planning Clinics only;

(L) S = RN, Dietary Counselor and PCO/HMO (may bill for maternity management services only); Social Worker (may bill for maternity management services and Administrative Medical Examinations and Reports only); Psychologists (may bill for Administrative Medical Examinations and Reports only).

(l) Charges Billed Medicare: Enter the total amount Medicare was billed for the service provided;

(m) Medicare's Allowed Charges: Enter the total dollar amount allowed by Medicare for this service provided;

(n) Total Charge: Add the charges and enter the total dollar amount billed to Medicare;

(o) Medicare Total Payment: Enter the dollar amount paid by Medicare for the services. Do not show Medicare and other insurance write-offs;

(p) Balance Due: Subtract the amount paid and enter the balance. There must be an amount in balance due;

(q) Physician's or Supplier's Name, Address, Zip Code and Phone Number: Enter the OMAP provider number of the actual service provider or the provider's billing service.

(2) The following information must be entered on the OMAP 505 when:

(a) SAIF/Accident Field: The condition was related to an accident or injury;

(b) Emergency Box: The service was performed as an emergency;

(c) Name of Referring Physician or Other Source: This service is the result of a referral, enter the OMAP provider number or UPON of the referring practitioner; if this service is the result of an HMO or PCO referral, the OMAP provider number of the HMO or PCO Plan (not the practitioner) must be entered;

(d) Prior Authorization: If the service requires prior authorization, enter the nine-digit prior authorization number issued by OMAP or the branch/unit shown on the Medical Care Identification;

(e) Provider Number: Enter your provider number if it is not used in another field on the form;

(f) Insurance Other Than Medicaid/Medicare: The client has other insurance. Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "0".

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

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 461-14-550; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94

410-130-0060

Adjustment Requests

(1) Overpayments, underpayments and payments received from other sources after OMAP has paid a claim must be resolved through the adjustment process. Only paid claims can be adjusted. If any item on the claim was paid by OMAP and further payment is due, submit an Individual Adjustment Request. If no payment was made on the entire claim, the claim must be resubmitted using a HCFA-1500 or when appropriate an Office of Medical Assistance Programs 505.

(2) Much of the information required on the Adjustment Request Form is printed on the Remittance Advice (RA). Documentation may be submitted to support your request. Adjustment Requests must be submitted in writing to Office of Medical Assistance Programs, Salem, OR.

(3) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much) unless instructed otherwise by the message on the Remittance Advice;

(b) Attach needed documentation;

(c) Mail your Adjustment Request to the address on the form;

(d) Enter the 13-digit Internal Control Number (ICN). This number can be found on the RA;

(e) Enter the client's recipient identification number. This number can be found on the RA, or on the client's Medical Card;

(f) Enter the client's name. Use the same name as is shown on the Medical Card;

(g) Enter your provider number; it is always six digits;

(h) Enter your provider name;

(i) Enter the date which is printed at the top of your RA;

(j) Description -- Possible areas you might want to change are listed. Only check those you want to change;

(k) Place of Service -- Enter place where service is provided:

(A) 1 = Inpatient hospital;

(B) 2 = Outpatient hospital/OP department/ Emergency room;

(C) 3 = Practitioner's office;

(D) 4 = Patient's home;

(E) 5 = Day care facility;

(F) 6 = Night care facility;

(G) 7 = Intermediate care facility;

(H) 8 = Skilled nursing facility;

(I) A = Independent laboratory;

(J) B = Other medical/surgical facility;

(K) C = Residential treatment center;

(L) D = Specialized treatment center).

(l) Type of Service -- Use only OMAP type of service indicators;

(m) Quantity/Unit -- The number of services you are billing;

(n) Billed Amount -- The amount you billed OMAP;

(o) Insurance Payment/Patient Liability -- The payments from other sources;

(p) Other -- Check if none of the above address your problems;

(q) Line # -- List the line number from the original claim (HCFA-1500) or OMAP 505 you are now adjusting;

(r) Service Date -- Enter the date you performed the service;

(s) Wrong Information -- Enter the incorrect information submitted on your original claim in this column;

(t) Right Information -- Enter the corrected information in this column;

(u) Remarks -- Enter any additional information regarding your request;

(v) Provider's Signature -- The provider or other authorized personnel must sign;

(w) Date -- Enter the date you completed the form.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS

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 461-14-560; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91

410-130-0080

EPSDT Program

(1) The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, formerly called Medicheck, offers "well-child" medical exams with referral for medically necessary comprehensive diagnosis and treatment for all children (0 through 20 years) covered by the Basic Health Care Package.

(2) EPSDT Screening Exams: Physicians (MD or DO), nurse practitioners, physician's assistants and other licensed health professionals may provide for EPSDT services. Screening services are based on the definition of Preventive Services in OAR 410-141-0000.

(3) 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 ages 1-5 when appropriate;

(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.

(4) The provider may bill for both lab and nonlab services using the appropriate CPT and HCPCS codes. Immunizations must be billed according to the guidelines shown in OAR 410-125-0800.

(5) Inter-periodic EPSDT Screening Exams are any medically necessary encounter with a physician (MD or DO), nurse practitioner, physician assistant, or other licensed health professional within their scope of practice.

(6) Referral for Further Diagnosis and Treatment:

(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the patient may be referred to medical providers, Mental Health and Developmental Disabilities Division, Office of Alcohol and Drug Abuse Programs, or dental providers for further diagnosis and/or treatment;

(b) The screening provider shall explain the need for the referral to the patient, patient's parent, or guardian;

(c) If the patient, patient'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/local branch will assist in making other necessary arrangements;

(e) The EPSDT Referral Form (OMAP 3066) is available from the Adult and Family Services Division. It is a four-part form intended to notify all parties concerned that a referral has been made. Use the form for prompt access to Mental Health and Alcohol and Drug services.

(7) Lead Toxicity Screening:

(a) All children ages six months to 72 months are considered at risk and must be screened for lead poisoning. The screening consists of both a risk questionnaire and, when indicated, blood lead testing;

(b) Use the following minimum screening schedule unless medically contraindicated;

(c) A questionnaire, Lead Screening Checklist, must be used at each EPSDT exam beginning at six months of age to assess the potential for high-dose lead exposure and the appropriate frequency of screening. Any "yes" answer on the risk questionnaire means the child should be screened as high risk. Use medical judgement to determine the appropriate screening schedule for "don't know" answers on the checklist. Retain this questionnaire in the patient's record. The questionnaire does not need to accompany the claim for reimbursement. OMAP will not stock this form. Photocopy the form as needed from the Forms Section of the Medical-Surgical provider guide. Providers may use this form for non-Medicaid clients also;

(d) Venipuncture sampling is preferred for lead testing. Capillary sampling is acceptable with careful skin preparation.

Erythrocyte protoporphyrin (E.P.) testing is not appropriate;

(e) All blood lead levels 10 ug/dL and greater must be reported to the Health Division by the lab;

(f) Low risk schedule:

(A) A child at low risk for exposure to high-dose lead sources should have an initial blood lead test at 12 months of age;

(B) If the 12 months blood lead result is:

(i) <10 g/dL, the child should be retested at 24 months since that is when blood lead levels peak;

(ii) 10-14 g/dL, the child should be retested every 3 to 4 months. After 2 consecutive measurements are <10 g/dL or three are <15 g/dL, the child should be retested in a year;

(iii) >15 g/dL, retest for confirmation within one month. Retest after confirmation at least every 3 to 4 months.

(g) High risk schedule:

(A) A child at high risk for exposure to high-dose lead sources should have an initial blood lead test at 6 months of age;

(B) If the initial blood lead result is:

(i) <10 g/dL, the child should be retested every 6 months. After 2 subsequent consecutive measurements are <10 g/dL or three are <15 g/dL, testing frequency can be decreased to once a year;

(ii) 10-14 g/dL, the child should be retested every 3 to 4 months. After 2 consecutive measurements are <10 g/dL or three are <15 g/dL, the child should be retested in a year;

(iii) >15 g/dL, retest for confirmation within one month. Retest after confirmation at least every 3 to 4 months.

(h) Children >24 months and <72 months of age:

(A) A questionnaire should be used at each EPSDT exam to assess the potential for high-dose lead exposure. Any child not previously having a blood lead test should be tested as soon as possible:

(i) All children who are at high risk should be screened at least once a year until their sixth birthday (age 72 months) or later, if indicated (for example, a retarded child with pica);

(ii) Children should also be re-screened any time history suggests exposure has increased;

(iii) Follow the above low/high risk blood lead testing schedule when blood lead levels are >10-14 g/dL.

(i) Follow-up for blood lead levels 15-19 g/dL:

(A) Retest for confirmation within one month;

(B) The family should be given education and nutrition counseling;

(C) A detailed history should be taken to identify sources of lead exposure;

(D) When the blood lead level remains at this level for 2 consecutive tests 3-4 months apart, environmental investigation and abatement should be pursued if resources permit.

(j) Blood lead levels of >20 g/dL:

(A) A confirmation test should be performed and if it is >20 g/dL, the child should receive further evaluation and management services;

(B) 20-44 g/dL, retest for confirmation within one week;

(C) 45-69 g/dL, retest for confirmation within 48 hours. The child should be retested at least every 3 to 4 months;

(D) 70 g/dL+, medical emergency. The child should be retested for confirmation immediately.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

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

410-130-0100

Maternity Case Management

(1) This program:

(a) Is available to all pregnant clients;

(b) Expands prenatal services to include management of non-medical services, which address social, economic and nutritional factors;

(c) Allows billings for intensive nutritional counseling;

(d) Is an additional set of services over and above current medical management of pregnant clients.

(2) Any time there is significant change in the social, economic or nutritional factors of the client, the primary care provider should be notified.

(3) The following are definitions and procedure code explanations of this program:

(a) Assessment - Documented systematic and ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas. Data sources include client interviews, available records and needs assessments, and contacts with the primary care provider, other professionals, or other parties on behalf of the patient;

(b) Case Management - An ongoing process to assist the client to obtain access to and effective utilization of necessary health, social, economic, nutritional, and other services;

(c) High Risk Case Management - Intensive case management services provided to a client identified and documented by the primary care provider as being at risk for a low birth-weight baby, and who is not able to follow medical treatment and actions listed in the Client Service Plan;

(d) Home Visit: A visit to the client's home which requires a home assessment, specific training and education (see procedure code MCM07 for further definition.);

(e) Nutritional Counseling - Intensive nutritional counseling for clients who have one of the following documented conditions:

(A) Chronic disease, i.e., diabetes, renal disease;

(B) Hematocrit less than 33 (first trimester); 31 (second trimester); or 29 (third trimester);

(C) Underweight (pre-gravida weight/height less than 85 percent of normal weight/height);

(D) Inadequate weight gain with pregnancy;

(E) Eating disorder;

(F) Pregnancy induced hypertension or diabetes;

(G) Other conditions identified by the primary care provider and for which adequate services are not available from a local Women, Infants and Children's Program (WIC).

(f) Patient Service Plan - A written systematic client coordinated plan of care which lists the goals and actions required to meet the needs of the client as identified in the Initial Needs Assessment;

(g) Primary Care Provider - The physician, physician assistant, or nurse practitioner providing prenatal, labor and delivery, and/or postnatal services to the client.

(4) Maternity Case Manager and Nutritional Counselor Qualifications:

(a) Maternity Management case managers must be:

(A) Currently licensed as a physician, physician's assistant, nurse practitioner, social worker, or a registered nurse with a minimum of two years experience; or

(B) Other professionals or paraprofessionals under the supervision of one of the above practitioners; or

(C) Licensed direct entry midwife.

(b) Nutritional counselors must:

(A) Be a registered dietician; or

(B) Have a bachelor's degree in a nutrition related field with two years of related work experience.

(5) MCM01 - Initial Needs Assessment:

(a) The initial needs assessment includes:

(A) Assessment of the patient, as outlined in the definition section of this rule;

(B) Making any referrals to meet emergency needs;

(C) Assisting with a referral to a primary care provider;

(D) Forwarding a copy of a complete assessment to the ongoing case manager and primary care provider;

(E) The client record must reflect the date and to whom the needs assessment was sent.

(b) Paid one time per pregnancy per provider. No other maternity management codes may be billed the same day as initial needs assessment.

(6) MCM02 - Case Management (Full Service) is paid one time per pregnancy after delivery when more than three months of services were provided and includes:

(a) Face-to-face client contacts;

(b) Development and monitoring of client service plan: The client's records must include the formal service plan, and written updates to the plan. Service plan activities involve making specific decisions regarding the client's needs and determining the resources available to meet those needs in a coordinated, integrated fashion;

(c) Assistance in delivery plans. Support Services provided and/or coordinated by the case manager to assist the client or client's family achieve the goals of the client service plan, particularly when resources are inadequate or the service delivery system is nonresponsive;

(d) Referral to services included in the client service plan. Implementation includes making referrals or providing information and assisting the client in self-referral, and maintaining contact with resources involved to ensure coordinated service delivery, sharing information, and assisting with any coordination problems that might arise;

(e) Service Plan Coordination must include the following:

(A) Contact with Adult and Family Services Division (AFSD) worker;

(B) Contact with primary care provider;

(C) Coordination with other community resources/agencies to address high-risk needs;

(D) Linkage to labor and delivery services;

(E) Linkage to family planning services by referral to family planning services and follow-up contact to assure compliance.

(f) Nutritional assessment with basic counseling or referral to WIC (Women, Infants and Children's Program);

(g) Client advocacy as necessary to facilitate access. The Case Manager will serve as a client advocate and intervene with agencies or persons to help the client receive appropriate benefits or services;

(h) Follow-up with client and referrals. Case Managers will maintain regular contact with the client to ensure services are meeting needs. Accountability consists of a set of activities to ensure that the client has received services in an efficient and effective manner, geared towards successful completion of the client service plan.

(7) MCM03 - Case Management (Partial Service):

(a) Partial service means that the provider served the client three months or less; or

(b) Can be billed when the client service plan has been developed and case management services (MCM02) were initiated and partially completed but not carried through to the date of delivery.

(8) MCM04 -High Risk Case Management (Full Service) is paid one time per pregnancy after delivery when more than three months of services were provided to patient:

(a) Intensive case management requires frequent client and referral contact (at least once per week). Intensive case management services provided only to a client identified and documented by the provider as being at risk for a low birth-weight baby, and who are not able to follow medical treatment and actions listed in the service plan;

(b) Can be billed in addition to MCM02;

(c) Requires frequent patient and referral contact, at least once per week.

(9) MCM05 - High Risk Management (Partial Service) is payable when the client becomes "high risk" during the later part of the pregnancy or intensive high risk case management services were initiated and partially completed but not

carried through to the date of delivery, or:

(a) Served client three months or less;

(b) Partial Service High Risk Case Management can be billed in addition to MCM02 or MCM03.

(10) MCM06 - Nutritional Counseling can be paid one time per pregnancy, and is available for clients who have one of the documented conditions under Definitions.

(11) Nutritional Counseling must include:

(a) Nutritional assessment;

(b) Nutritional care plan;

(c) Regular client follow-up;

(d) Nutritional counseling can be billed in addition to other maternity case management services. Paid one time per pregnancy.

(12) MCM07 - Home Services must include home assessment, at least two training and education topics:

(a) No more than two home visits will be covered by OMAP in the immediate six weeks postpartum;

(b) A total of 4 individual home visits (MCM07) may be billed per pregnancy. (Home Visits can be billed separately, in combination, or when all services/visits have been provided);

(c) Home Assessment - Prenatal home assessment includes:

(A) Environment:

(i) Adequacy of shelter;

(ii) Home sanitation;

(iii) Environmental hazards.

(B) Food:

(i) Food preparation capabilities;

(ii) Food storage;

(iii) Adequacy of family diet;

(iv) Planning for infant nutritional needs.

(C) Health Status:

(i) Pre-term birth signs/symptoms;

(ii) Common discomforts of pregnancy;

(iii) Substance/alcohol abuse;

(iv) Elimination; rest/exercise;

(v) Family planning needs;

(vi) Nutritional needs.

(D) Emotional: Household management support.

(d) Postpartum home assessment includes:

(A) Infant Care:

(i) Feeding - infant growth;

(ii) Clothing needs;

(iii) Sleep;

(iv) Wellness care.

(B) Parenting:

(i) Infant/parent interaction;

(ii) Bonding/attachment;

(iii) Infant communication patterns/cues;

(iv) Developmental milestones;

(v) Frustration/sleep deprivation.

(e) Training and Education - At least 2 of the following topics must be covered during each home visit:

(A) Pre-term birth prevention:

(i) Factors associated with increased risk;

(ii) Early detection of symptoms;

(iii) Obtaining help/information;

(iv) Stress reduction.

(B) Family Planning:

(i) Pregnancy danger signs and symptoms;

(ii) Substance/alcohol abuse.

(C) Infant care:

(i) Feeding/nutrition;

(ii) Safety;

(iii) Health care needs;

(iv) Immunization schedules;

(v) Well-child care;

(vi) Emergencies;

(vii) Clothing needs;

(viii) Sleep.

(D) Preparation for childbirth:

(i) Labor and birth process;

(ii) Coping strategies;

(iii) Common interventions;

(iv) Emergencies.

(E) Early parenting:

(i) Infant communication;

(ii) Parental frustration/sleep deprivation;

(iii) Community resources;

(iv) Child abuse.

(F) Nutrition:

(i) Weight gain;

(ii) Food selection;

(iii) Nutrient/calorie intake;

(iv) Digestive tract changes.

(13) MCM08 - Total Maternity Management Package - Full Service Case Management - includes:

(a) Initial Needs Assessment (MCM01);

(b) Four Home Visits (MCM07);

(c) Full Service Case Management (MCM02).

(14) The procedure code MCM08 can only be used when all of the services in (a) through (c) above are provided. It is paid one time per pregnancy. Nutritional counseling is billed separately when provided.

(15) MCM09 - Total Maternity Management Package - Full Service High Risk Case Management:

(a) This procedure can only be used when all of the services below are provided:

(A) Initial Needs Assessment (MCM01);

(B) Four Home Visits (MCM07);

(C) Full Service Case Management (MCM02);

(D) High Risk (MCM04).

(b) Paid one time per pregnancy;

(c) Nutritional Counseling is billed separately when provided.

Stat. Auth.: ORS Ch. 409

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 461-14-200 & 461-14-201; 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 461-14-580; 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

410-130-0145

Bone Marrow Procedures

The following services are covered for payment. They require prior authorization from the Medical Director's Office:

(1) 38230, Bone marrow harvesting for transplantation.

(2) 38231, Blood-derived peripheral stem cell harvesting for transplantation, per collection.

(3) 38240, Bone marrow transplantation; allogenic.

(4) 38241, autologous.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: ORS 414.065

Hist.: HR 10-1996, f. 5-31-96, cert. ef. 6-1-96

410-130-0150

Cardiovascular Procedures

(1) M0300, IV chelation therapy (chemical endarterectomy). Not covered for adults or children.

(2) M0301, Fabric wrapping of abdominal aneurysm (MNP). Not covered for adults or children.

(3) M0302, Assessment of cardiac output by electrical bioimpedance. Not covered for adults or children.

(4) 33930, Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft. Organ acquisition or other donor charges are reimbursed according to contract between OMAP and transplant center (provider). Services considered bundled.

(5) 33935, Heart-lung transplant with recipient cardiectomy-pneumonectomy. Prior Authorization (PA) Required - Contact OMAP for PA.

(6) 33940, Donor cardiectomy, with preparation and maintenance of allograft. Organ acquisition or other donor charges are reimbursed according to contract between OMAP and transplant center (provider). Service is considered bundled.

(7) 33945, Heart transplant, with or without recipient cardiectomy. Covered - PA Required - Contact OMAP for PA.

(8) 36415, Routine venipuncture or finger/heel/ear stick for collection of specimen(s). Bundled services, included in the visit or lab procedure. Use G0001 for venipuncture.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: HR 10-1996, f. 5-31-96, cert. ef. 6-1-96

410-130-0160

Codes

(1) CPT:

(a) Beginning April 1, 1997, use only 1997 CPT and HCPCS codes. Codes from either the 1996 or 1997 CPT and HCPCS code books may be used until April 1; however, 1996 and 1997 codes may not both be used for the same service;

(b) Always use the most applicable CPT, OMAP Unique or HCPCS code. Do not fragment coding when services can be included in a single code;

(c) Always read the definition in the CPT/HCPCS book to verify your level of service; especially office visits;

(d) Unless otherwise specified in the Medical-Surgical provider guide, use the guidelines from CPT/HCPCS;

(e) OMAP will recognize only modifiers from CPT, HCPCS and Aetna/Medicare of Oregon. Use only one of the two-digit modifiers; do not use five digit modifiers;

(f) When billing for the modifiers listed in subsections (A) through (M) of this rule, use the corresponding OMAP guidelines;

(g) A complete listing of modifier codes and guidelines is included in the CPT and HCPCS publications and Aetna/Medicare's guidelines. Use these guidelines except as noted in section (f) of this rule:

(A) -22 - Report required;

(B) -24 - Diagnoses must indicate unrelated services;

(C) -25 - Report required;

(D) -47 -Regional blocks are the only anesthetic services payable to surgeons in addition to surgical procedures. See CPT codes 64400-64450;

(E) -50 - Bill primary procedure without a modifier. Bill secondary procedure with a modifier 50. Do not use with radiology codes - bill appropriate quantities;

(F) -51 - Not required;

(G) -54 - Required when applicable;

(H) -55 - Use same procedures codes as surgeon - billable once per surgery;

(I) -56 - Required when applicable;

(J) -62 - Designate percentage of total services provided;

(K) -66 - Designate percentage of total services provided;

(L) -79 - Diagnoses must indicate unrelated services;

(M) -90 - Clinical and pathology lab services (80000-89999) must be billed by the laboratory actually performing the service;

(N) -99 - Use for 2 or more modifiers - list specific modifier on line below.

(h) All unlisted codes ending in "...99" must have an explanation attached supporting the service as these claims are manually reviewed prior to payment. These codes cannot be processed if submitted electronically. Rebill on a hard copy of the appropriate claim form;

(i) Do not use both CPT and HCPCS codes for the same procedure. This is duplicate billing.

(2) Health Care Financing Administration Common Procedure Coding System (HCPCS) - Providers may not use both CPT and HCPCS codes for the same procedure. This would be duplicate billing.

(3) ICD-9-CM:

(a) Providers must use diagnosis codes to the 4th/5th digits, where they exist, from the ICD-9-CM code book. The only exceptions are those ICD-9-CM codes listed in OAR 410-120-1280, which do not require coding to the highest degree of specificity;

(b) Always use the primary diagnosis code;

(c) OMAP will accept up to three additional diagnosis codes only if the claim includes charges for services related to the additional diagnosis;

(d) Diagnosis codes are required on all billings including those from independent laboratories and portable X-ray providers;

(e) OMAP requires the following ICD-9-CM codes to be specified only up through the fourth digit:

(A) 001-139.8;

(B) 240-279.9 (except 250.0- 250.03);

(C) 280-289.9;

(D) 290-319;

(E) 390-459.9 (except 451.8-451.89);

(F) 460-519.9;

(G) 520-579.9 (except 560.39 and 569.85);

(H) 580-629.9;

(I) 680-709.9.

(4) Only HCPCS/CPT codes which require authorization, have limitations or are not covered for payment and OMAP Unique codes are listed in the Medical-Surgical Services provider guide.

(5) Reimbursements for some services are "bundled" (Combined) into the payment for another service (e.g., payment for obtaining a PAP smear is bundled into the payment for the office visit). Bundled services are considered covered and shall not be billed separately to the client or OMAP. The abbreviation "BND" in the code list in the OMAP Medical-Surgical Services provider guide indicates the procedure is bundled into another one.

(6) The Prioritized List of Health Services (OAR 410-141-520) determines covered services.

(7) Always supply the ICD-9-CM to ancillary services providers when prescribing services, equipment and supplies.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-610; 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

410-130-0180

Drugs

(1) Not covered services include:

(a) Laetrile;

(b) Home pregnancy kits and products designed to promote fertility;

(c) DMSO (except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis.) This services does not require prior authorization.

(2) Drug administration:

(a) Use an appropriate CPT therapeutic injection code for administration of injections;

(b) Use an appropriate HCPCS "K" or "J" code for the specific drug. Bill all drugs at acquisition cost;

(c) Do not bill for drugs under code 99070;

(d) When billing unclassified drugs, use the following codes:

(A) J3490 - unclassified drugs;

(B) J7699 - NOC drugs, inhalation, administered through DME solution;

(C) J7799 - NOC drugs, other than inhalation drugs, administered through DME;

(D) J8499 - prescription drug, oral, non-chemotherapeutic, NOS;

(E) J9999 - NOC, anti-neoplastic.

(e) Include the name of the drug, NDC number, and dosage;

(f) The following temporary "K" HCPCS drug codes are covered:

(A) K0119-K0120;

(B) K0122-K0123.

(g) Epoetin Alpha (EPO) Codes Q9920-Q9940 are covered;

(h) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(3) Brand Name Pharmaceuticals:

(a) The Office of Medical Assistance Programs (OMAP) pays for drugs in their generic form. However, payment for brand name drug products will be made if the prescribing practitioner certifies that a brand name product is medically necessary by writing in his/her handwriting on the face of the prescription one of the following phrases:

(A) "Brand medically necessary";

(B) "Medically necessary";

(C) "Brand necessary".

(b) Payment will not be made for brand name pharmaceutical products if the above hand written certification does not appear on the face of the prescription;

(c) Rubber stamp, initials or a box to check to this effect are unacceptable. "Brand medically necessary" certification, either on the prescription or on a separate sheet and attached to the prescription, must be filed with the prescription by the pharmacist within 30 days of filling the prescription. A faxed copy of the certificate is acceptable.

(4) Prior Authorization: Depending on the product and/or diagnosis, the prior authorization (PA) will be denied or granted. There are two distinct prior authorization procedures:

(a) Automated Information System (AIS):

(A) For durable medical equipment, products that have cosmetic indicators and nutritional supplements, a prior authorization must be obtained through the Automated Information System;

(B) A pharmacy can obtain a prior authorization for the above drug categories only if the prescribing physician writes the diagnosis on the prescription.

(b) First Health Pharmacist:

(A) Physicians (or other licensed personnel) may contact First Health's Prior Authorization Pharmacist by phone or FAX to review the patient's medication history and request a prior authorization;

(B) All prior authorizations must be requested by the prescribing physician or other licensed personnel within the physician's office;

(C) If a diagnosis is below the "funded line" on the Prioritized List of Health Services, the drug categories listed below will not be paid by OMAP. If the diagnosis is above the "funded line" and the drug is FDA approved for the treatment, a prior authorization is required for payment. The drug categories include:

(i) Acute anti-ulcer therapy;

(ii) Anti-fungals;

(iii) Antihistamines;

(iv) Excessive daily dosages;

(v) Nasal inhalers;

(vi) Weight reduction drugs (amphetamines and amphetamines derivatives).

(D) When a physician prescribes a drug which requires a prior authorization, he/she (or appropriately licensed personnel) should call the PA Help Desk to request prior authorization. The request may also be transmitted to the PA Help Desk by FAX using the form found in the Medical-Surgical Services provider guide;

(E) The PA Help Desk is available 24 hours a day, seven days per week. The PA Pharmacist will ask for some or all of the following information, depending on the class of drug requested:

(i) Patient name and Medicaid ID number;

(ii) Diagnosis;

(iii) Brand name, strength, size and quantity of medication;

(iv) Physician name and phone number;

(v) Medical justification for use of selected drug;

(vi) Pharmacy name and phone number, if available.

(vii) After a prior authorization request is approved, the patient will be able to fill the prescription at any OMAP-contracted pharmacy. There is no need for a prior authorization number.

(5) Acute Anti-Ulcer Therapy: Patients are allowed to receive eight weeks of acute anti-ulcer therapy without prior authorization. If the acute dosage is to be continued beyond the initial eight weeks, a prior authorization must be obtained. Daily doses greater than those listed below will be denied, without prior authorization after eight weeks of acute therapy:

(a) Prilosec (Omeprazole), daily dose greater than 19 mg;

(b) Prevacid (Lansoprazole), daily dose greater than 16 mg;

(c) Zantac (Ranitidine), daily dose greater than 151 mg;

(d) Tagament (Cimetidine), daily dose greater than 401 mg;

(e) Pepcid (Famotidine), daily dose greater than 21 mg;

(f) Axid (Nizatidine), daily dose greater than 151 mg;

(g) Carafate (Sucralfate), daily dose greater than 2 gm.

(6) Durable Medical Equipment - Products with an NDC number provided through a pharmacy require prior authorization.

(7) Products that have cosmetic indications - Client must be screened for pregnancy before Accutane will be authorized. Retin-A and Accutane will only be allowed for diagnoses that are above the "funded line" on the Prioritized List of

Health Services.

(8) Nutritional Supplements - Prescriptions for nutritional supplements must have prior authorization. For pharmacies to obtain authorization, the diagnosis must be written on the prescription. OMAP will pay for nutritional supplements when the patient meets the following criteria:

(a) All clients - tube-fed nutritional supplements are covered when medically necessary;

(b) Clients Age 7 and Over:

(A) Recent unplanned weight loss of 10 percent or more and one of the following:

(i) Increased metabolic need from severe trauma;

(ii) Malabsorption difficulties (e.g., short-gut syndrome, fistula, cystic fibrosis, renal dialysis);

(iii) Ongoing cancer treatment, advanced AIDS, or pulmonary insufficiency.

(B) Or nutritional deficiency shown by:

(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.

(c) Clients Age 6 and under: If any of the above criteria are met or diagnosis is failure to thrive;

(d) Clients in a nursing facility - If client cannot consume food items or meals; the nutritional supplement must be their total nutrition.

(9) The drug product clozapine (Clozaril) is covered by OMAP only for the treatment of chronic schizophrenic patients who have failed therapy with at least two anti-psychotic medications:

(a) Only pharmacists or physicians may bill using the OMAP Unique Code CMS01. Only one provider may bill per week per client;

(b) The provider billing for clozapine supervision must document all of the following:

(A) Exact date and results of weekly WBCs - including weekly WBCs for four weeks following discontinuation of clozapine therapy;

(B) Date and result of WBC and differential count before initial clozapine therapy;

(C) Notations of current dosage and change in dosage;

(D) Evidence of an evaluation on a weekly basis of the current recommended dosage level based upon the current week's WBC;

(E) Dates provider sent required information to manufacturer.

(10) OMAP Unique Codes: CMS01, Clozapine supervision, management and recordkeeping of clozapine dispensings as required by the manufacturer of clozapine. Limited to five units per 30 days per client.

(11) Drug Use Review: refer to OAR 410-121-0100.

(12) Prudent Pharmaceutical Purchasing Program: refer to 410-121-0157.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-620; 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

410-130-0190

Smoking Cessation Product Therapy

(1) Not covered services:

(a) Smoking cessation programs;

(b) Behavior modification programs.

(2) Smoking cessation therapy products (e.g., nicotine patches and gum) are covered if all the criteria for prescribing listed below are met and documented in the patient's clinical record:

(a) Initial Prescription:

(A) The patient must be diagnosed as nicotine dependent. The patient's response to at least four of the following questions must be "yes" to be considered nicotine dependent:

(i) Are you unable to stop smoking for more than two consecutive days?

(ii) After making a commitment to stop smoking, have you set "quit dates" at least five times and then failed to quit smoking?

(iii) Do you smoke at least one pack of cigarettes each day?

(iv) Do you habitually smoke within 30 minutes of waking up in the morning?

(v) Is the first cigarette in the morning the most difficult to give up?

(vi) Do you experience at least three nicotine withdrawal symptoms within 24 hours of quitting smoking?

(vii) Do you smoke even when you are sick enough to be in bed?

(B) The patient must also make a commitment to stop smoking by setting a "quit date" within 30 days -- Preferably within 15 days of the initial office visit for an assessment of nicotine dependency;

(C) The patient does not have a disease state where use of a smoking cessation product is contraindicated;

(D) Patient must certify in writing that the pharmaceutical manufacturer's product self-help kit and/or handout information for the specific product prescribed was verbally explained and that he/she understood the explanation. This certificate must be kept in the patient's clinical record.

(b) Additional Prescriptions:

(A) The patient must be contacted by the prescriber or the prescriber's staff at the end of the initial two weeks of smoking cessation product therapy to review the patient's progress, offer counseling regarding smoking cessation and verify that the patient has ceased smoking. This contact may be by phone;

(B) The patient must be contacted by the prescriber by phone or visit whenever the dosage strength is changed (i.e., reduction from 21 to 14mg) to verify the patient has continued to cease smoking and to offer counsel;

(C) If the patient has resumed smoking at any time, no additional prescription may be given for a period of six months. The prescriber must certify that the patient has completed a behavior modification program before again prescribing smoking cessation products.

(3) The initial prescription must be a written order by the prescriber and may not exceed a two week supply. Additional prescriptions may be written or verbal.

(4) Prescriptions may not exceed the manufacturer's recommended duration dosages and/or quantities for each specific product prescribed.

(5) Smoking cessation products may be prescribed only for FDA approved indicated uses.

(6) Prescribers are subject to monetary recoupment of payment by OMAP for visits related to smoking cessation and for prescription expenses if the patient's clinical record is not properly documented.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS

Hist.: HR 36-1992, f. & cert. ef. 12-1-92

410-130-0200

Prior Authorization

(1) If the client is covered by a managed care plan contact the appropriate managed care plan for prior authorization requirements and instructions for billing the plan.

(2) Hospital admissions do not require prior authorization (PA) unless the procedure requires prior authorization. Prior authorization is not required for emergent or urgent procedures or services. Treating and performing practitioners are responsible for obtaining prior authorization.

(3) Contact OMAP for prior authorization for transplants other than kidney and cornea, and requests for non-emergent or non-urgent out-of-state service. Kidney and cornea transplants do not require prior authorization. Refer to the OMAP Transplant Guide for further information. Refer to the General Rules for further information concerning out-of-state services.

(4) Services for clients of the Medically Fragile Children's Unit must be authorized by the Unit.

(5) All other procedures listed in the Medical-Surgical Services provider guide with a PA indicator must be prior authorized by OMPRO when performed in any setting. A second opinion may be requested by OMAP or OMPRO before authorization of payment is given for a surgery.

(6) If the patient has both Medicare and Medicaid coverage, prior authorization is not required for services covered by Medicare, except for most transplants.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-14-045; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-630; 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

410-130-0220

General Areas of Not Covered Services

(1) The following services are not covered by the Office of Medical Assistance Programs:

(a) Cosmetic surgeries/procedures;

(b) Experimental treatments;

(c) Pain clinics;

(d) Post-mortem exams or charges;

(e) Room charges (only service and supply covered);

(f) Telephone calls;

(g) Trans-sexual services/procedures;

(h) Weight loss program;

(i) "After hours" visits during regularly scheduled hours;

(j) Assessment of cardiac output by electrical bioimpedance;

(k) Immunizations for foreign travel;

(l) Provocative allergy testing;

(m) Psychotherapy services (covered only through local Mental Health Departments);

(n) Routine postoperative visits (included in the payment for the surgery);

(o) Services outside the practitioner's office or unusual office hours at the patient's request.

(2) This is not an inclusive list. Refer to the OMAP General Rules and Oregon Health Plan Medicaid Demonstration Project Administrative Rules.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-640; 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

410-130-0240

General Medicine

(1) Allergy Desentization - Bill single and multiple dose vials of allergy extract per vial (not per dose).

(2) Chemical dependency services must be provided by programs approved by the state Office of Alcohol and Drug Abuse Programs. Payable to private physicians, psychologists and social workers who have a current Letter of Approval. Outpatient and outpatient opiate substitution treatment, provided by approved programs, is billable for persons who are not members of a managed care plan.

(3) Psychiatric services; Psychiatric or psychological evaluations(administrative exams and reports) can be requested by the local AFS, SDSD, MHDDSD, OYA or SOSCF branch office or OMAP. Refer to OAR 410-130-0900 for more information.

(4) Psychiatrists can be reimbursed by OMAP for symptomatic diagnosis and services which are somatic (physical) in nature. Contact local Mental Health Department for "covered" psychiatric and psychological services.

(5) Mental health services must be provided by local Mental Health Clinics or a patient's Mental Health Organization. Not payable to private physicians, psychologists, social workers.

(6) Payment for polysomnographies and multiple sleep latency test (MSLT) are each limited to two in a 12-month period.

(7) If the service is performed by a physical therapist, refer to the Physical and Occupational Therapy Services provider guide.

(8) OMAP Unique Codes: NFR01, Periodic visit, supervision and care of a nursing facility resident, as required by level of care determination, by Congregate Care Physician Agreement only. Not to exceed one visit per month.

(9) The following HCPCS codes are not covered for adults or children:

(a) M0300, IV chelation therapy;

(b) M0301, Fabric wrapping of abdominal aneurysm.

(10) These services require prior authorization: 90901, Biofeedback training by any modality.

(11) The following codes are bundled: 95105, Medical conference services, (e.g., use of mechanical and electronic devices, climatotherapy, breathing exercises and/or postural drainage) are not covered for payment as they are bundled with Evaluation/Management services codes.

(12) 99070, Use only for lost PKU card. Use specific HCPCS Level II codes for supplies and materials, including drugs.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-14-021 & 461-14-056; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-650, 461-14-690 & 461-14-700; 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 410-130-320, 410-130-340, 410-130-360 & 410-130-740; 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

410-130-0250

Neonatal/Pediatric Intensive Care Guidelines

(1) Refer to **Neonatal Intensive Care Guidelines** in the CPT codebook for guidelines. Neonatal Intensive Care Unit (NICU) procedure codes are reimbursed only to neonatologists and pediatric intensivists for services provided to infants under one year of age 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.

(2) Consultations by specialists other than neonatologists and pediatric intensivists are payable in addition to these unique codes.

(3) Neonatal Intensive Care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use specific CPT ECMO codes for ECMO services.

(4) Bill the level of service the infant is in at 12:01 am of each 24 hour-period, regardless if the infant is later listed in a different level of care in that same 24-hour period.

(5) OMAP Unique Procedure Codes. 9982D - Subsequent NICU care, per day, for the evaluation and management of a stable neonate or infant requiring frequent monitoring and assessment and continuing on graduated feedings.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

Hist.: 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 42-1994, f. 12-30-94, cert. ef. 1-1-95

410-130-0260

Ophthalmology Services

(1) Comprehensive eye exams are limited to one examination every 24 months for adults.

(2) Eye examinations related to medical problems are not limited.

(3) Refer to the OMAP Visual Services provider guide for covered ophthalmological/optometric materials and services. All materials and supplies must be obtained from OMAP's vision contractor.

(4) Not covered services include:

(a) Surgical vision corrections;

(b) Cosmetic surgeries and procedures.

(5) Services that are not covered (NC), or may require prior authorization (PA) from OMPRO: **Table 1**.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: PWC 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 57-1983, f. 11-29-83, ef. 1-1-84; 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 50-1986, f. 6-30-86, ef. 8-1-86; AFS 18-1988, f. & cert. ef. 3-4-88; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; Renumbered from 461-14-050; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-660; HR 6-1994, f. & cert. ef. 2-1-94; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97

410-130-0280

Otorhinolaryngology 92502-92599

(1) Not covered services include: bilateral hearing aids for adults (except some visually impaired clients and group hearing tests or therapies.

(2) Payment for hearing aids and speech therapy must be authorized before the service is delivered.

(3) Refer to the Speech-Language Pathology, Audiology, and Hearing Aid Service guide for detailed information.

(4) HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists and hearing aid dealers.

(5) The following services are not covered or required Prior Authorization: **Table 2**.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-670; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 6-1994, f. & cert. ef. 2-1-94; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97

410-130-300

Acupuncture - ACP01

(1) This code is an OMAP unique procedure code.

(2) Acupuncture may be performed by a physician or a physician's employee-acupuncturist under the physician's supervision or by a licensed acupuncturist. This code includes patient evaluation and management services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-680; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 23-1997, f. & cert. ef. 10-1-97

410-130-0370

Supervising Physicians Providing Services in a Teaching Setting

(1) Supervising faculty physicians in a teaching hospital may not bill OMAP on a HCFA-1500 when serving as an employee of the hospital during the time the service is provided or when the hospital reports the service as a direct medical education cost on the Medicare and OMAP Cost Report.

(2) Supervising faculty physicians in a teaching hospital may bill OMAP on a HCFA-1500 when:

(a) Providing services in a private capacity (i.e., the physician is receiving no reimbursement from the hospital for the period of time the service is provided);

(b) Providing services when the following criteria are met:

(A) The supervising physician provides personal and identifiable direction to interns or residents who are participating in the care of the supervising physician's patient; and

(B) The supervising physician is identified as the attending physician; and

(C) In cases of major surgical procedures or other complex and dangerous procedures or situations, such personal direction must include supervision in person by the attending physician; or

(D) The supervising physician's level of responsibility should be the same as that which occurs when the supervising physician provides care for private patients. The physician must demonstrate this responsibility by:

(i) Reviewing the patient's history and conducting a physical examination;

(ii) Personally examining the patient within a reasonable period of time after admission;

(iii) Confirming or revising diagnoses;

(iv) Determining the course of treatment to follow;

(v) Assuring that any supervision needed by the interns and residents is furnished; and

(vi) Frequently reviewing the patient's progress;

(vii) Notes made by the supervising physician in the patient's record must indicate that he/she provided the services listed above, even though the resident or intern may routinely write or dictate the physician's notes or operative reports and may provide a substantial proportion of the care to the patient.

(3) Use appropriate modifiers to designate supervision.

(4) Policy covering supervising physicians providing services in a teaching setting applies to all Medicaid clients, including those who receive benefits under the Oregon Health Plan (OHP).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

Hist.: HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94

410-130-0380

Surgery

(1)The Office of Medical Assistance Programs will reimburse all covered surgical procedures as global packages:

(a) Major Surgery - Initial consultation or evaluation of the problem by the surgeon to determine the need for surgery is not included in the Global payment. Global payment for major 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 within 90 days after the surgery;

(E) Hospital discharge;

(F) Treatment of complications not requiring a return trip to the operating room.

(b) Minor Surgery - Initial evaluation and management services and initial consultation is not included in the Global payment. - 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 15 days after the surgery;

(E) Hospital discharge.

(c) Endoscopy - Initial consultations and initial Evaluation/Management services are not included in the Global payment. 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.

(2) Prior Authorization: All surgical procedures (other than emergent) listed in the **Medical-Surgical Services Guide** with prior authorization (PA) indicated require prior authorization, unless they are emergent.

(3) Do not bill separately for procedures which are considered to be bundled in (included in or incidental to) another procedure. Payment for bundled services is included in the primary surgery payment.

(4) Co-surgeons and Team Surgeons are two or more surgeons with separate functions during one major or complex surgery:

(a) Each should bill their usual charge and percentage of the total services provided;

(b) Payment will be determined by medical review.

(5) Concurrent surgical providers are two or more surgeons performing separate surgeries at the same operative session:.

(a) Each should bill the usual charge for that procedure in this setting;

(b) Payment will be determined by medical review.

(6) Multiple Surgical Procedures performed during the same operative session will be paid at:

(a) Primary Procedure - 100% of OMAP's maximum fee for that procedure;

(b) Second and Third Procedure - 50% of OMAP's maximum fee;

(c) Fourth, Fifth, etc. - 25% or less as determined by OMAP;.

(d) Endoscopic Procedures - 100% of OMAP's maximum fee for the primary level procedure. OMAP's fee for insertion will be deducted from the maximum fee for each additional procedure performed at the same site;

(e) Bilateral procedures must be billed on two lines. Use modifier -50 only on the second line;

(f) Bill each procedure on separate lines (including multiples of the same procedure) unless the code description specifies "each additional";

(g) Reimbursement for Laparoscopy is included in the surgical procedure and should not be billed separately or in addition to surgical procedures.

(7) Surgical Assistance: Payment is restricted to physicians, podiatrists, dentists, nurse practitioners, naturopaths and registered physician assistants:

(a) The assistance must be medically necessary;

(b) No payment will be made for surgical assistants 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 most appropriate modifier to indicate assistance.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

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. 12-1-984; 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 461-14-048, 461-14-049, 461-14-053, 461-14-055 & 461-14-056; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-710; 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

410-130-0400

Anesthesia

(1) When billing for a procedure that gains access to a venous port, CPT codes 36533-36535, 64450 or 64415, use type of service "2". All other anesthesia services must be billed with type of service "7".

(2) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services.

(3) It is the responsibility of the anesthesiologist to verify that all OMAP requirements have been met. If prior authorization was not obtained on a procedure that required prior authorization, then the anesthesia services may not be paid.

(4) Use the American Society of Anesthesiologists' Standards when calculating charges for anesthesia services. Bill OMAP the sum of the charges (global charges) on a single line of the claim. Show the number of units included in the global charge.

(5) A valid consent form is required for all sterilizations and hysterectomies. Use only OMAP Unique Code ANE01 for sterilizations and ANE02 for hysterectomies.

(6) Do not use CPT codes 99100 - 99140. These charges are to be included in the global fee.

(7) Except for anesthesia services for abortions and oral surgery in an office setting, OMAP pays a percentage of the usual and customary fees billed. Anesthesia services will be paid at a maximum allowable rate for abortions or when provided by an oral surgeon in an office setting.

(8) Anesthesia services are not payable to the provider performing the surgical procedure, except for general anesthesia, provided by an oral surgeon in an office setting.

(9) OMAP unique procedure codes:

(a) ANE01 -- All inclusive anesthesia services for sterilization;

(b) ANE02 -- All inclusive anesthesia services for hysterectomy;

(c) ANE04 -- General anesthesia by oral surgeon; initial 30 minutes (includes all materials, set-ups, and drugs used to administer anesthesia);

(d) ANE05 -- General anesthesia by oral surgeon; each additional 15 minutes (includes all materials, set-ups and drugs used to administer anesthesia);

(e) ANE09 -- General anesthesia services for abortions.

(10) Services not covered (NC), or may require prior authorization (PA) from OMPRO:

(a) 99100 -- Anesthesia for patient of extreme age, under one year and over seventy. Use anesthesia codes from the 00100 - 01999 series. -- Services considered bundled;

(b) 99116 -- Anesthesia complicated by utilization of total body hypothermia. Use anesthesia codes from the 00100 - 01999 series. Services considered bundled;

(c) 99135 -- Anesthesia complicated by utilization of controlled hypotension. Use anesthesia codes from the 00100 - 01999 series. Services considered bundled;

(d) 99140 -- Anesthesia complicated by emergency conditions (specify). Use anesthesia codes from the 00100 - 01999 series. Services considered bundled;

(e) 00532 -- Anesthesia for access to central venous circulation -- Prior authorization required;

(f) 00580 -- Anesthesia for heart transplant or heart/lung transplant. Prior authorization required;

(g) 00796 -- Anesthesia for intraperitoneal procedures in upper abdomen, including bowel shunts: Liver transplant (recipient) Prior authorization required;

(h) 00802 -- Anesthesia for procedures on lower anterior abdominal wall; panniculectomy. Not covered;

(i) 00846 -- Anesthesia for intraperitoneal procedures in lower abdomen; radical hysterectomy. Use OMAP unique code ANE02 for hysterectomies. Not covered;

(j) 00855 -- Anesthesia for intraperitoneal procedures in lower abdomen; cesarean hysterectomy. Use OMAP unique code ANE02 for hysterectomies. Not covered;

(k) 00938 -- Anesthesia for procedures on male external genitalia, insertion of penile prosthesis (perineal approach) Prior authorization required;

(l) 00944 -- Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy. Use OMAP unique code ANE02 for hysterectomies. Not covered;

(m) 01900 -- Anesthesia for injection procedure for hysterosalpingography. Not Covered;

(n) 00103 -- Anesthesia for procedures on eye, blepharoplasty. Not covered.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-720; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, 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 16-1993, f. & cert. ef. 7-2-93; 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

410-130-0420

Integumentary

Not covered services include:

(1) Procedures primarily for cosmetic purposes.

(2) Routine foot care such as trimming of nails and calluses and routine hygiene.

(3) Services that are not covered (NC), or may require prior authorization (PA) from OMPRO:

(a) M0075, Cellular therapy - Not covered;

(b) M0076, Prolotherapy - Not covered;

(c) M0100, Intragastric hypothermia using gastric freezing (MNP) - Not Covered;

(d) M0101, Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventative maintenance care (excludes debridement of nails) - Not covered;

(e) 11960, Insertion of tissue expander(s) for other than breast, including subsequent expansion - Prior Authorization Required;

(f) 11970, Replacement of tissue expander with permanent prosthesis - Prior Authorization Required;

(g) 17106, Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm; prior authorization required - (coverage limited to face only);

(h) 17107, 10.0 - 50.0 sq cm; prior authorization required - (coverage limited to face only);

(i) 17108, Over 50.0 sq cm; prior authorization required - (coverage limited to face only);

(j) 19350, Nipple/areola reconstruction - PA required;

(k) 19367, Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), single pedicle, including closure of donor site - PA required;

(l) 19368, With microvascular anatomosis (super-charging) - PA required;

(m) 19369, Double pedicle, including closure of donor site - PA required.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-730; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, 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, 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

410-130-0440

Musculoskeletal System

(1) Not covered services include: Cosmetic surgeries and procedures.

(2) The following codes require prior authorization. **Table 3**

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-740; HR 23-1990(Temp), f. & cert. ef. 7-20-90; HR 25-1990(Temp), f. 8-31-90, cert. ef. 9-1-90; HR 30-1990(Temp), f. & cert. ef. 9-10-90; HR 44-1990, f. & cert. ef. 11-30-90; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 40-1992, 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

410-130-0460

Respiratory Procedures

Services that are not covered (NC), or may require prior authorization (PA) from OMPRO:

Table 2

30400 -- Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip -- Prior Authorization (PA) Required

30410 -- Complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip -- PA Required

30420 -- Including major septal repair -- PA Required

30430 -- Rhinoplasty, secondary; minor revision (small amount of nasal tip work) -- PA Required

30435 -- Intermediate revision (bony work with osteotomies) -- PA Required

30450 -- Major revision (nasal tip work and osteotomies) -- PA Required

30460 -- Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only. -- Prior Authorization Required

30462 -- Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteomies. -- Prior Authorization Required

32850 -- Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver). Organ acquisition or other donor charges are reimbursed according to contract between OMAP and Transplant Center (provider). Covered but not reimbursable by OMAP because services are considered bundled.

32851 -- Lung transplant, single; without cardiopulmonary bypass; prior authorization required

32852 -- With cardiopulmonary bypass; prior authorization required

32853 -- Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass; prior authorization required

32854 -- With cardiopulmonary bypass; prior authorization required

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-750; 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 40-1992, 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

410-130-0480

Digestive System

Not covered services include appendectomy as an incidental procedure and some transplant services.

Table 3

The following services are covered and require prior authorization:

40840 -- Vestibuloplasty; anterior

40842 -- Posterior, unilateral

40843 -- Posterior, bilateral

40844 -- Entire arch

40845 -- Complex (including ridge extension, muscle repositioning)

43631 -- Gastrectomy, partial, distal; with gastroduodenostomy

43632 -- With gastrojejunostomy

43633 -- With Roux-en-Y reconstruction

43634 -- With formation of intestinal pouch

47135 -- Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age -- covered, requires prior authorization -- Contact the OMAP Medical Director's Office for Prior Authorization.

47136 -- Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age -- covered, requires prior authorization -- Contact the OMAP Medical Director's Office for Prior Authorization

48160 -- Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islets. Covered, requires prior authorization -- Contact the OMAP Medical Director's Office for Prior Authorization

48554 -- Transplantation of pancreatic allograft. Covered, requires prior authorization -- Contact OMAP Medical Director,s Office for prior authorization.

48556 -- Removal of transplanted pancreatic allograft -- Covered, requires prior authorization -- contact OMAP Medical Director's Office for prior authorization

49000 -- Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) separate procedure. Prior authorization required only if elective. Prior authorization not required if emergent.

Payment for the following services is bundled with other procedures:

47001 -- Biopsy of liver, needle; when done for indicated purpose at time of other major procedure.

47100 -- Biopsy of liver, wedge.

47133 -- Donor hepatectomy, with preparation and maintenance of allograft; from cadaver donor. Organ acquisition or other donor charges are reimbursed according to contract between OMAP and Transplant Center (provider).

47134 -- Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor. Organ acquisition or other donor charges are reimbursed according to contract between OMAP and Transplant Center (provider).

48550 -- Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation Organ acquisition or other donor charges are paid according to contract between OMAP and the Transplant Center.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-760; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, cert. ef. 5-1-91; 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

410-130-0500

Male Genital System

(1) Not covered services include:

(a) Infertility services;

(b) Services related to impotence;

(c) Gender change.

(2) A properly completed OMAP-742 Consent to Sterilization is required for all sterilizations. The OMAP 742 must be signed at least 30 days before the surgery.

(3) The following codes require prior authorization:

(a) 54360, Plastic operation on penis to correct angulation;

(b) 54400, Insertion of penile prosthesis; non-inflatable (semi-rigid);

(c) 54401, Inflatable (self contained);

(d) 54402, Removal or replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis;

(e) 54405, Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir;

(f) 54407, Removal, repair or replacement of inflatable (multi-component) penile prosthesis including pump and/or reservoir and/or cylinders;

(g) 54409, Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or reservoir and/or cylinders.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-280; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, cert. ef. 5-1-91; 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

410-130-0530

Nervous System

Laminectomies and other spinal procedures require prior authorization for adults and children:

(1) 63001 -- Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (e.g., spinal stenosis), one or two vertebral segments, cervical.

(2) 63003 -- Thoracic.

(3) 63005 -- Lumbar, except for spondylolisthesis.

(4) 63011 -- Sacral.

(5) 63012 -- Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure).

(6) 63015 -- Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (e.g., spinal stenosis), more than two vertebral segments, cervical.

(7) 63016 -- Thoracic.

(8) 63017 -- Lumbar.

(9) 63020 -- Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, one interspace, cervical.

(10) 63030 -- One interspace, lumbar.

(11) 63035 -- Each additional interspace, cervical or lumbar.

(12) 63040 -- Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, re-exploration, cervical.

(13) 63042 -- Lumbar.

(14) 63045 -- Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis), single vertebral segment, cervical.

(15) 63046 -- Thoracic.

(16) 63047 -- Lumbar.

(17) 63048 -- Each additional segment, cervical, thoracic or lumbar.

(18) 63194 -- Laminectomy with cordotomy, with section of one spinothalamic tract, one stage, cervical.

(19) 63195 -- Thoracic.

(20) 63196 -- Laminectomy with cordotomy, with section of both spinothalamic tracts, one stage, cervical.

(21) 63197 -- Thoracic.

(22) 63198 -- Laminectomy with cordotomy with section of both spinothalamic tracts, two stages within 14 days, cervical.

(23) 63199 -- Thoracic.

(24) 63200 -- Laminectomy, with release of tethered spinal cord, lumbar.

(25) 63250 -- Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord, cervical.

(26) 63251 -- Thoracic.

(27) 63252 -- Thoracolumbar.

(28) 63265 -- Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural, cervical.

(29) 63266 -- Thoracic.

(30) 63267 -- Lumbar.

(31) 63268 -- Sacral.

(32) 63270 -- Laminectomy for excision of intraspinal lesion other than neoplasm, intradural, cervical.

(33) 63271 -- Thoracic.

(34) 63272 -- Lumbar.

(35) 63273 -- Sacral.

(36) 63275 -- Laminectomy for biopsy/excision of intraspinal neoplasm, extradural, cervical.

(37) 63276 -- Extradural, thoracic.

(38) 63277 -- Extradural, lumbar.

(39) 63278 -- Extradural, sacral.

(40) 63280 -- Intradural, extramedullary, cervical.

(41) 63281 -- Intradural, extramedullary, thoracic.

(42) 63282 -- Intradural, extramedullary, lumbar.

(43) 63283 -- Intradural, sacral.

(44) 63285 -- Intradural, intramedullary, cervical.

(45) 63286 -- Intradural, intramedullary, thoracic.

(46) 63287 -- Intradural, intramedullary, thoracolumbar.

(47) 63290 -- Combined extradural-intradural lesion, any level.

(48) 63300 -- Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion,

single segment, extradural, cervical.

(49) 63301 -- Extradural, thoracic by transthoracic approach.

(50) 63302 -- Extradural, thoracic by thoracolumbar approach.

(51) 63303 -- Extradural, lumbar or sacral by transperitoneal or retroperitoneal approach.

(52) 63304 -- Intradural, cervical.

(53) 63305 -- Intradural, thoracic by transthoracic approach.

(54) 63306 -- Intradural, thoracic by thoracolumbar approach.

(55) 63307 -- Intradural, lumbar or sacral by transperitoneal or retroperitoneal approach.

(56) 63308 -- Each additional segment (list separately in addition to codes for single segment (63300 - 63307)).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

Hist.: HR 6-1994, f. & cert. ef. 2-1-94

410-130-0540

Female Genital System

(1) Not covered services include:

(a) Infertility services;

(b) Cosmetic surgeries and procedures;

(c) Gender change;

(d) Hysterectomy for purposes of sterilization;

(e) In vitro fertilization.

(2) Elective diagnostic laparoscopies require prior authorization. **Table 4**

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 11-1978(Temp), f. 3-2-78, ef. 3-3-78; AFS 26-1978, f. 6-30-78, ef. 7-1-78; AFS 44-1978, f. & ef. 11-20-78; AFS 4-1979(Temp) f. & ef. 3-8-79; AFS 11-1979, f. 6-28-79, ef. 7-1-79; AFS 42-1979(Temp), f. & ef. 11-1-79; AFS 54-1979(Temp), f. 12-31-79, ef. 1-1-80; AFS 8-1980, f. 2-15-80, ef. 3-1-80; AFS 18-1980, f. & ef. 3-31-80; AFS 66-1980(Temp), f. & ef. 9-23-80; AFS 77-1980(Temp), f. & ef. 10-17-80; AFS 11-1981, f. 2-11-81, ef. 3-1-81; AFS 45-1981(Temp), f. 7-10-81, ef. 7-12-81; 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 80-1982(Temp), f. & ef. 8-20-82; AFS 95-1982, f. & ef. 10-19-82; AFS 4-1985, f. 1-17-85, ef. 2-1-85; AFS 23-1986, f. 3-19-86, ef. 5-1-86; Renumbered from 461-14-031 & 14-052; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-830; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 21-1991, f. 4-16-91, 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 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 410-130-560 & 410-130-561; 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

410-130-0562

Abortion

(1) Do not use CPT codes 59840 through 59857.

(2) Use only the following OMAP Unique Procedure Codes based on gestational age or bipolar diameter and site of service when billing for abortions and abortion related services.

(3) Therapeutic abortion services provided in an office or clinic setting include: Preoperative visits, surgical procedures, materials and supplies (including medications such as Rho immune globulin), radiology services (including ultrasounds), and postoperative follow-up visits for 90 days following the surgery.

(4) Therapeutic abortion services provided in an Ambulatory Surgical Center (ASC), outpatient hospital or inpatient hospital setting include: preoperative visits, surgical procedures, professional components of radiology services (including ultrasounds), and postoperative follow-up visits for 90 days following the surgery.

(5) Payment for technical components of radiology services and materials and supplies is included in the payment to Ambulatory Surgical Centers and hospitals.

(6) Reimbursement for ultrasounds performed by outside labs, radiology departments or other physicians is the responsibility of the provider billing OMAP Unique Abortion codes.

(7) OMAP Unique Procedure Codes. **Table 5**

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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

410-130-0580

Sterilizations

(1)Prior authorization is not required. A copy of a properly completed OMAP-742 or the consent form in the federal brochures, **DHHS Publication No. (05) 79-50062 (Male)** and **DHHS Publication No. (05) 79-50061 (Female)** must be submitted to OMAP for all sterilizations. The original consent form must be retained in the clinical records.

(2)Voluntary Sterilization:

(a)Consent for sterilization must be an informed choice. It is not valid if signed when the client is in labor, seeking or obtaining an abortion, or under the influence of alcohol or drugs;

(b)For those age 15 and over:

(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 C-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 C-section), the consent form must have been signed at least 72 hours before the sterilization was performed.

(B) The consent form must be signed and dated by the person obtaining the consent after the client has signed but before the date of the sterilization. If an interpreter assists the client in completing the form, the interpreter must also sign the consent;

(C) The person 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 person the detailed information appearing on the Form OMAP 742 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.

(c) For those under age 15, the parent or guardian must sign the consent form at least 30 days before the date of the procedure.

(3) Involuntary Sterilization -- Minors (15 years to 21 years) and incapacitated clients:

(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 a sterilization, it issues a Sterilization Order. The order must be attached to the billing invoice. No waiting period or additional documentation is required.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS

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 461-14-030; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-840; 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

410-130-0585

Family Planning Services

(1) Family planning services are available to individuals of childbearing age (including minors who can be considered to be sexually active) who desire such services. Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size. Counseling services, laboratory tests, medical procedures, and pharmaceutical supplies and devices are covered if provided for family purposes. Family planning clinics will only be reimbursed for services related to family planning.

(2) These services are billed using appropriate CPT, HCPCS or OMAP unique codes.

(3) Family planning methods include natural family planning, abstinence, I.U.D, cervical cap, prescriptions, subdermal implants, condoms and diaphrams.

(4) All family planning billings must be coded with the most appropriate diagnosis codes under V25 (Contraceptive Management) of the ICD-9-CM.

(5) Radiology and laboratory services are payable in addition to OMAP unique codes for family planning.

(6) Use specific CPT codes for insertion and removal of subdermal contraceptive implants and IUDs. Use J7300 for IUD supply.

(7) Office of Medical Assistance Programs (OMAP) Unique Codes for Family Planning Services:

(a) FPS01 - Annual Family Planning Visit. New or established patient visit for family planning, education, examination and explanation of the full range of contraceptive information and methods (includes FPS02). Payable once per calendar year;

(b) FPS02 - Comprehensive Contraceptive Counseling Explanation of the full range of contraceptive information and methods. Not payable on the same date of services as FPS01.

(8) Contraceptive Supplies. Use the listed OMAP Unique/HCPCS codes for contraceptive supplies and bill at acquisition cost:

(a) Do not bill 99070 or J7140 for contraceptive supplies;

(b) Code FPS03, Contraceptive supplies other than injectables and implants: Oral contraceptives, female and male condoms, diaphragms, cervical caps, contraceptive sponges, foams, creams, and jellies;

(c) Code A4260, Subdermal Contraceptive Implant Kit;

(d) Code J1055 Injection, medroxyprogesterone acetate (Depo Provera) for contraceptive use, 150 mg.;

(e) J7300, Intrauterine copper construction.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 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

410-130-0660

Radiology

(1) CPT codes 76805, 76815, and 76816 are not payable for therapeutic abortions. Ultrasounds for therapeutic abortions are bundled in global abortion codes paid to the physician or facility.

(2) Not covered services include infertility testing or procedures and experimental procedures.

(3) Provision of diagnostic radionuclide(s) (CPT 78990 is payable only when used in conjunction with nuclear medicine procedures (CPT codes 78000 through 79999).

(4) 79900, provision of therapeutic radio-nuclide(s) is payable only when used in conjunction with radiation therapy and nuclear medicine procedures (77401-79999).

(5) Contrast Materials:

(a) Reimbursement for contrast is bundled in the radiologic procedure, except for low osmolar contrast materials (LOCM). Supply of LOCM (A4644-A4646) may be billed in addition to the radiology procedure, only when the following criteria is 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; or

(B) History of asthma or significant allergies; or

(C) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension; or

(D) Decrease in renal function; or

(E) Diabetes; or

(F) Dysproteinemia; or

(G) Severe dehydration; or

(H) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage); or

(I) Sickle cell disease; or

(J) Generalized severe debilitation.

(b) Bill LOCM per milliliter (ml).

(6) Routine screening mammographies must be billed under 76092.

(7) HCPCS codes R0070 thru R0076 are covered.

Table 6

Services that are not covered (NC), or may require prior authorization (PA) from OMPRO:

74740 -- Hysterosalpingography; supervision and interpretation - Not covered

74742 -- Transcervical catheterization of fallopian tube, radiological supervision and interpretation -- not covered

78459 -- Myocardial Imaging, Positron Emission Tomography (PET), metabolic evaluation -- requires prior authorization

78810 -- Tumor Imaging, Positron Emission Tomography (PET), metabolic evaluation -- requires prior authorization

A4647 -- Supply of paramagnetic contrast material, e.g., gadolinium; contrast is covered but not reimbursable by OMAP because code is bundled in procedure reimbursement.

A4642 -- Supply of satumomab pendetide, radiopharmaceutical diagnostic imaging agent, per dose -- covered but not reimbursable by OMAP because code is bundled in procedure reimbursement

A4643 -- Supply of additional high dose material(s) during magnetic resonance imaging, eg, godoteriodol injection (consistent with contrast labeling criteria) -- covered but not reimbursable by OMAP because code is bundled in procedure reimburse-ment

Q0092 -- Set-up portable x-ray equipment; covered but not reimbursable by OMAP because service is Bundled in radiology procedures

G0030 - G0047 -- PET (Positron Emission Tomography) Myocardial Perfusion Imaging, single and multiple studies. Refer to the current CPT guide for a detailed description of each procedure -- prior authorization required

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-790; 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

410-130-0680

Pathology and Laboratory

(1) Not covered services include:

(a) Tests related to infertility (male and female);

(b) Chemical screens for surveillance purposes;

(c) Post-mortem tests;

(d) Experimental procedures;

(e) Paternity tests;

(f) Pre-marital profiles;

(g) Whole blood;

(h) Travel for specimen collection (except for homebound patient not residing in a nursing facility).

(2) Automated Multichannel Tests: All lab procedures performed on a single multi-channel run must be billed under one multi-channel code (80002 - 80019, G0058 - G0060); these tests must not be billed separately. Providers must use the appropriate code in the 80002-80019, G0058 - G0060 series when billing for tests listed under the "Automated, Multichannel Tests" in CPT.

(3) Organ Panels: OMAP will only cover organ panels as defined by CPT. When labs include other tests in their panels or profiles which are not listed in the CPT panel description, those tests may not be billed unless specifically ordered by the practitioner; otherwise payment for those tests is considered included in the panel. When all tests provided are listed within a CPT panel, they may not be billed individually even when they are ordered separately. The same Organ Panel

may be billed only once per day per client.

(4) Laboratory charges may only be billed by and paid to the performing provider or a designated billing agent.

(5) A provider who sends a specimen to another provider for testing may bill OMAP only for drawing a blood sample through venipuncture or collecting a urine sample by catheterization. Collection of other specimens (such as PAP or other smears, voided urine samples, stool specimens, PKU) are considered bundled in the visit or lab procedures. Venipuncture and urinary catheterization are payable only once per day regardless of the frequency performed. Handling costs are considered bundled in the reimbursement for the total testing service or the visit and are not payable in addition to the laboratory test.

(6) Pass-along charges from the performing laboratory to another laboratory/Doctor do not qualify for payment by OMAP.

(7) Laboratory services performed by any provider are reimbursable only after the provider is certified by HCFA as meeting the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and HCFA has notified OMAP of the assignment of a ten-digit CLIA number.

(8) PKU (84030) is not payable as this service is performed by the State lab. Replacement of lost PKU cards may be billed with code 99070 and loss must be documented in the patient's medical record.

(9) All lab tests must be specifically ordered by licensed practitioners within the scope of their practice.

(10) Upon written notification by OMAP, only certified laboratory providers with Clinical Laboratory Improvement Amendments (CLIA) numbers will be allowed to bill for laboratory procedures (for which they are certified) CLIA establishes two categories of laboratory certification:

(a) Certificate of Waiver Laboratory. Payment for covered laboratory services furnished by these laboratories is limited to the following procedures:

(A) 81025 -- Urine pregnancy tests, by visual color comparison methods;

(B) 83026 -- Hemoglobin; by copper sulfate method, non-automated;

(C) 82962 -- Glucose, blood; by glucose monitoring device(s) cleared by the FDA specifically for home use;

(D) 82270 -- Blood, occult, feces screening, 1-3 simultaneous determinations;

(E) 81002 -- Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy;

(F) 85013 -- Blood count; spun microhematocrit;

(G) 85651 -- Sedimentation rate, erythrocyte; non-automated.

(b) Certificate of Registration Laboratory. These laboratories are approved to continue performing all laboratory tests at the same level approved under Medicare until OMAP is officially notified of the CLIA survey results. After labs are surveyed they may perform only those procedures authorized by HCFA.

(11) Procedure Code 84830, Ovulation tests, by visual color comparison methods for human luteinizing hormone is considered a fertility test and is not reimbursable by OMAP.

(12) All lab orders must be signed or initialed by the ordering provider.

(13) The medical necessity for all lab services must be documented in the client's medical record.

(14) Transplant lab codes are covered only if the transplant service is covered and the transplant has been authorized.

(15) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests as provided by the referring lab.

(16) The date of collection must be used as the date of service (DOS) regardless of the actual date performed.

(17) Blood and blood products (codes P9010-P9013 and P9016-P9022) are not covered under the Medical-Surgical Services Program.

(18) Special Services and Reports: A provider who sends a specimen to another provider for testing may only bill OMAP for drawing a blood sample through venipuncture or collecting a urine sample by catheterization. Use specific HCPCS codes for venipuncture (G0001) and urinary catheterization (G0002).

(19) OMAP will pay for procedure codes 99052 (service between 10 pm and 8 am in addition to basic service) or 99054 (service on Sundays and holidays in addition to basic service) when the service provided is outside the practitioner's usual or scheduled working hours. These services are not payable to emergency room based physicians. **Table 6**

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

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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 461-14-056; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-800; 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

410-130-0700

Supplies - DME and Other Materials

(1) Bill all supplies and materials with HCPCS codes at acquisition cost (purchase price plus postage). Use 99070 only for lost PKU cards.

(2) Materials normally used in the office setting do not qualify for extra payments. Such items generally include small sterile trays/setups, cleaning agents, examination utensils, lubricants, local anesthetics, and small bandages.

(3) Medical and Surgical Supplies HCPCS Codes (A4000-A5499):

(a) Only the following HCPCS codes are covered under the Medical-Surgical Services program when provided in the office setting:

(A) A4641 - A4647 (see Radiology);

(B) A4216 - A4255;

(C) A4260 - A4263;

(D) A4270 - A4401;

(E) A4403 - A4595;

(F) A4615 - A4628;

(G) A4635 - A4637;

(H) A4649;

(I) A5051 - A5149.

(b) All other services under HCPCS codes A4000 - A5499 must be referred to DME providers;

(c) Reimbursement for office surgical suites and office equipment is bundled in the surgical procedures;

(d) For contraceptive supplies see Family Planning Services.

(4) Home Enteral and Parenteral Nutrition and IV Services (B4000-B9999): HCPCS codes B4000-B4036 and B4150 - B9999 are not covered under the Medical-Surgical Services program, but are covered under the Home Enteral and Parenteral Services program. These services must be referred to home enteral and parenteral providers.

(5) Durable Medical Equipment (E0100-E1799):

(a) Only the following DME HCPCS codes are covered under the Medical-Surgical Services program when provided in an office setting:

(A) E0100 - E0116;

(B) E0191;

(C) E1399.

(b) Refer all other items with "E" series HCPCS codes, such as walkers, commodes, hospital beds, oxygen, monitoring equipment, ventilators, glucose monitors, TENS units, wheelchairs and accessories, to DME providers.

(6) Drugs (J0000-J9999): See OAR 410-130-0180 for coverage of drugs under J0000-J9999 and temporary "K" HCPCS codes.

(7) Temporary Codes (K0001-K0167):

(a) Only the following temporary HCPCS codes are covered for Medical-Surgical providers:

(A) K0277-K0279;

(B) K0407-K0408;

(C) K0410;

(D) K0411;

(E) Refer all other items with "K" series HCPCS codes to DME providers.

(b) Orthotic and Prosthetic Procedures (L0100-L9999):

(A) Refer to the OMAP Durable Medical Equipment and Medical Supplies provider guide for coverage criteria for orthotics and prosthetics;

(B) All codes in the L0100-L9999 series are covered except: **Table 7**.

(C) Reimbursement for orthotics is a global package which includes:

(i) Measurements;

(ii) Moldings;

(iii) Orthotic item;

(iv) Adjustments;

(v) Fittings.

(D) Evaluation/management codes are covered only for the diagnostic visit where the medical necessity of the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.

(c) Unlisted HCPCS codes should be billed for items that do not have specific HCPCS codes. Bill at acquisition cost. Acquisition cost is purchase price plus postage.

(9) A9000 - A9999 codes (Administrative, Miscellaneous and Investigational) are not covered.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-14-056; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-14-830; 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

410-130-0760

Hysterectomy

(1) Hysterectomies performed for the sole purpose of sterilization are not covered.

(2) A properly completed Hysterectomy Consent (OMAP-741 form) or a statement signed by the performing physician depending upon the following circumstances is required for all hysterectomies.

(3) In cases where a woman is capable of bearing children, 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. The woman or her representative, if any, must sign the consent to acknowledge she received that information.

(4) In cases where 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.

(5) In cases where a hysterectomy is required because of a life-threatening emergency situation in which the physician determines that prior acknowledgement 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 acknowledgement was not possible and describe the nature of the emergency.

(6) 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 state the cause of the sterility; or

(c) The hysterectomy was performed because of a life-threatening emergency situation in which prior acknowledgement was not possible and describe the nature of the emergency.

(7) Radical hysterectomies do not require prior authorization. All other hysterectomies require prior authorization.

(8) Do not use the Consent to Sterilization form (OMAP 742) for hysterectomies. **Table 8**

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1997, f. 1-31-97, cert. ef. 2-1-97

410-130-0780

Maternity Care and Delivery

(1) Use Evaluation/Management codes when providing three or fewer antepartum visits.

(2) Multiple births: Bill the most involved procedure with the appropriate CPT code. Bill the 2nd or 3rd, etc. delivery under MCD04 and attach a report. Send the claim and report to OMAP Provider Services.

(3) The following services are not covered or may require prior authorization:

(a) 59412, External cephalic version with or without tocolysis (for delivery). When performed during labor and delivery, external cephalic version is considered bundled in labor and delivery payment. Payable only if performed prior to labor;

(b) 99360, Physician standby services, requiring prolonged physician attendance; each 30 minutes (eg, operative standby, standby cesarean/high risk delivery for newborn care). Covered only for standby at cesarean/high risk delivery of newborn;

(c) MCD01 - Total Obstetrical Care, Clinic Setting, includes all services identified in 59400 and all auxiliary services and supplies related to clinic delivery including PKU card packet. Does not include RhoGam. Must provide four or more antepartum visits. Not billable if delivery performed in a birthing center, ambulatory surgical center, or hospital setting;

(d) MCD02 - Total Obstetrical Care, Home Setting, includes all services identified in 59400 and all auxiliary services and supplies related to home delivery including PKU card packet. Does not include RhoGam. Must provide four or more antepartum visits;

(e) MCD03 - Labor management only, in any setting;

(f) MCD04 - Multiple births.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1997, f. 1-31-97, cert. ef. 2-1-97

410-130-0800

Immunizations

(1) The Vaccines for Children Program began April 1, 1996. Under this federal program, certain immunizations are free for clients from birth through 18 years of age. As a result, OMAP no longer reimburses providers for the cost of vaccines covered by this federal program.

(2) Not covered services include immunizations for foreign travel.

(3) Use standard billing procedures for vaccines that are not part of the Vaccines for Children (VFC) Program.

(4) Use the following procedures when billing immunizations included in the VFC Program:

(a) When the sole purpose of the visit is to administer an immunization, the provider shall bill the appropriate immunization procedure code with modifier -26. Do not bill CPT code 99211;

(b) When the immunization is administered as part of an Evaluation and Management service (e.g., well-child visit) the provider shall bill the appropriate Evaluation and Management code and immunization code with modifier -26.

(5) The following immunization codes are included in the Vaccines for Children Program for clients from birth through 18 years of age:

(a) 90700 - 90713;

(b) 90716;

(c) 90719 - 90721;

(d) 90737;

(e) 90744-90745.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1997, f. 1-31-97, cert. ef. 2-1-97

410-130-0900

Administrative Medical Examinations and Reports

(1) These services are covered only when requested by an AFS, SDSD, MHDDSD, OYA or SOSCF branch office or approved by OMAP. The branch office may request an administrative medical examination or a medical report (OMAP 729) to establish client eligibility for an assistance program or casework planning.

(2) Use only diagnosis code V68.89 when billing.

(3) If testing is needed for diagnosis, instruct the ancillary provider to bill using diagnosis code V68.89 and the appropriate CPT or HCPCS procedure code. For psychiatric/psychological testing, contact the branch office for the appropriate administrative exam.

(4) Retain a copy of the OMAP 729 for your records.

(5) Send the report to the requesting branch office.

(6) Only medical doctors, osteophaths, psychologists, licensed clinical social workers and optometrists may provide these services, per Social Security Regulation 404.1513.

(7) Use the following OMAP Unique Procedure Codes to bill these services:

(a) ADM11, Comprehensive medical history and physical examination with narrative report that includes diagnosis, prognosis, and objective clinical evidence to support the impairment and the individual's limitations to perform normal functions;

(b) ADM12, Completion of Physical Residual Function Capacity Report during examinations or from existing records;

(c) ADM13, Completion of Mental Residual Function Capacity Report (OMAP 729F) during examinations or based on existing records;

(d) ADM03, Ophthalmic/optometric examination with completion of OMAP 729C;

(e) ADM04, Intellectual assessment by psychologist or psychiatrist with narrative report;

(f) ADM05, Intermediate psychiatric or psychological evaluation with completion of OMAP 729B;

(g) ADM06, Personality assessment (including but not limited to MMPI) by psychologist or psychiatrist with narrative report;

(h) ADM07, Comprehensive psychiatric or psychological evaluation (no testing) with narrative report per recommended outline OMAP 729A form;

(i) ADM08, Comprehensive evaluation and testing (intellectual, personality and organicity) by psychologist or psychiatrist with narrative report;

(j) ADM09, Comprehensive evaluation without testing by social worker with narrative report;

(k) ADM10, Copies of all existing office records. Include progress notes, laboratory reports, X-ray reports, special study reports beginning with the date requested. Include recent hospital admission records, if available;

(l) ADM01, Completion of GA Impairment Report (OMAP 729X form) from existing records;

(m) ADM02, Completion of a physical capacity evaluation;

(n) PIN01, Comprehensive psychosexual evaluation by psychiatrist, psychologist, or licensed clinical social worker, including assessment of history and degree of offending behaviors, cognitive distortions, empathy, hospitality, compulsivity and impulsivity with narrative report. Only for SOSCF or OYA clients;

(o) PIN03, Plethysmograph testing by psychiatrist or psychologist with narrative report. Only for SOSCF or OYA clients.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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1998 Compilation

DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 131

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

410-131-0000

Foreword

(1) The **Physical and Occupational Therapy Services Guide** is a user's manual designed to assist provider in program information and preparation of claims for medical assistance clients. This **Guide** is used in conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Administrative Rules.

(2) Administrative Rules, procedures codes, instructions on completing claim forms, and examples of forms are included in this **Guide**.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 8-1995, f. 3-31-95, cert. ef. 4-1-95

410-131-0020

Purpose

In conjunction with the General Rules of Oregon Medical Assistance Programs and the Oregon Health Plan Medicaid Demonstration Project Administrative Rules, these rules are hereby established by the Office of Medical Assistance Programs (OMAP) for the purpose of supervising and controlling payment for physical and occupational therapy services provided to those Medical Assistance clients eligible to receive such services under the provisions of Oregon

State Statutes. OMAP will reimburse for the lowest level of service that meets the medical needs.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: 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 63-1987, f. 12-30-87, ef. 4-1-88; HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; Renumbered from 461-23-000; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95

410-131-0040

Physical Therapy

Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards of Practice for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapist Assistant established by the American Physical Therapy Association will govern the practice of physical therapy.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 688.010 - 688.225

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91

410-131-0060

Occupational Therapy

Occupational Therapy Licensing Board, ORS 675.210 to 675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association Inc., will govern the practice of occupational therapy.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 675.210 - 675.340

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91

410-131-0080

Therapy Expected Outcome

(1) Therapy is based on a medically necessary plan of treatment with goals and objectives developed from an evaluation or re-evaluation.

(2) The therapy regimen, whenever possible, will be taught to the patient, family, foster parents, and/or caregiver who will carry out the therapy regimen to assist in the achievement of the goals and objectives.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92

410-131-0100

Maintenance

(1) Therapy becomes maintenance when any of the following develop:

(a) The therapy plan of treatment goals and objectives is reached;

(b) There is no progress toward the therapy plan of treatment goals and objectives;

(c) The therapy plan of treatment does not require the skills of a therapist;

(d) The patient, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are responsible for the maintenance therapy.

(2) Maintenance therapy is not reimbursable.

(3) For maintenance therapy, re-evaluation to change the plan of care and/or for brief retraining of the patient, family, foster parents or caregiver is reimbursable.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92

410-131-0120

Limitations

(1) A licensed occupational or physical therapist, or a licensed occupational or physical therapy assistant under the supervision of a therapist, must be in constant attendance while therapy treatments are performed.

(2) Therapy treatments will not exceed one hour per day each for Occupational and Physical Therapy.

(3) Up to two modalities may be authorized per day of treatment.

(4) Supplies and materials for the fabrication of splints must be billed at the acquisition cost, not to exceed $60. Acquisition cost is purchase price plus shipping. Time for splint fabrication may be reimbursed up to one and one-half (1-1/2) hours for each splint.

(5) Therapy records must include:

(a) A written order, including type, number and duration of services, and therapy treatment plan signed by a physician;

(b) Documents, evaluations, re-evaluations and progress notes to support the therapy treatment plan and physician's orders for changes in the therapy treatment plan;

(c) Modalities used on each date of service;

(d) Procedures performed and amount of time spent performing the procedures is documented and signed by the

therapist;

(e) Documentation of splint fabrication and time spent fabricating the splint.

(6) The therapy treatment plan and regimen will be taught to the patient, family, foster parents, and/or caregiver during the therapy treatments and no extra treatments will be authorized for teaching.

(7) Maintenance therapy means the goals and objectives have been reached, or there is no progress toward the goals and objectives, or the therapy does not require the skills of a therapist, and the patient, family, foster parents, or caregiver have been taught and can carry out the therapy regimen. Maintenance therapy is not reimbursable.

(8) A re-evaluation to reassess or change the treatment plan and retrain the patient, family, foster parents, or caregiver are reimbursable.

(9) Physical capacity examinations are not a part of the Occupational and Physical Therapy program, but may be reimbursed as Administrative Examinations when ordered by the local branch.

(10) Services Which Do Not Require Payment Authorization:

(a) Up to two Initial Evaluations for Occupational Therapy in any 12 month period;

(b) Up to two Initial Evaluations for Physical Therapy in any 12 month period;

(c) Up to four Occupational Therapy re-evaluation services in any 12 month period;

(d) Up to four Physical Therapy re-evaluation services in any 12 month period.

(11) Services Which Require Payment Authorization - All Occupational and Physical Therapy treatments require payment authorization.

(12) Services Not Covered:

(a) Services not medically appropriate;

(b) Back School/Back Education Classes;

(c) Work hardening;

(d) Services for those diagnoses which do not appear on a line of the Prioritized List of Health Services which has been funded by the Oregon Legislature (OAR 410-141-0520);

(e) Constant Motion Machine Rental;

(f) Therapy balls;

(g) Hippotherapy;

(h) Mobility Monitor;

(i) Urinary incontinence therapy.

(13) Rules 410-131-0020 - 410-131-0160 also apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. They do not apply to services provided to hospital inpatients. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments is to be in accordance with the rules in their respective provider guides.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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

410-131-0140

Prescription Required

The provision of physical and occupational therapy services must be supported by a written order and a therapy treatment plan signed by a physician. The order must specify the services, amount and duration required and be on file in the provider's therapy record. The written order and the treatment plan will be reviewed and signed by the physician every six months.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: 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 63-1987, f. 12-30-87, ef. 4-1-88; HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; Renumbered from 461-23-001; HR 19-1992, f. & cert. ef. 7-1-92; HR 28-1993, f. & cert. ef. 10-1-93

410-131-0160

Payment Authorization

(1) Payment authorization (PA) is approval by the OMAP Medical Group or Senior and Disabled Services Division branch for services which are medically necessary. Payment authorization (PA) is required for physical and occupational therapy services as indicated in the Procedure Code section of the Physical and Occupational Therapy guide. For treatment requiring authorization, providers must contact OMAP or SDSD for authorization within five working days following initiation of services. Authorization will be given based on medical necessity and appropriateness of the therapy given. If service is provided prior to receiving authorization, the provider may be at risk for denial of authorization. Obtaining a PA is the responsibility of the provider. The FAX or postmark date is recognized by OMAP as the date of request.

(2) Services for persons having Medicare and Medicaid will require payment authorization after Medicare has reimbursed the maximum allowable for the year.

(3) Verify eligibility for Medicaid clients by checking the client's Medical Care ID or calling the Automated Information System (AIS).

(4) Where to Request Payment Authorization:

(a) Services for clients identified on the Medical Care Identification as Adult and Family Services (AFS) and State Office for Services to Children and Families (SOSCF) will be authorized by Office of Medical Assistance Programs (OMAP), Medical Group. All required documentation should be mailed to OMAP;

(b) Services for clients identified on their Medical Care Identification as Senior and Disabled Services Division (SSD) clients will be authorized by the local branch designated on the Medical Care Identification;

(c) Services for clients identified on their Medical Care Identification as having an "OMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures.

(5) A copy of the written prescription, the OMAP 3071 (Prior Authorization and Status Report for Physical, Occupational and Speech Therapy Form) or a reasonable facsimile of the OMAP 3071 which contains the same information, must be submitted to the authorizing agency with each request. The request must document medical necessity, (including diagnosis) and specific services requested (e.g., physical or occupational therapy 30 minutes three times a week for four weeks). The OMAP 3071 should contain:

(a) Client's name;

(b) Medicaid recipient ID number;

(c) Procedure codes;

(d) Provider number;

(e) Procedures to be used, frequency, and duration;

(f) Therapist's name;

(g) Medical justification;

(h) Dates of services;

(i) Diagnosis;

(j) ICD-9-CM codes to their highest degree of specificity, as stated in OAR 410-120-1280, and supplied by the prescribing provider;

(k) Goals and objectives.

(5) A Payment Authorization number must be present on all occupational/physical therapy claims requiring payment authorization or the claim will be denied for payment.

(6) Payment authorization does not guarantee eligibility or payment. It is the provider's responsibility to check for eligibility on the date of service.

(7) Requests to change an existing prior authorization should be mailed or faxed to the agency which issued the original authorization; or call the managed health care plan to determine their procedures. Include the following information: client name, Medicaid recipient ID number, payment authorization number, and documentation to support the change.

(8) Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding provision of services.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 461-23-015; 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

410-131-0180

Billing Forms

(1) Billings for physical and occupational therapy services listed in this guide are submitted on a HCFA-1500 or an OMAP 505. The Office of Medical Assistance Programs (OMAP) will accept a claim up to 12 months after the date of service (General Rule 410-120-0340). HCFA-1500 forms are not provided by OMAP. A common source for obtaining these forms is a local forms supplier.

(2) The provider shall forward the completed HCFA-1500 claim form to Office of Medical Assistance Programs, Salem, OR 97309.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91

410-131-0200

Medicare/Medicaid Claims

(1) If a patient has both Medicare and Medicaid coverage, providers must bill Medicare first. If Medicare transmits incorrect information to OMAP or if an out-of-state Medicare carrier or intermediary was billed, providers must bill OMAP using an OMAP 505 form. If any payment is made by OMAP, an Adjustment Request must be submitted to correct payment, if necessary.

(2) OMAP payment will be based on the lesser of Medicare's maximum allowable rate, or OMAP's maximum allowable rate.

(3) If a patient has Medicare coverage and has not met the $750 Medicare maximum, bill Medicare first (no prior authorization is required). Medicare will automatically forward the bill to OMAP.

(4) For physical or occupational therapy services above the $750 Medicare maximum an OMAP prior authorization number must be obtained and OMAP must be billed directly using an OMAP 505.

(5) Supplies of OMAP 505 forms can be obtained by following the usual procedures for obtaining OMAP forms. Providers send all completed OMAP 505 forms to: Office of Medical Assistance Programs, Salem, Oregon 97309.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91

410-131-0220

Instructions on How to Complete the Health Insurance Claim Form (HCFA-1500)

(1) The HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedure. Do not "carry over" totals from one

HCFA-1500 to another. The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight digit number found on the OMAP Medical Care Identification;

(b) Patient's Name: The name as it appears on the OMAP Medical Care Identification;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, FCHP (if the client is in a prepaid health plan), or the primary care case manager if the patient is restricted;

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, FCHP (if the client is in a prepaid health plan), or the primary care case manager if the patient is restricted;

(e) Date of Service: Must be numeric. If "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(f) Place of Service: Where service is provided:

(A) 3 -- practitioners office;

(B) 4 -- patient's home;

(C) 7 -- intermediate care facility;

(D) 8 -- skilled nursing facility;

(E) D -- specialized treatment center.

(g) Type of Service Codes (TOS): Enter Type of Service "S";

(h) Procedures, Services or Supplies: Enter the appropriate code listed in the Physical/Occupational Therapy provider guide;

(i) Charges: Enter your usual and customary charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge field minus the information in the Amount Paid field). Do not include insurance write-off amounts;

(m) Provider Number: Enter the OMAP billing or provider number here. Note: Only one number may be entered in this field;

(n) Diagnosis or Nature of Illness or Injury: Enter the primary diagnosis/condition of the patient indicated by current ICD-9-CM code number, as supplied by the physician. Enter up to four codes in priority order. The codes should be carried out to their highest degree of specificity. Do not enter the decimal point or unnecessary characters.

(2) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Care Identification. When appropriate, use the two-digit Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related to: Complete only when an injury is involved;

(c) Prior Authorization Number: If required enter the 9-digit Prior Authorization number here. Do not bill prior authorized and non-prior authorized services on the same form;

(d) Reserved for Local Use (Field 10d): Put a "Y" in this box if treatment was an emergency;

(e) Reserved for Local Use -- (24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(f) Amount Paid: Enter the total amount paid from other resources. Do not show any payment from OMAP on this line.

(3) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage list. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

(I) NE -- Service Not Considered Emergency by Insurance;

(J) NP -- Service Not Provided by Primary Care Provider/ Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/Condition;

(L) RI -- Requested Information Not Received by Insurance from Patient;

(M) RP -- Requested Information Not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- not paid within 30 days (effective November 1, 1991);

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary paid;

(B) SU -- Primary Insurance Paid -- Secondary under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why not TPR payment was made).

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97

410-131-0240

Instructions on How to Complete the OMAP 505

(1)* Patient's Name: Enter the name as it appears on the OMAP Medical Care Identification.

(2)* Insured's Medicaid No.: Enter the 8 digit number from the OMAP Medical Care Identification.

(3)* Insured's Group No.: The Medicare number as it appears on the client's Medicare Identification Card. (Example: 123456789A or 234567890C1).

(4)* Other Health Insurance Coverage: If no payment was received from Medicare, this space must be used to explain

why no payment was made. Select a 2 digit "reason" code from the Third Party Resource (TPR) codes that are found in the billing section of this guide. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the Third Party Resource (Medicare). Example: Medicare paid nothing ("reason" code NC, Not Covered). Enter: NC - Medicare. Do not mail the Medicare EOB in with your claims.

(5)** Was Condition Related to: Complete only if service is related to an injury/accident.

(6)** If An Emergency Check Here: Complete if the service was performed as an emergency.

(7)* Name of Referring Physician or Other Source: Enter the OMAP provider number or UPIN of the referring (requesting) practitioner.

(8)** Prior Authorization: Enter the 9-digit prior authorization number issued by OMAP or the Branch/Unit shown on the OMAP Medical Care Identification here.

(9)* Date of Service: Use a six digit numeric date. If a "From - To" date range is used, all services must be on consecutive days.

(10)* Place of Service: Where service is provided: (3 = practitioner' office, 4 = patient's home, 7 = intermediate care facility, 8 = skilled nursing facility, D = specialized treatment center).

(11)* Procedure Code: Enter only the CPT codes, HCPCS codes or OMAP unique procedure codes listed in the Physical/ Occupational Therapy Services provider guide.

(12)* Days or Units: Enter the number of services or units billed.

(13)* Type of Service Codes (TOS): Use Type of Service "S".

(14)* Charges Billed Medicare: Enter the total dollar amount billed to Medicare for each service.

(15)* Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare for each service.

(16)** Provider Number: Enter your OMAP performing provider number here if a billing provider number is used in Field 34.

(17)* Total Charge: Add the charges in Field 24G and enter the total dollar amount Medicare was billed.

(18)* Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services.

(19)** Insurance Other than Medicaid/ Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "0".

(20)* Balance due: Subtract the amounts in Fields 28 and 30 from Field 27 and enter the balance in this field. An amount must be put in this field.

(21) Your Patient's Account No.: If the patient account number is entered here, OMAP will print that number on the Remittance Advice.

(22)* Provider Number: Only the OMAP provider number is required.

(23)* Diagnosis or Nature of Illness or Injury: Enter primary diagnosis/condition of the patient indicated by current ICD-9-CM code number. Enter up to four codes in priority order. The codes should be carried out to their highest degree of specificity. Do not key the decimal point or unnecessary characters.

(24)* Diagnosis Code: Enter a single diagnosis reference number as shown in field 23A.

* = Required Field ** = Required When Applicable

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95

410-131-0260

Individual Adjustment Request

(1) Overpayments, underpayments and payments received after OMAP has paid a claim can be resolved through the adjustment process.

(2) Obtain Individual Adjustment Request forms from the AFS Forms Distribution Center. Much of the information required on the Adjust-ment Request form is printed on the Remittance Advice. Documentation may be submitted to support the request. Adjustment Requests must be submitted in writing to: Office of Medical Assistance Programs, Salem, OR 97309.

(3) How to Complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b)Thisisaremindertoattachneeded documentation;

(c) Mail your Adjustment Request to this address;

(d) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide**);

(e) Enter the client's identification number in this space. This number can be found on the RA in Field 6, or on the Medical Card;

(f) Enter the client's name in this area. Use the same name as is shown on the Medical Card;

(g) Enter the six-digit provider number in this space;

(h) This space is for the provider name;

(i) Enter the date printed at the top of the Remittance Advice;

(j) Description: This column contains possible areas you might want to correct. Only check the box you want to change:

(A) Place of Service -- Enter place where service is provided:

(i) 3 = Practitioner's office;

(ii) 4 = Patient's home;

(iii) 5 = Day care facility;

(iv) 6 = Night care facility;

(v) 7 = Intermediate care facility;

(vi) 8 = Skilled nursing facility;

(vii) B = Other medical/surgical facility;

(viii) C = Residential treatment center;

(ix) D = Specialized treatment center).

(B) Type of Service -- Use only Type of Service "S";

(C) Quantity/Unit -- Enter the number of services being billed;

(D) NDC/Procedure -- Codes from this guide must be used;

(E) Insurance Payment/Patient Liability -- Enter the payments received from other sources;

(F) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(G) Billed Amount -- Enter the amount billed OMAP;

(H) Other -- Use this box if none of the above address the problems.

(k) Line # -- List the line number from the original claim (HCFA-1500 or OMAP 505) now being adjusted;

(l) Service Date -- Enter the date the service was performed;

(m) Wrong Information -- Enter the incorrect information submitted on the original claim in this column;

(n) Right Information -- Enter the corrected information in this column;

(o) Remarks -- This is the area to give additional information or explain the request;

(p) Provider's Signature -- The signature of the provider or other authorized personnel must be in this space;

(q) Date -- Enter the date this form was completed.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 12-1992, f. & cert. ef. 4-1-92

410-131-0280

Occupational and Physical Therapy Procedure Codes

(1) Occupational therapists and physical therapists should use any of the following codes which are applicable according to their Licensure and Professional Standards.

(2) Services which do not require payment authorization: **Table 1.**

(3) Administrative exam services authorized by the Branch Office:

(a) Use Diagnosis Code V68.89 when billing;

(b) Send the report to the requesting branch office;

(c) Retain a copy of the OMAP 729 for your records;

(d) Send the completed HCFA-1500 claim form to OMAP.

(e) ADM02 - One hour Physical Capacity Evaluation (PCE) with narrative report.

(4) Services which require payment authorization: Modalities - need to be billed in conjunction with a therapeutic procedure code; Supervised - Application of a modality that does not require direct (one on one) patient contact by the provider. Each individual code in this series may be reported only once for each patient encounter: **Table 2.**

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the Agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 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 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 8-1995, f. 3-31-95, cert. ef. 4-1-95; HR 4-1996, f. & cert. ef. 5-1-96; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 132

PRIVATE DUTY NURSING SERVICES

410-132-0000

Purpose - Effective for Services Provided on or after November 1, 1996

(1) The private duty nursing services administrative rules are included in the Office of Medical Assistance Programs' Private Duty Nursing Services Guide. This guide is also a user's manual designed to assist providers in preparing claims for services provided to medical assistance clients. It is published by the Office of Medical Assistance Programs (OMAP) in an attempt to furnish medical providers with current information on program changes and governmental requirements.

(2) This Private Duty Nursing Services Guide is used along with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Administrative Rules and the Oregon State Board of Nursing Oregon Revised Statutes and Administrative Rules. This Private Duty Nursing Services Guide includes private duty nursing administrative rules, procedure codes, instructions for completing claim forms, and examples of those forms.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: 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.; HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; Renumbered from 461-19-201; HR 6-1997, f. & cert. ef. 2-19-97

410-132-0020

Private Duty Nursing Services - Effective for Services Provided on or after November 1, 1996

(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 31, 45, and 47.

(2) Private duty nursing is considered supportive to the care provided to the client by the family, foster parents, and/or

delegated caregivers, as applicable. Nursing services shall be based on medical necessity. Increases or decreases in the level of care and number of hours or visiits authorized shall be based on a change of condition of the client, limitations of the program, and the ability of the family, foster parents, or delegated caregivers to provide care.

(3) The need for private duty nursing shall be established based on a physician's order and the following information:

(a) Nursing Assessment;

(b) Nursing Care Plan;

(c) Documentation of condition and medical necessity;

(d) Identified skilled nursing needs;

(e) Goals and objectives of care provided.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 678.010-678.410

Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 6-1997, f. & cert. ef. 2-19-97

410-132-0030

Definitions - Effective for Services Provided on or after November 1, 1996

(1) Activities of Daily Living - Activities usually performed in the course of a normal day in an individual's life; such as eating, dressing, bathing and personal hygiene, mobility, bowel and bladder control, behavior modification, meal preparation, housecleaning, and food acquisition.

(2) Admission - 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 - Procedures that do not require the education or training of a registered nurse or licensed practical nurse, which 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 will vary from setting to setting depending on the client population served in that setting and the acuity/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. SBON OAR 851-47-0010(5).

(4) Critical/Fluctuating Condition - A situation where the client's clinical and behavioral state is of a serious nature expected to rapidly change and in need of continuous reassessment and evaluation.

(5) Delegation - A registered nurse authorizes an unlicensed person to perform special tasks of client/nursing care in selected situations and indicates that authorization in writing. Delegation occurs only after assessment of a specific situation (including the ability of the delegate), teaching the task and ensuring supervision. SBON OAR 851-45-0000(8).

(6) Discharge - Client no longer meets the Office of Medical Assistance Programs' rules and criteria of the private duty nursing program.

(7) Emergency Medical Services - "The health care and services provided for diagnosis and treatment 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:

(a) Placing the health of the individual in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part; or, . . ." General Rule 410-120-0000.

(8) Home -- A place of temporary or permanent residence, not including a hospital, ICF/MR, nursing facility, or licensed residential care facility.

(9) Maintenance Care -- The level of care needed when the goals and objectives of the care plan are reached, the condition of the client is stable/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.

(10) Medically Fragile Children's Unit (MFCU) -- A Department of Human Resources organizational unit that coordinates and may fund appropriate services for children ages 0 to 18 years with intensive medical needs that require in home and technological supports and meet MFCU criteria.

(11) Member of the Household -- Any person sharing a common abode 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.

(12) Plan of Care -- 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 Rule 410-132-0070, Documentation Requirements.

(13) Private Duty Nursing Shift Care -- 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.

(14) Practice of Nursing -- 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. SBON OAR 851-045-0010.

(15) Private Duty Nursing Visit -- 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.

(16) Respite -- Short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

(17) Responsible Unit -- The agency responsible for approving or denying prior authorization.

(18) Shift -- Four to twelve hours of private duty nursing.

(19) Skilled Nursing Services -- 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 must 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. Such services will comply with the Nurse Practice Act and Administrative Rules of the Oregon State Board of Nursing, which rules are by this reference made a part of.

(20) Special Tasks of Client/Nursing Care -- Tasks that require the education and training of a registered nurse or licensed practical nurse to perform. Special tasks will 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.

(21) Stable/Predictable Condition -- 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. SBON OAR 851-045-0001(19).

(22) Teaching -- The registered nurse instructs an unlicensed person in the correct method of performing a selected task of client/nursing care. SBON OAR 851-045-0000(22).

(23) Visit -- Nursing service supplied on an intermittent basis.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 6-1997, f. & cert. ef. 2-19-97

410-132-0060

Private Duty Nursing Transition into Maintenance - Effective for Services Provided on or after November 1, 1996

Private duty nursing services become maintenance care when any one of the following situations occur:

(1) Medical and nursing documentation supports that the condition of the client is stable/predictable.

(2) The plan of care does not require a Licensed Nurse to be in continuous attendance.

(3) 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; or

(4) The combined score on the Acuity Grid and Psychosocial Grid is less than 54.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 14.065

Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 6-1997, f. & cert. ef. 2-19-97

410-132-0070

Documentation Requirements - Effective for Services Provided on or after November 1, 1996

(1) Documentation of services provided is to be maintained in the client's place of residence by the private duty nurse until discharged from service. Payment will not be made for services where the documentation does not support the definition of skilled nursing. Documentation must meet the standards of the Oregon State Board of Nursing.

(2) The private duty nurse must ensure completion and documentation of a comprehensive assessment of the client's capabilities and needs for nursing services within 7 days of admission. Comprehensive assessments must be updated and submitted to the responsible unit by the next work day after any significant change of condition and reviewed at least every 62 days. Some examples of significant change in condition are hospital admission, emergency room visit, change in status, death, or discharge from care.

(3) The nursing care plan must 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:

(a) The nursing care plan must be completed within 7 days after admission. The nursing care plan must be reviewed, updated, and submitted whenever the client's needs change, but at least every 62 days;

(b) The nursing care plan must 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 must include interventions, measurable objectives, goals and time frames in which the goals and objectives will be met and by whom;

(c) The nursing care plan must include the rehabilitation potential including functional limitations related to ADLs, types and frequency of therapies, and activity limitations per physician order;

(d) The nursing care plan must include services related to school-based care according to the Individual Education Plan, if applicable;

(e) The nursing care plan must show coordination of all services being provided, for instance the client or representative, RN case manager, DHR case worker, physician, other disciplines involved and all other care providers involved in the client's treatment plan;

(f) The nursing care plan must include a statement of the client's potential toward discharge. Timelines must be included in the Plan outline;

(g) The nursing care plan must be available to and followed by all caregivers involved with care of the client.

(4) Documentation of private duty shift care must be written at least every hour on the narrative or flow sheet and must 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 must be expanded on the narrative;

(e) Interventions;

(f) Outcomes including clients response to services delivered;

(g) Nursing assessment of 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 must be in accordance with the Oregon State Board of Nursing Rules.

(6) For documentation to be submitted with prior authorization, see Rule 410-132-0100.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 6-1997, f. & cert. ef. 2-19-97

410-132-0080

Limitations - Effective for Services Provided on or after November 1, 1996

(1) General:

(a) Private duty nursing is not covered if the client is:

(A) A resident of a nursing facility;

(B) A resident of a licensed intermediate care facility for the developmental disabled;

(C) In a hospital;

(D) In a licensed residential care facility.

(b) Private duty nursing is not authorized solely to allow the client's family or caregiver to work or go to school;

(c) Private duty nursing is not covered soley to allow respite for caregivers or client's family;

(d) Payment for private duty nursing will 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 programs Rules OAR 410-142-0000 through 410-142-0360 and OAR 410-127-0000 through 410-127-0200;

(f) Home nursing visits as defined in the Home Enteral/ Parenteral Nutrition and IV Services Rules OAR 410-121-0640 through 410-121-0900, are not covered in conjunction with private duty nursing services;

(g) Private duty nursing is not automatically covered in the school setting even if the Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) indicates the need. The level of need still must be determined by the score on the Private Duty Acuity Grid. All other criteria and limitations must be addressed;

(h) Holidays are paid at the same rate as non-holidays;

(i) Hours nurses spend in training are not reimbursed;

(j) Travel time to reach the job site is not reimbursable;

(k) Maintenance care is not covered.

(2) Private Duty Nursing Visit:

(a) The nursing care plan and documentation supporting the necessity for private duty nursing must be reviewed every 60 days to continue the service. Reviews must be conducted by the Responsible Unit;

(b) Private duty nursing visits are limited to two per day.

(3) Private Duty Nursing Shift Care and Group Nursing:

(a) Medically necessary private duty nursing shift care for clients 18 years old and under may be covered for acute episodes of illness, injury, or medical condition up to 62 continuous days in cases where it has been determined that

constant skilled management by a licensed nurse is required;

(b) A client may be referred to the MFCU at the time of the initial request for services, on or about day 50 of continuous service, or anytime thereafter (even if it is before the 62nd day) if any of the following are determined to exist:

(A) The client's medical needs are maintenance; or

(B) The client's medical needs are long term; or

(C) The client meets MFCU's criteria for admission (Refer to the Medically Fragile Children's In-Home Supports Program Administrative Rules).

(c) Private Duty Nursing shift care for clients age 19 and over will be referred to SDSD 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 (OMAP 591), Table 1:

(A) Must 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) Must 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) Must 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 (OMAP 590) will 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.

(c) Banking, saving, or accumlating unused prior authorized hours used for the convenience of the family or caregiver is not covered.

[ED. NOTE: The Table(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

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

410-132-0090

Group Nursing - Effective for Services Provided on or after November 1, 1996

(1) Group nursing services may be provided to two clients on a shift basis in their home at the same time.

(2) The skilled nursing care provided to each client in the group must be ordered by a physician and must be medically necessary and the lowest cost alternative that effectively meets each client's need.

(3) One nurse may take care of two clients unless medical necessity requires one- on-one skilled nursing care according to the criteria in the Acuity Grid in Rule OAR 410-132-0080.

Stat. Auth.: ORS Ch. 409

Stats. Implemented ORS 414.065

Hist.: HR 6-1997, f. & cert. ef. 2-19-97

410-132-0100

Prior Authorization - Effective for Services Provided on or after November 1, 1996

(1) Payment may be made only for private duty nursing services when authorized prior to initiation of services. It is the provider's responsibility to obtain prior authorization.

(2) The requesting provider must provide the following information to obtain prior authorization:

(a) Client's name and Medicaid recipient ID number;

(b) Performing provider name and OMAP provider number;

(c) Physician's orders for service must be dated within seven days of date of request;

(d) Physician's name and provider number;

(e) Diagnosis with the ICD-9-CM codes to their highest specificity as supplied by the physician;

(f) Procedure codes;

(g) Date range of services;

(h) Frequency of service;

(i) Medical justification for services requested;

(j) The plan of care with short-term goals, long-term goals and objectives including time-lines for meeting the goals and objectives dated within one week of date of request;

(k) Usual and customary charge;

(l) A comprehensive assessment must be submitted with each request for private duty nursing shift care;

(m) A completed Private Duty Nursing Acuity Grid;

(n) A completed Psychosocial Grid, if needed.

(3) Prior authorization does not guarantee eligibility or payment. It is the provider's responsibility to check for the client's eligibility on the date of service and to follow all applicable rules regarding provision of service.

(4) Providers must request payment authorization for services provided for an emergency medical service on the first business day following the emergency service. This request must include all information needed to request prior authorization, and clear medical justification for the retroactive authorization.

(5) To extend an ongoing authorization, the following must be submitted at least 7 days prior to the expiration of the current prior authorization. Extension of authorization requires:

(a) Daily nursing notes from the past month;

(b) Flowsheets from the past month;

(c) Updated plan of care;

(d) Progress reports;

(e) Physician's orders for services must be dated within seven days of date of request;

(f) Recent significant clinical findings from physician;

(g) Recent clinic summaries;

(h) A current (within one week of request) completed Private Duty Nursing Acuity Grid (OMAP 591).

(6) To obtain eligibility status information:

(a) Check the client's current Medical Care Identification. An explanation of eligibility and coverage messages shown on the Medical Care Identification is included in the General Rules; or

(b) Call Automated Information System (AIS). See the AIS User's Guide for instructions.

(7) Where to request prior authorization:

(a) Managed Health Care (MC) Clients: Services for clients identified on their OMAP Medical Care Identification as having an "OMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;

(b) AFS and SCF Clients: Services for clients identified on the Medical Care Identification as Adult and Family Services (AFS) and State Office for Services to Children and Families (SCF) will be authorized by OMAP;

(c) SSD Clients: Services for clients identified on the Medical Care Identification as Senior and Disabled Services Division (SSD) clients will be authorized by the local branch designated on the Medical Care Identification.

(8) There are two types of notice of prior authorization forms that you may see:

(a) Computer-generated OMAP-1072C form (the authorization number is located in field 11);

(b) Manually completed OMAP-1072 form (the authorization number is located in the space below the provider's name).

Stat. Auth.: ORS Ch. 409

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

410-132-0120

Billing Information - Effective for Services Provided on or after November 1, 1996

(1) If the client has the Basic Health Care benefit package, but is not enrolled in a prepaid health plan, bill with the appropriate OMAP unique procedure codes and follow the instructions on how to complete the HCFA-1500.

(2) Submit your claim on a HCFA-1500, electronically or on paper. Send your paper HCFA-1500 to OMAP.

(3) For information about electronic billing, contact the OMAP Electronic Billing Representative.

(4) When billing for Group Nursing, bill one client per HCFA-1500. Use PNA05 or PNA06 (depending on your license) for one client. Use PNA07 or PNA08 for the second client.

(5) When billing for clients with Medicare, bill on a HCFA-1500 and enter the appropriate TPR Explanation Code in Field 9.

Stat. Auth.: ORS Ch. 409

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

410-132-0140

Instructions on How to Complete the HCFA-1500 - Effective for Services Provided on or after November 1, 1996

(1) The HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another:

(a) Insured's I.D. Number. The eight digit number found on the OMAP Medical Care Identification;

(b) Patient's name. The name as it appears on the OMAP Medical Care Identification;

(c) Name of Referring Physician or Other Source. Enter the name of the referring provider;

(d) ID Number of Referring Physician: Enter the OMAP provider number or UPIN of the referring provider;

(e) Date of Service. Must be numeric. If "From-To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(f) Place of Service. Where service is provided:

(A) 4 - patient's home;

(B) B - school district facility.

(g) Type of Service (TOS). Enter type of service "S" in this field;

(h) Procedures, Services or Supplies. Enter the appropriate code listed in the OMAP Private Duty Nursing Services guide;

(i) Charges. Enter the provider's usual and customary charge for each line item;

(j) Days or Units. This number must match the number of days in the Date of Services field or the number of units of services provided;

(k) Total Charge. Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due. Enter the amount due after subtracting the Amount Paid from the Total Charge. Do not include insurance write-off amounts;

(m) Provider Number. Enter the OMAP provider number of the provider to whom the check should be sent (actual service provider or the provider's billing service);

(n) Diagnosis or Nature of Illness or Injury. Enter the primary diagnosis/condition of the patient indicated by current ICD-9-CM code number. Enter up to four diagnosis codes in priority order. Carry the codes out to their highest degree of specificity. Do not enter the decimal point or unnecessary characters;

(o) Diagnosis Code. Enter a single diagnosis reference number as shown in Field 21.

(2) The following fields are required, when applicable:

(a) Other Insured's Name. If the client has other health insurance coverage as listed on the Medical Care Identification, and no payment was received from that resource, this space must be used to explain why no payment was made. Select a 2 digit "reason" code for the Third Party Resource (TPR) codes shown in the Private Duty Nursing Services guide. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the Third Party Resource;

(b) Is Patient's Condition Related to. Complete only when an injury is involved;

(c) Reserved for Local Use (Emergency Services). Put a "Y" in this field if service was an emergency;

(d) Reserved for Local Use (Performing Provider). Enter the OMAP performing provider number here if a billing provider number is used in Field 33;

(e) Amount Paid. Enter the total amount paid by any other insurance or resource. Do not show any payment from OMAP on this line. (If the patient has other insurance and this amount is zero, there must be a 2-digit "reason" code in Field 9.);

(f) Prior Authorization Number. If billing for a prior authorized service, enter the 9-digit Prior Authorization number here.

(3) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

(I) NE -- Service Not Considered Emergency by Insurance;

(J) NP -- Service Not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/Condition;

(L) RI -- Requested Information Not Received by Insurance from Patient;

(M) RP -- Requested Information Not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- not paid within 30 days;

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary paid;

(B) SU -- Primary Insurance Paid -- Secondary under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why not TPR payment was made);

(S) AP -- Insurance mandated under administrative/court order through an absent parent -- not paid within 30 days.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 6-1997, f. & cert. ef. 2-19-97

410-132-0160

Individual Adjustment Request - Effective for Services Provided on or after November 1, 1996

(1) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much).

(2) This is a reminder to attach needed documentation.

(3) Mail the Adjustment Request to this address.

(4) Enter the 13 digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in the OMAP Private Duty Nursing Services guide).

(5) Enter the client's identification number in this space. This number can be found on the RA in Field 6, or on the client's OMAP Medical Care Identification.

(6) Enter the client's name in this area. Use the same name as is shown on the Medical Care Identification.

(7) Enter the six digit provider number in this space.

(8) This space is for the provider name.

(9) Enter the date printed at the top of the RA.

(10) Description -- This column contains possible areas that may need to be corrected. Only check the box that needs to change:

(a) Place of Service -- Enter the place where service is provided. Use Place of Service indicators from the HCFA--1500 instructions;

(b) Type of Service -- Use only OMAP Type of Service indicators;

(c) Quantity/Unit -- Enter the number of services being billed;

(d) NDC/Procedure -- Codes from the OMAP Private Duty Nursing services guide must be used;

(e) Insurance Payment/Patient Liability -- Enter the payments received from other sources;

(f) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(g) Billed Amount -- Enter the amount billed OMAP;

(h) Other -- Use this box if none of the above address the problem.

(11) Line # -- List the line number from the original claim (HCFA-1500) which is now being adjusted.

(12) Service Date -- Enter the date the service was performed.

(13) Wrong Information -- Enter the incorrect information submitted on the original claim in this column.

(14) Right Information -- Enter the corrected information in this column.

(15) Remarks -- This is the area to give additional information or explain the request.

(16) Provider's Signature -- The signature of the provider or other authorized personnel must be in this space.

(17) Date -- Enter the date this form was completed.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 6-1997, f. & cert. ef. 2-19-97

410-132-0180

Procedure Codes - Effective for Services Provided on or after November 1, 1996

(1) All private duty nursing services require prior authorization. See definitions).

(2) Private Duty Nursing Visit:

(a) PNA01 -- Private duty nursing services by an RN -- 1 unit equals one visit;

(b) PNA02 -- Private duty nursing services by an LPN -- 1 unit equals one visit.

(3) Private Duty Nursing Shift Care:

(a) PNA03 -- Private duty nursing services by an RN -- 1 unit equals one hour;

(b) PNAO4 -- Private duty nursing services by an LPN -- 1 unit equals one hour.

(4) Group Nursing:

(a) PNA05 -- Private duty group nursing shift care services by an RN -- 1 unit equals one hour;

(b) PNA06 -- Private duty group nursing services shift care by an LPN -- 1 unit equals one hour;

(c) PNA07 -- Rate for additional client by an RN -- 1 unit equals one hour;

(d) PNA08 -- Rate for additional client by an LPN -- 1 unit equals one hour.

Stat. Auth.: ORS Ch. 409

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

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 133

SCHOOL-BASED HEALTH SERVICES

410-133-0000

Foreword -- For Services Provided on or After September 1, 1991

(1) The **School-Based Health Services Guide** is a user's manual designed to assist education facility providers in preparing billings to the Office of Medical Assistance Programs, Department of Human Resources, for eligible Medical Assistance clients. This **Guide** is used in conjunction with the General Rules for Oregon Medical Assistance Programs. Rules and definitions within that **Guide** are applicable to provision of services.

(2) Instructions on completing claim forms, Administrative Rules and examples of some completed forms are included in this **Guide**. A section listing procedure codes and their definitions, restrictions and limitations is also included.

(3) The Office of Medical Assistance Programs (OMAP) 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 are responsible to maintain current publications provided by OMAP

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 409.010

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

410-133-0020

Purpose -- For Services Provided on or After September 1, 1991

(1) The Oregon Administrative Rules in Chapter 581, Division 15 for the Department of Education outline Oregon's program to meet the federal provisions of the Individuals with Disabilities Education Act of 1990. The rules of School-

Based Health Services define Oregon's program to reimburse the health services provided under that Act to Oregon's Medicaid-eligible children.

(2) The Oregon Department of Education and the Office of Medical Assistance Programs recognize the unique intent of health services provided for medical disabilities in the special education setting. The **School-Based Health Services Guide** addresses the health aspects of special education services.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 &184.770

Stats. Implemented: ORS 409.010

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

410-133-0040

Definitions

(1) "Adequate Recordkeeping" -- Documentation in the student file that shows that the health services provided to the student and billed to OMAP are in compliance with OMAP rules. (See 410-133-300).

(2) "Assessment" -- Used in determining eligibility for Medicaid related services, obtaining information about the student and yielding outcomes that are helpful for developing Individual Education Programs/Plans. An IEP Assessment is helpful in determining short term objectives and documenting progress. Assessment is also used after plans are established and there is the need for further information gathering to restructure the IEP.

(3) "Augmentative Communication Services" -- Services provided by Augmentative Communication Specialists with training and expertise in the use of alternative communication systems.

(4) "Certification" -- See "licensure".

(5) "Consultation" -- Services that are provided by health care professionals, under the scope of their licensure, to other professionals or family members. These services or expertise are related to specific goals and objectives in a student's IEP.

(6) "Delegation of Task" -- A non-licensed person assigned by a registered nurse to perform selected tasks of nursing care which are identified in the nursing care/health management plan as part of the IEP/IFSP.

(7) "Department" -- Refers to the Oregon Department of Education.

(8) "Early Childhood Special Education" --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 kindergarten. Instruction may be provided in any of the following settings: home, hospitals, institutions, special schools, classrooms, and community child care or preschool settings or both.

(9) "Early Intervention" -- A state-operated program designed to address the unique needs of preschool children with disabilities, from birth until three years of age.

(10) "Treatment Plan" -- A child specific plan as defined by the IEP/IFSP or health management nursing care plan.

(11) "Education Assistant" -- See Health Care Aide.

(12) "Education Entity" -- A local school district, Department of Education regional program, Education Service

District, state-operated institution or facility.

(13) "Education Service District (ESD)" -- An education entity established to offer a resource pool of cost effective, education-related, state-mandated services to multiple local school districts within geographic areas described in ORS 334. ESDs have cooperative relationships to furnish student services beyond the capability of individual schools in the assigned geographic area.

(14) "Eligibility for Special Education" -- A child meets the eligibility criteria for early intervention, early childhood special education or special education as defined in ORS 343 and OAR, Chapter 581, Division 15.

(15) "Evaluation" -- Assessment procedures to determine a child's specific needs under IDEA and in accordance with OAR 581-15-071, and which must be completed by licensed health care providers practicing under the scope of their licensure.

(16) "HCFA-1500" -- A standard billing form used to bill medical services. HCFA is an acronym for Health Care Financing Administration.

(17) "Health Care Aide/Delegated Health Care Aide" -- A non-licensed person assigned by a Registered Nurse to perform selected tasks of nursing care identified in the Nursing Care/Health Management Plan as part of the IEP/IFSP.

(18) "Health Services" -- The medical evaluation, testing and/or treatment services required to achieve the health/education-related goals set forth in a child's IEP or IFSP so the child can benefit from a special education program (3 - 21) or an early intervention program.

(19) "ID Number" -- The number issued by the DHR agency used to identify Medicaid clients. May also be referred to as Recipient Identification Number; Prime Number; Client Medical ID Number or Medicaid ID Number.

(20) "IEP Team" -- An IEP team is responsible for developing, reviewing and revising a handicapped child's IEP and includes participants as required by OAR Chapter 581, Division 15.

(21) "Individualized Education Plan (IEP)" -- A plan developed and implemented under OAR Chapter 581, Division 15, for each disabled school age child eligible for special education and related services. The plan is designed to meet the individual needs of the child which address the child's disabilities as they impair the child's functioning, learning and educational progress. The IEP addresses disabilities that will continue and cannot be resolved by short-term therapies.

(22) "Individualized Family Service Plan (IFSP)" -- A written plan of early childhood special education, related services, early intervention services, and other services developed in accordance with requirements set forth in OAR Chapter 581, Division 15, to meet the needs of a child with disabilities as defined by OAR Chapter 581, Division 15, from birth to the age of eligibility into kindergarten.

(23) "Intervention Activity" -- Term used in the education setting to indicate a service or treatment.

(24) "Medical Services" -- The care and treatment provided by a licensed medical provider to prevent, diagnose, treat, correct or address a medical problem, whether physical, mental or emotional. For the purposes of this guide, this term shall be synonymous with health-related services required by an IEP or IFSP, as defined in OAR Chapter 581, Division 15.

(25) "Medically Qualified Staff" -- Staff employed by and/or through contract with a School Medical Provider who meets qualifications under State law and rule 410-133-120.

(26) "Multidisciplinary team (MDT)" -- A team of people who determine a child's eligibility for special education and the special education placement of the child following the development of an Individual Education Program (IEP) or an Individualized Family Service Plan (IFSP).

(27) "Nursing Care Plan (Health Management Plan)" -- The plan of care established to meet the health needs of a child

in the educational setting.

(28) "Nursing Services" -- Health care services required by the IEP or IFSP and provided to an eligible child by a registered professional nurse, a licensed practical nurse or delegated health care aide, within the scope of practice as defined by State law. Nursing services include preparation of treatment plans, consultation and coordination of service activities as well as direct patient care and supervision.

(29) "OMAP Rate" -- The amount OMAP will reimburse for a service.

(30) "Orientation and Mobility Training" -- Evaluation and training provided by a certified or equivalently trained Orientation and Mobility Specialist to correct or alleviate mobility difficulties created by a loss or lack of vision.

(31) "Prime Number" -- See definition of ID Number.

(32) "Provider Agreement" -- A contract between the Medical Assistance program and an enrolled Medical Assistance provider which commits both parties to the provisions of the Medical Assistance Program General Rules and related guide rules.

(33) "Qualified Provider/School Medical Provider (SM)" -- Within the context of this guide this term means a provider who is certified by the Department of Education and OMAP as qualified to perform IEP/IFSP school-based health services under the Medcal Assistance program as an educational entity.

(34) "Recipient" -- See Client in the General Rules. This term is synonymous with "student" or "child" in this guide.

(35) "Regional Program" -- Special Education, Early Childhood Special Education, Early Intervention and/or related services provided on a multi-county basis, under contract from the Department of Education. These programs provide services to eligible children who are visually impaired, hearing impaired, deaf-blind, autistic, and/or severely orthopedically impaired.

(36) "Rehabilitative Services" -- For purposes of this guide, any medical, psychological or remedial service recommended by a physician or other licensed practitioner within the scope of his practice under State law, for reduction, correction, stabilization or functioning improvement of physical or mental disability of a client (See 410-133-0060).

(37) "Related Services" -- Transportation and such developmental, corrective, and other supportive services which may be required to assist a child with disabilities to benefit from early intervention or special education services. Services include speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training. Not all "related services" are covered for payment by Medicaid.

(38) "School-Based Health Services" -- A related health service required by an IEP or IFSP during a child's education or preschool program. (See 410-133-0060).

(39) "School Medical Provider (SM)" -- A provider type established by OMAP to designate the provider of school-based health services.

(40) "Screening" -- A limited examination to determine a child's level of functioning ability in areas such as hearing, speech, vision, motor skills, learning abilities, mental processes, or to determine the existence of a disabling condition. Screening is often followed by more extensive testing and/or evaluation if a disability is suspected.

(41) "Special Education Services" -- 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.

(42) "State Education Agency (SEA)" -- The Oregon Department of Education which provides oversite to public education entities for ensuring compliance with Federal and Oregon state laws relating to the provision of services required by the Individuals with Disabilities Education Act of 1990 (IDEA).

(43) "State-Operated Schools" -- Facilities such as the Oregon School for the Blind or the Oregon School for the Deaf, that are operated by the Department of Education to address specific student disabilities.

(44) "Student Health/Medical/Nursing Records" -- Records kept in a student's education file that document, for Medicaid purposes, the child's diagnosis or the results of tests, screens or treatments; treatment plan; the IEP or IFSP; and the record of treatments given to the child. Those records created by health professionals as required by their scope of practice to document Medicaid covered services to Medicaid eligible students (410-133-300).

(45) "Teachers Standards and Practices Commission (TSPC)" -- Commission which governs licensing of teachers, personnel service specialists, and administrators as set forth in OAR 584-036-0005 through 584-052-0027.

(46) "Testing" -- See "Assessment".

(47) "Transportation as a Related Service" -- Transportation to Medicaid eligible services that are described on the IEP/IFSP and under the procedure code RS 118 in rule 410-133-0300 of the School-Based Health Services guide.

(48) "Billing Time Limit" -- Refers to the rules concerning the period of time allowed to bill a services to OMAP under "Timely Submission of Claims", OAR 410-120-0340.

(49) "Conference" -- A scheduled meeting, regarding a student with special needs, between several interested parties. A conference might be one of the following:

(a) An MDT meeting to determine a child's early intervention or special education eligibility;

(b) An IEP or IFSP meeting to plan a child's appropriate educational program or early intervention plan;

(c) A child study team meeting to discuss the child' progress;

(d) A meeting with other health care professionals to discuss the child's medical and educational or early intervention needs.

(50) "Direct Services" -- Personal interventions of the service provider with the student.

(51) "Licensure" -- The process of state agencies insuring licensure which shows that those licensed are qualified to perform specific duties and services within a legal standard recognized by that agency.

(52) "Observation" -- A service performed by a medical provider in an attempt to better understand the child's needs, skills and progress by observing the student in their natural environment.

(53) "Third Party Billing" -- The process of sending a bill to a public or private insurance company for a medical or health service given to someone who is insured.

(53) "Local Education Agency" -- See Education Entity.

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 409.010

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

410-133-0060

Health Services

(1) School-based health service is a health service which:

(a) Addresses physical or mental disabilities of a child; and

(b) Is identified in a child's Individual Education Program/Plan (IEP), Individualized Family Service Plan (IFSP), or Health Management Plan; and

(c) Is recommended by a physician or other licensed practitioner within the scope of practice under State law.

(2) School-based health services may be:

(a) Psychological services and evaluations;

(b) Nursing evaluations and services;

(c) Physical and occupational therapy and evaluations;

(d) Speech evaluation and therapy;

(e) Audiology evaluation and services;

(f) Vision evaluation and services;

(g) Medical evaluations.

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95

410-133-0080

Coverage

The Office of Medical Assistance Programs will reimburse for the following services:

(1) Health services required by a child's Individual Education Plan (IEP or IFSP) or similar plan;

(2) Evaluation and testing services necessary to determine a child's participation in an individualized plan;

(3) Transportation services as documented in the child's IEP and defined in this guide;

(4) Rehabilitative health activities under Part B or H of the Individuals with Disabilities Education Act of 1990. Only Low Incidence Regional programs enrolled as School Medical Providers may bill for IFSP health-related services;

(5) Evaluation and transportation services for the child's IFSP provided by the Local Education Agency (LEA).

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95

410-133-0090

Provider Payment

Payment will be made to the enrolled education entity as the performing provider for those services provided by the employed staff person. While the education entity shall hold primary responsibility for providing these services with its own qualified staff, it may also contract, on a supplement basis only, for covered services with individuals or organizations that meet qualifications for medical staff as outlined in OAR 410-133-0120.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110

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

410-133-0100

Provider Requirements -- For Services Provided on or After September 1, 1991

The School Medical Provider is responsible to:

(1) Provide services required in the child's individual plan for special education under OAR Chapter 581, Division 15.

(2) Provide services through staff who are medically qualified to perform the service.

(3) Provide appropriate medical supervision for delegated tasks.

(4) Document service in writing as required in OAR 410-133-0320.

(5) Maintain adequate records in the student file.

(6) Make the records required by OAR 410-133-0320 and other rules of this **Guide** available for a period of five years.

(7) Establish a schedule of fees.

(8) Provide access for on-site review of students' records and provisions of service.

(9) Document any changes in the IEP plan related to treatment.

(10) Assure that services billed reflect health services and do not reimburse education services.

(11) Comply with all applicable provisions of the OMAP General Rules

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

410-133-0120

Medically Qualified Staff

The School Medical provider shall furnish reimbursable services through the following qualified staff who provide services within the scope of their licensure:

(1) Physical or occupational therapy treatments shall be provided by licensed physical therapists, licensed occupational therapists, licensed physical therapy assistants or certified occupational therapy assistants within the scope of their licensure. Physical or occupational therapy evaluations and treatment plan development can only be provided by licensed physical therapists or licensed occupational therapists. Special education teachers are not recognized as medically qualified staff for these services;

(2) Medical evaluations, assessments or testing are services that are provided by licensed physicians and osteopaths;

(3) Nursing evaluations and treatment for disabled children shall be provided by licensed Registered Nurses, Licensed Practical Nurses or licensed Nurse Practitioners within the scope of their licensure. Delegated nursing tasks shall be provided by trained health care aides;

(4) Psychological evaluations, testing, psychological services and/or treatments shall be provided by individuals who meet the relevant requirements of the Teacher Standards and Practices Commission and/or professional state licensure. Individuals who meet those requirements include: Basic School Psychologist (OAR 584-044-0014), Standard School Psychologist (OAR 584-044-0023), Standard Counselor (OAR 584-044-0023), Child Development Specialist with Master's Degree (OAR 581-023-0050), Standard Handicapped Learner Endorsement I or II with Master's Degree (OAR 584-040-0260, 584-040-0265), licensed physician, licensed psychologist, licensed psychiatrist, licensed clinical social worker, and licensed Counselor;

(5) Speech therapy treatments and speech therapy evaluations shall be provided by speech pathologists who are either licensed by the Board of Speech Examiners in Speech Pathology and Audiology or hold the American Speech and Hearing Association (ASHA) Certificate of Clinical Competence (CCC) or a graduate speech pathologist being supervised in the Clinical Fellowship Year (CFY);

(6) Audiological evaluations/screenings and services shall be provided by licensed audiologists or licensed audiometrists within the scope of State law;

(7) Vision services shall be provided by licensed ophthalmologists or optometrists for services within the scope of their licensure. Trained orientation and mobility specialists with TSPC licensure with an endorsement in the area of Visually Impaired or AER (Association for Education and Rehabilitation) Division 9 Orientation and Mobility Specialist Certification can provide services eligible for reimbursement;

(8) Delegated Health Care Services shall be provided by medically trained health care aides or trained transportation attendants specifically trained by a registered nurse or nurse practitioner, within the scope of their licensure, to provide medical services to children with disabilities under supervision of the licensed professional.

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 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

410-133-0140

Enrollment Provisions -- For Services Provided on or After September 1, 1991

(1) Providers of School Medical Health Services will be certified to OMAP by the Oregon Department of Education as qualified to be enrolled as School Medical (SM) Providers.

(2) The provider enrollment process will consist of:

(a) Certifying letters of approval from the Oregon Department of Education;

(b) Enrollment with the Office of Medical Assistance Programs.

(3) An approved enrollment application is a contracting agreement that binds the provider to comply with OMAP General Rules and OMAP **Guide** rules.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

410-133-0160

Licensed Practitioner Recommendation

Requests for payment of medical services required by a child's individualized plan must be supported by written documentation of a licensed medical practitioner recommending the service. The recommendation must be updated annually and can be satisfied by the annual IEP/IFSP review process.

Stat.Auth.: ORS 409.010

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95

410-133-0180

Duplication of Service -- For Services Provided on or After September 1, 1991

(1) A contracted provider of a specific service may not submit a separate claim to OMAP as the performing provider for services provided under the school-based health service codes, unless separate billing has been previously agreed between the School Medical Provider and the contracted provider and the School Medical Provider will not bill the contracted service.

(2) Duplicate billings are not allowed and payments will be recovered. Services will be considered as duplicate if: The same services are billed by more than one educational entity to address the same need; i.e., an Education Service District 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 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

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 OMAP.

(2) Medical care not related to the child's individualized plan is not covered for payment by OMAP, under the School-Based Health Services program.

(3) Also not covered:

(a) Activities related to researching student names, determine Medicaid eligibility status, administrative activities such as data entry of billing claim forms, travel time by service providers. Administrative costs related to health services and recordkeeping have been calculated into the payment rates;

(b) Family therapy where the focus of treatment is the family;

(c) Routine health nursing services provided to all students by school nurses; nursing intervention for students who become ill or injured in the school setting;

(d) Educational workshops, training classes, parent training (exception: delegated, but child specific training by an RN or Nurse Practitioner, within the scope and practice of their licensure, to a health care aide or transportation attendant;

(e) Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95

410-133-0220

Billing and Payment -- For Services Provided on or After September 1, 1991

(1) The School Medical Provider must bill OMAP at a rate no greater than the rate established by the provider for billing the service to any other resource. Payment by OMAP will not exceed OMAP established rates.

(2) Services must be billed on a HCFA-1500 or by electronic media claims (EMC) submission using only those procedure codes found in the **School-Based Health Services Guide**.

(3) OMAP will accept a claim up to 12 months from the date of service.

(4) HCFA-1500 forms are not provided by OMAP. A common source for getting these forms is a local forms supplier. Send all completed HCFA-1500 Forms to: Office of Medical Assistance Programs, Salem, OR 97309.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

410-133-0240

How to Complete the HCFA-1500

(1) If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another.

(2) The following fields must always be completed:

(a) Insured's I.D. Number: Enter student's eight digit number as it appears on the Medicaid records or is given by AIS;

(b) Patient's (Students) Name: Enter the name as it appears in the Medicaid records. Enter last name first, first name, middle initial. If the Medicaid records show Robert Smith, but school records show Bob Smith, the billing must be under Robert Smith. (Field 26 may be used to cross-reference to school records - information up to 12 characters entered here will print out on the Remittance Advice);

(c) Date of Birth: Enter the student's date of birth;

(d) Date of Service: Must be a six-digit numeric date. If one of the cumulative codes is billed, use the last day of service during that month. Otherwise, use the specific date of service. For transportation, use the last date of transport during the month being billed;

(e) Place of Service: Enter "B" to indicate school district facility;

(f) Type of Service Codes (TOS): Use Type of Service "S";

(g) Procedures, Services or Supplies: Enter the most appropriate unique procedure code listed in the School-Based Health Services guide. Use only one code to bill a unit of time;

(h) Charges: Enter a total charge for each line item. If billing more than one unit of service you will reflect the multiplied total cost in 24F for that procedure code line;

(i) Days or Units: Enter the total number of units or services provided for each procedure code billed. For procedures billed for a single date of service, enter the total units of service under that code for that day. For codes that are billed for services added up to the last date of service, use the cumulative total of units under that code for the month as the number of units billed;

(j) Total Charge: Enter the total amount for all charges from the Field title "Charges" listed on this HCFA-1500;

(k) Balance Due: Enter the balance (Total Charge minus Amount Paid);

(l) Provider Number: The six-digit number assigned by OMAP to the School Medical provider is entered here;

(m) Diagnosis or Nature of Illness or Injury: Enter the diagnosis/condition of the patient indicated by current ICD-9-CM code number (can use primary diagnosis). Enter up to four codes in priority order. The code should be carried out to their highest degree of specificity;

(n) Diagnosis Code: Enter a one-digit line number which refers to the diagnosis from Field 21 (Diagnosis or Nature of Illness or Injury) for each service.

(3) The following fields must be completed when applicable:

(a) Other Insured's Name: Use "NC" as an indication the insurer does not cover the procedure;

(b) Amount Paid: Enter the total amount paid from other resources.

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 12-1992, f. & cert. ef. 4-1-92; HR 21-1995, f. & cert. ef. 12-1-95

410-133-0260

AdjustmentRequests

Overpayment, underpayments, and payments received from other sources after OMAP has paid a claim must be resolved through the adjustment process:

NOTE: Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation must be submitted to support your request. Adjustment Requests must be submitted by completing the Form 1036 and mailing to: Office of Medical Assistance Programs, Salem, OR 97309.

(1) Check the appropriate box if this request is for an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much).

(2) This is a reminder to attach needed documentation.

(3) Mail the Adjustment Request to this address.

(4) Enter the 13-digit Internal Control Number (ICN) in this space. This number can be found on the RA in Field 7. (See information on Remittance Advice (RA) in this **Guide.**)

(5) Enter the client's identification number in this space. This number can be found on the RA in Field 6.

(6) Enter the client's name in this area. Use the name as shown in the Medicaid records.

(7) Enter the six-digit school Medicaid provider number from the Remittance Advice.

(8) This space is for the provider name.

(9) Enter the date printed at the top of the Remittance Advice.

(10) Description: This column contains possible areas that may need to be corrected. Only check the box that needs to be changed:

(a) Place of Service -- Use Place of Service "B" indicator from HCFA-1500 instructions;

(b) Type of Service -- Use Type of Service "S";

(c) Quantity/Unit -- The number of services being billed;

(d) NDC/Procedure -- Codes from this **Guide** must be used;

(e) Revenue Center Code (Hospital Only) -- Do not check this box. This is for hospital billing only;

(f) Insurance Payment/Patient Liability -- The payments from other sources;

(g) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billing only;

(h) Billed Amount -- The amount billed OMAP;

(i) Other -- Use this box if none of the above address the problem.

(11) Line # -- List the line number from the original claim (HCFA-1500) which needs to be adjusted.

(12) Service Date -- Enter the date the service was performed.

(13) Wrong Information -- Enter the incorrect information submitted on the original claim here.

(14) Right Information -- Enter the corrected information in this column.

(15) Remarks -- This is the area to give additional information or explain the request.

(16) Provider's Signature -- The signature of the provider or other authorized personnel must be in this space.

(17) Date -- Enter the date this form was completed.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 12-1992, f. & cert. ef. 4-1-92

410-133-0280

Rebilling -- For Services Provided on or After September 1, 1991

In order to correct a claim that does not include all services given during the same time period, the provider must request an adjustment. The paid claim must be corrected on the Individual Adjustment Request Form (OMAP 1036) to allow revision of the original claim. Rebilling additional units of service on a HCFA-1500 for the same timeframe would be denied as duplicate services.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

410-133-0300

Procedure Codes

(1) The provider must use the procedure code from the School-Based Health Services guide which best describes the specific service or item provided. Unit values equal 15 minutes of service unless otherwise stated. These time units must be documented in the child's records under the services billed. Account for each unit of service under one code only.

(2) RS110. Basic Health Service - Maximum units limited to 264 units per month. Includes reimbursement for

corrective treatments (individual and group) and related activities as described in a student's individual plan and the preparation of written records for those treatments. The payment rate for this code includes the case management and supervision functions and necessary supplies for these services. These services must be provided by personnel who meet the standards of licensing or certification for the service being provided:

(a) Licensed physical or occupational therapist;

(b) Licensed physical therapy assistant or certified occupational therapy assistant;

(c) Licensed speech pathologist;

(d) Licensed audiologist or audiometrist;

(e) Licensed ophthalmologist or optometrist;

(f) Licensed psychologist;

(g) Licensed psychiatrist;

(h) Licensed clinical social worker;

(i) Licensed counselor, basic school psychologist, standard school psychologist, standard counselor, child development specialist with Masters Degree, Standard Handicapped Learner Endorsement I or II with Masters Degree; or

(j) Other licensed or certified medical practitioners.

(3) RS112. Screening, Testing, Evaluation - Maximum units limited to 144 units per year. These services will be reimbursed only when provided by a licensed or certified practitioner as listed under RS110, within the scope of their licensure. Reimbursable time is:

(a) Student-practitioner interactive services;

(b) Student observation by qualified staff; and

(c) Preparation of the written evaluation/testing reports.

(4) RS114. Nursing Services - Maximum units limited to 264 units per month. This code is not intended to reimburse nursing activities of a Private Duty RN or LPN that is otherwise billing OMAP for those services. Services will be provided by an RN or LPN or Nurse Practitioner within the scope of their licensure. Services under this code would be:

(a) Development, assessment and/or coordination of the treatment plan; or

(b) Direct nursing care services; or

(c) Training and oversight of any health care aides performing delegated nursing services; or

(d) Other services within the scope of nursing care.

(5) RS116. Delegated Health Care Aide or Transportation Attendant - Maximum units are limited to 352 units per month. (The child's individual plan must document the need for the transport aide.) A unit equals 15 minutes of service. This code reimburses health care delegated to a health care aide trained to meet the specific requirements of the student's individual plan within the professional standards for that care. Allowable services are:

(a) Accompanying students that cannot be transported safely without an additional attendant for behavioral or physical reasons; or

(b) Delegated nursing services as allowed under the Oregon State Board of Nursing published Standards for Registered Nurse Teaching and Delegation to Unlicensed Persons (OAR 851-045-0011).

(6) RS118. Medical Transportation Mileage/ Transportation -- school-based health service-- Units are equal to the number of miles:

(a) This service is covered only for the miles from student pickup to student drop off as required in the IEP or IFSP to obtain Medicaid covered related services. Medicaid related services are speech therapy, physical therapy, occupational therapy, psychological and/or nursing services. Transportation for education purposes only is not covered by OMAP;

(b) For on-going transportation mileage, transportation must be needed because of the child's disability. The "Related Services" for which the child is being transported must be linked to the child's disability and clearly stated on the IEP or IFSP. For example, the "related" service (i.e. Physical Therapy) is identified on the child's IEP or IFSP and is treatment for the child's disability (Orthopedically Impaired). If transportation is not identified on the IEP or IFSP as a "related service" and the IEP or IFSP does not indicate the covered service to which the transport is needed, the school medical provider cannot bill for the transportation mileage to on-going services;

(c) The provider may bill for the transportation for a Medicaid covered evaluation service Transportation to an evaluation service is covered, regardless of whether or not an IEP or IFSP is established;

(d) Transportation is not reimbursable by OMAP when provided by the parent or relative of the child.

(7) RS120. Contracted Consult Service -- Each daily service equals one unit regardless of time involved. Maximum units are limited to 24 per year. This procedure code reimburses schools for furnishing consultations to IEP or IFSP students for the purpose of evaluation or testing from licensed medical professionals other than provider staff. This service may be on a contracted basis for a number of students. Allowable services must be furnished through a personal service contract between the School Medical provider and the licensed practitioner. This service would only be billed to OMAP when the licensed practitioner did not bill OMAP directly under other programs for the same services.

Stat. Auth.: .ORS 409.010

Stats. Implemented: ORS 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

410-133-0320

Recordkeeping Requirements

Providers will retain information to document the level of service provided to the child as billed to OMAP for five years. The student health record will include:

(a) A copy of the child's IEP or IFSP or similar special education plan as well as any addendum to the plan;

(b) A notation of the diagnosis and/or condition being treated or evaluated;

(c) Results of analysis of any health/medical screenings, evaluations, and/or tests;

(d) A description of the duration and extent of each service or intervention activity given, by the date of service;

(e) The record of who performed the service and their credentials or position;

(f) The medical recommendation to support the service.

Stat. Auth.: ORS 409.010

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95

410-133-0340

Client Rights or Record Confidentiality -- For Services Provided on or After September 1, 1991

Providers are required to provide OMAP access to client medical records when requested as a condition of accepting Medicaid reimbursement. Client rights of confidentiality are respected in accordance with the provisions of **42CFR Part 431, Subpart F** and ORS 411.320.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 411.320

Hist.: HR 39-1991, f. & cert. ef. 9-16-91

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 135

RURAL HEALTH CLINIC SERVICES

410-135-0000

Rural Health Services Guide

(1) All information found in the **Rural Health Services Guide**, effective April 1, 1988, page 1 through 49, including the revision of July 1, 1996 is incorporated and adopted as rule by reference.

(2) The material referenced above can be obtained from the Rules Coordinator in the Office of Medical Assistance Program (OMAP).

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

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 29-1991(Temp), f. & cert. ef. 7-1-91; HR 33-1991, f. & cert. ef. 8-16-91; Renumbered from 461-14-415; 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.e f. 12-1-96

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 136

MEDICAL TRANSPORTATION SERVICES

410-136-0020

Purpose

In conjunction with the General Rules For Oregon Medical Assistance Programs, and the Oregon Health Plan Medicaid Demonstration Project Administrative rules, the rules incorporated in the Medical Transportation Services Provider Guide govern the provision and reimbursement of medically necessary medical transportation services provided to persons who are Title XIX and GA eligible

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: PWC 815, f. & ef. 10-1-76; AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 64-1986, f. 9-8-86, & ef. 10-1-86; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-00; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0030

Contracted Medical Transportation Services

(1) Contracts may be implemented for the provision of medical transportation services in order to achieve one or more of the following purposes:

(a) To obtain services in a more cost effective manner, i.e., to reduce the cost of program administration and/or to obtain comparable services at a lesser cost to OMAP;

(b) To ensure access to necessary medical services in areas where transportation may not otherwise be available or existing transportation would be at a higher cost to OMAP;

(c) To more fully specify the scope, quantity and/or quality of the medical transportation services provided.

(2) Reimbursement for contracted medical transportation services will be made according to the terms defined in the contract language.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.085

Hist.: HR 28-1994, f. & cert. ef. 9-1-94

410-136-0040

Reimbursement

(1) The following will be reimbursed according to OMAP's approved rate or schedule of maximum allowances for:

(a) Ambulance, Air Ambulance, Stretcher Car, Wheelchair Car/Van:

(A) Base Rate;

(B) Mileage;

(C) Base rate - each additional client;

(D) Extra Attendant.

(b) Taxi;

(c) Secured Transport -- If county or city ordinance prohibits any provider from charging for services identified in the Medical Transportation Services Administrative Rules or if the provider does not charge the general public for such services, or if no transport, medical service or treatment was provided, OMAP cannot be billed.

(2) Reimbursement:

(a) Is based on the condition that the service to be provided at the point of origin and/or destination is a medical service covered under the Title XIX program regardless of the client's specific benefit package;

(b) Will be at the lesser of the amount charged the general public (public billing rate), the amount billed or OMAP's maximum allowed;

(c) For transportation services covered by Medicare, will be based on the lesser of Medicare's allowed amount or OMAP's maximum allowed;

(d) Will be made only when a transport of the client has occurred;

(e) By OMAP is considered to be payment in full.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 1-1981, f. 1-7-81, ef. 2-1-81; AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 5-1984, f. & ef. 2-3-84; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-025 & 461-20-026; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; HR 14-1996(Temp), f. & cert. ef. 7-1-96; HR 25-1996, f. 11-29-96, cert. ef. 12-1-96

410-136-0050

Out-of-State Medical Transportation

(1) OMAP may authorize and make payment for out-of-state transportation when each of the following three conditions are met:

(a) The service to be obtained out of state is covered under the client's benefit package;

(b) the service is not available in-state;

(c) The service has been authorized in advance by the OMAP Out-of-State Coordinator.

(2) OMAP may also authorize out-of-state medical transportation when OMAP deems it to be cost-effective.

(3) The least expensive mode of transportation that meets the medical needs of the client will be authorized.

(4) Reimbursement will not be made for medical transportation out-of-state to obtain services that are not covered under the client's benefit package, even though the client may have Medicare or other insurance that covers the service being obtained.

(5) If the client is enrolled in a Prepaid Health Plan and the Plan has authorized the service, OMAP may authorize and make payment for out-of-state transportation providing the criteria set forth in subsections (1)(a) and (b) of this rule are met.

(6) If a Prepaid Health Plan arranges and authorizes services out-of-state and those services are available in-state, the PHP is responsible for all transportation, meals and lodging costs for the client and any required attendant (OAR 410-141-0420).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0060

Taxi Services

(1) OMAP will make payment for taxi services, when those services have been authorized by the Branch.

(2) Reimbursement will be made for the most cost-effective route from point of origin to point of destination and billing is limited to the actual meter charge. OMAP definition of meter charge includes:

(a) Flag rate;

(b) Actual patient miles traveled;

(c) "In route" waiting time, i.e. red lights, railroad tracks, medical interval, etc.

(3) Charges for assistance or "waiting time" incurred prior to the time the client enters the taxi or assistance after the client exits the taxi are not reimbursable.

(4) Meter charges that include "waiting time" billed to OMAP for a medical interval must be clearly documented in the provider records. Medical interval is defined as any delay in a transport already in progress for one of the following:

(a) Nausea, vomiting after dialysis or chemotherapy; or

(b) Pharmacy stop to obtain prescription; or

(c) Other medically necessary episode.

(5) When client circumstance requires an escort or attendant or when a second client is transported from the same point of origin to the same destination, no additional charge beyond the meter charge is allowed. If more than one client is transported from a single pickup point to different destinations, or from different pickup points to a single destination, only the meter charge incurred from the first pickup point to the final destination may be billed. No additional flag rate or duplicated miles traveled may be billed.

Stat. Auth.: ORS Ch. 409

Stats.Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0080

Additional Client Transport

(1) Ambulance, Wheelchair Car/Van, Stretcher Car. If two or more Medicaid clients are transported at the same time, OMAP will reimburse at the full base rate for the first client and 1/2 the appropriate base rate for each additional client.

(2) Reimbursement will not be made for duplicated miles traveled.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 5-1984, f. & ef. 2-3-84; AFS 30-1985, f. 5-30-85, ef. 7-1-85; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-032; HR 30-1993, f. & cert. ef. 10-1-93

410-136-0100

Deceased Client

Reimbursement will be determined as follows:

(1) When death of the client occurs before the arrival of the provider, no payment will be made by OMAP.

(2) When death of the client occurs after the transport has begun but before the destination is reached, payment is limited to the appropriate base rate and mileage.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: PWC 815, f. & ef. 10-1-76; AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-050; HR 14-1996(Temp), f. & cert. ef. 7-1-96; HR 25-1996, f. 11-29-96, cert. ef. 12-1-96

410-136-0120

Transportation of Inpatient Client from Hospital to Other Hospital (or Facility) and Return

OMAP will not reimburse for the transport or return of an inpatient client from the admitting hospital to another hospital (or facility) for diagnostic or other short-term services when the return of the patient occurs within the first 24-hour period. The transportation provider must bill the admitting hospital directly for these transports.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93

410-136-0140

Conditions for Payment

To qualify for reimbursement by OMAP, a provider of ambulance, air ambulance, chair car, wheelchair car, stretcher car, taxi or secured transport services must meet the following conditions:

(1) Establish rates to be charged to the general public, customarily charge the general public at those rates and routinely pursue payment of unpaid charges with the intent of collection. Any volunteer, community resource or other carrier that operates without charge or provides services without charge to the community will not be reimbursed by OMAP when those same services are provided to OMAP clients.

(2) If providing ground or air ambulance services, be in compliance with ORS 823.010 through 823.990 (and any rules and regulations pertinent thereto) and must be licensed by the Oregon Health Division of the Department of Human Resources to operate as ground or air ambulance.

(3) An ambulance service provider located in a contiguous state which regularly provides transports for OMAP clients must be licensed by the Oregon Health Division of the Department of Human Resources as well as by the state in which it is located.

(4) Be in compliance with all statutes, required certifications or regulations promulgated by any local government entity that, by law, oversees and/or regulates non-ambulance methods of conveyance within the State of Oregon.

(5) In the absence of any local regulatory body, a provider must be enrolled with OMAP as a provider of the level of service provided. If providing wheelchair transports, a provider in an unregulated area must be enrolled as a wheelchair transport provider and bill OMAP using the specific codes defined in the **Procedure Codes Section** of the **Medical Transportation Services Provider Guide**.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: PWC 815, f. & ef. 10-1-76; AFS 1-1981, f. 1-7-81, ef. 2-1-81; AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 5-1984, f. & ef. 2-3-84; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-060; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94

410-136-0160

Non-emergency Medical Transportation (Without Need for an Emergency Medical Technician)

(1) OMAP will make payment for prior authorized non-emergency medical transportation including client-reimbursed travel, that does not require the services of an Emergency Medical Technician when the client's branch office has determined the transport is medically necessary.

(2) OMAP will not make payment for transportation to a specific provider based solely on client or client/family preference or convenience For purposes of authorizing non-emergency medical transportation, the medical service or practitioner must be within the client's local area. Local area is defined as "in or nearest" the client's city or town of residence. If the service to be obtained is not available locally, transportation may be authorized to a practitioner within the accepted community standard or the nearest location where the service can be obtained or to a location deemed by OMAP to be cost-effective.

(3) If a managed care client selects a Primary Care Physician (PCP) or Primary Care Case Manager (PCCM) outside of the client's local area when a PCP or PCCM is available in the client's local area, transportation to the PCP or PCCM is the client's responsibility and is not a covered service.

(4) The client will be required to utilize the least expensive mode of transportation that meets the medical needs and/or condition. Ride sharing by more than one client is considered to be cost effective and may be required unless written medical documentation in the branch record indicates ride sharing is not appropriate for a particular client. The written documentation will be made available for review upon request by OMAP.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: PWC 815, f. & ef. 10-1-76; AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 6-1982(Temp), f. 1-22-82, ef. 2-1-82; AFS 73-1982, f. & ef. 7-22-82; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-020; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0180

Base Rate

(1) Ambulance -- All Inclusive. OMAP reimbursement for ambulance base rate includes any procedures/services performed, all medications, non-reusable supplies and/or oxygen used, all direct or indirect costs including general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance provider, use of reusable equipment, and any other miscellaneous medical items or special handling that may be required in the course of transport. Reimbursement of the first ten miles is included in the payment for the base rate.

(2) Wheelchair Car/Van -- Stretcher Car. OMAP reimbursement of the first ten miles is included in the payment for the base rate.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93

410-136-0200

Emergency Medical Transportation (With Need For an Emergency Medical Technician)

(1) A service will qualify for OMAP Reimbursement as an emergency ambulance transport when at least one of the following conditions is met:

(a) The client's condition requires evaluation and transport for any of the following:

(A) Abdominal pain;

(B) Administration of drugs;

(C) Altered mental status;

(D) Amputation;

(E) Anaphylaxis;

(F) Bradycardia;

(G) Cardiac arrest;

(H) Cardiac dysrhythmia;

(I) Cardiac chest pain;

(J) Childbirth;

(K) Coma;

(L) Defibrillation;

(M) Emergency synchronized cardioversion;

(N) Endotracheal intubation;

(O) External cardiac pacing;

(P) Fractures and dislocations;

(Q) Head trauma;

(R) Hypertensive emergencies;

(S) Hyperthermia - environmental heat injury;

(T) Hypoglycemia;

(U) Hypothermia;

(V) Initiation of IV;

(W) Near drowning;

(X) Needle chest decompression for tension Pneumothorax;

(Y) Needle cricothyrotomy;

(Z) Poisons and overdoses;

(AA) Respiratory distress;

(BB) Seizures;

(CC) Shock;

(DD) Spinal immobilization;

(EE) Spine trauma;

(FF) Suppression of ventricular ectopy;

(GG) Supraventricular tachycardia;

(HH) Syncope;

(II) Tachydysrhythmias;

(JJ) Treatment for burns;

(KK) Vaginal bleeding;

(LL) Ventricular tachycardia.

(2) The client accessed the ambulance service by dialing 911 and declaring an emergency.

(3) In either of the above instances, where transport occurs, the client must be transported to the nearest appropriate facility able to meet the client's medical needs.

(4) Billings for emergency ambulance services provided to clients enrolled in Fully Capitated Health Plans (FCHPs) must be submitted to the FCHP. The FCHP will review for medical necessity prior to payment. Depending on the individual FCHP, authorization in advance of service provision may or may not be required.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 5-1984, f. & ef. 2-3-84; AFS 30-1985, f. 5-30-85, ef. 7-1-85; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-032; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0220

Air Ambulance Transport

OMAP will make payment for an air ambulance transport when *at least one* of the following conditions is met:

(1) The client's medical condition is such that the length of time required to transport, current road conditions, the instability of transport by ground conveyance, or the lack of appropriate level of ground conveyance would further jeopardize or compromise the client's medical condition; or

(2) The service (if non-emergent) has been authorized by the client's branch office or OMAP.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93

410-136-0240

Secured Transports

(1) OMAP will make reimbursement for secured transports when the following conditions are met:

(a) The provider must be able to transport children and adults who are in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse;

(b) The provider must be recognized by OMAP as a provider of secured transports. This requires written advance notice to OMAP (prior to or at the time of enrollment) that the provider has met each of the following conditions:

(A) Conveyance vehicle. The vehicle must:

(i) Have a secured rear seat in an area separated from the driver;

(ii) Have a safety shield that prohibits physical contact with the driver;

(iii) Have plexiglass or secured window guards covering any windows in the secured area;

(iv) Be washable and non-breakable in the secured area;

(v) Be absent of inside locks or door handles in the secured area;

(vi) Have wrist and ankle restraints (preferably soft non-metal) for use when necessary to control violent or overt client behavior;

(vii) Be absent of any foreign item(s) or instrument(s) in the secured area that may be used by the client to inflict harm to self, attendant or person accompanying client;

(viii) Have an operating cellular phone or other communication device for use in transit;

(ix) Have adequate ventilation/heating appropriate to the season in the secured area.

(B) Attendants/escorts. The provider must provide personnel appropriate to the client i.e. male or female as well as:

(i) Any driver/attendant training should include basic first aid techniques, CPR certification, training in behavior management techniques and the ability to meet the individual clients toileting needs during transport;

(ii) When medically necessary (to administer medications, etc. in-route) or in those cases where legal requirements must be satisfied (i.e. a parent, legal guardian or escort is required during transport) that person will be allowed to escort at no additional charge to OMAP. OMAP's reimbursement is considered to be payment in full for the transport.

(C) The provider must submit a copy of all rates charged to the general public to OMAP, Provider Enrollment, at the time of enrollment. Any changes to those rates must also be submitted to OMAP in writing within 30 days of the change. The notification must indicate the rate changes and effective date.

(3) Reimbursement will be authorized on an individual client basis in keeping with OMAP's rules regarding level of transport needed, eligibility, cost effectiveness and medical necessity. In the event transport was provided on an emergent basis authorization will be made when appropriate after provision of service.

(4) Reimbursement will not be made by OMAP for any secured transport provided to a client in the custody of or under the legal jurisdiction of any law enforcement agency or institution. Reimbursement will not be made for any transport resulting from a court ordered placement, any transport to/from a court hearing, or to/from a commitment hearing.

(5) The client must be transported to a Title XIX facility recognized by OMAP as having the ability to treat the immediate medical, mental and/or emotional needs of a client in crisis.

(6) OMAP must assume that a client being returned to place of residence is no longer in crisis or at immediate risk of harming him/herself or others, and is, therefore, able to utilize nonsecured transport. In the event a secured transport is medically necessary to return a client to place of residence, written documentation stating the circumstances and signed by the treating physician must be obtained by the branch and retained in the branch record (along with a copy of the order) for OMAP review.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 28-1994, f. & cert. ef. 9-1-94; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0260

Neonatal Intensive Care Transport

(1) OMAP will make reimbursement for a neonatal intensive care transport when one of the conditions listed below is met.

(2) The provider must be recognized by OMAP as a provider of neonatal intensive care transports. This requires advance written notice to OMAP that theprovider has met *each* of the following conditions:

(a) The conveyance vehicle must:

(A) Have the ability to generate 110 volts for a minimum of two hours;

(B) Carry two size 80 (or equivalent) oxygen tanks;

(C) Have lock down for isolette;

(D) Have the ability to regulate oxygen tanks at 50 PSI;

(E) Have sufficient capacity to transport isolette and four team members;

(F) Have immobilized compressed air and oxygen.

(b) The transport destination point must be recognized by OMAP as a tertiary neonatal intensive care hospital unit.

Stat. Auth.: ORS 409.010, 409.110 & Ch. 414

Stats. Implemented: ORS 414.065

Hist.: AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 5-1984, f. & ef. 2-3-84; AFS 30-1985, f. 5-30-85, ef. 7-1-85; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-032

410-136-0280

Required Documentation

(1) For all claims submitted, the provider records must contain completed documentation (pertinent to the service provided) that include, but is not limited to:

(a) Client Name, ID Number and Date of Service;

(b) Emergency Technician Report. The report must indicate at least one or more of the conditions listed in OAR 410-136-0200;

(c) Medical appropriateness of air ambulance transport (as defined in OAR 410-136-0220);

(d) Point of origin, i.e. client address, Nursing Home name and address, location of accident, etc;

(e) Destination point, i.e. hospital name, doctor name, address, etc.;

(f) Circumstances when billing includes charges for in-route waiting time for medical interval (as defined in OAR 410-136-0060) or unusual waiting time due to unforeseen traffic delay;

(g) Number of actual patient miles traveled;

(h) Justification for extra attendant beyond two (if ambulance or stretcher car) or beyond one (if wheelchair van);

(i) Provider copy of the OMAP 405T (or OMAP 406 or any equivalent) for all non-emergency medical transportation;

(j) Second (or additional) destination point(s) address, etc.

(2) All required documentation must be retained in the provider files for the period of time specified in the general rules.

(3) A copy of the Medical Transportation Order must be attached to all billings submitted for secured transports.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0300

Authorization

(1) Authorization of payment is required for the following:

(a) Non-Emergency Ambulance;

(b) Non-Emergency Air ambulance;

(c) Stretcher car (including stretcher car services provided by an ambulance);

(d) Wheelchair car/van;

(e) Taxi;

(f) Client -- reimbursed transportation (includes medically necessary meals, lodging, attendant);

(g) Secured transport, (including transports arranged for and/or provided outside of normal branch office hours).

(2) Authorization will be made for the services identified in Section 1 of this rule when:

(a) The transport is medically necessary considering the medical condition of the client;

(b) The destination is to a medical service covered under the Title XIX program;

(c) The client medical transportation eligibility screening indicates the client has no resources or that no alternative resource is available to provide appropriate transportation without cost or at a lesser cost to OMAP;

(d) The transport is the least expensive medically necessary mode of conveyance available considering the medical condition of the client.

(3) How to obtain Authorization:

(a) Authorization must be obtained in advance of service provision. A provider authorized to provide transportation will receive a completed Medical Transportation Order (OMAP 405T or OMAP 406). All transportation orders, including any equivalent must contain the following information:

(A) Provider Name or Number;

(B) Client Name and ID Number;

(C) Pickup Address;

(D) Destination Name and Address;

(E) Second (or more) Destination Name and Address;

(F) Appointment Date and Time;

(G) Trip Information, i.e.:

(i) Ambulance;

(ii) Stretcher Car or WC Van or Lift;

(iii) Air Ambulance;

(iv) Taxi;

(v) 1 Way, Round Trip, or 3 Way.

(H) Current Date;

(I) Branch Number;

(J) Worker/Clerk ID;

(K) Money authorized (if special/secured transport).

(b) If the Medical Transportation Order indicates "on-going" transports have been authorized, additional information, as follows is also required:

(A) Begin and End Dates;

(B) Appointment Time(s);

(C) Days of Week.

(c) Additional information identifying any special needs of the individual client shall also be indicated on the Order in the Comments section. If the order is for a secured transport, the name and telephone number of the medical professional requesting the transport, as well as information regarding the nature of the crisis, is required;

(d) Authorization for Medically Fragile Children - Medical transportation for children OMAP has identified as "Medically Fragile" will be prior authorized by the Medically Fragile Childrens Unit (MFCU). The MFCU will utilize the OMAP 405T for authorizing the transports and will be contacting the provider directly rather than the branch office.

(4) Authorization for non-emergency services after service provided:

(a) Occasionally, a client may contact the provider directly "after hours" (i.e., when the Branch Office is closed) and order an urgent care medical transport. In this case only, it is appropriate for the provider to initiate the Medical Transportation Order). All required information (except the Branch Number, dollars authorized and Worker/Clerk ID) must be completed by the provider before submitting the Order to the Branch for final authorization. In addition, the Order must indicate the time and day of week the client called;

(b) The partially completed authorization order must be received at the appropriate Branch Office within 30 calendar days following provision of the service;

(c) After Branch review (and if approved) the Branch will complete the Branch Number, dollars authorized (if special or secured transport), Worker/Clerk ID and current date; and

(d) Return the Order to the provider within 30 calendar days. The provider may not bill OMAP until the final approved order is received;

(e) A provider requesting branch authorization for "after hours" rides may be at risk of non-payment if the branch determines the ride was not for the purpose of obtaining urgent medical services.

(5) Authorization does not guarantee reimbursement:

(a) Always check eligibility on the date of service by calling AIS or requesting a copy of the client's Medical Care Identification. This is especially important when ongoing services have been authorized beyond the current month of eligibility;

(b) Always ensure the service to be provided is currently a medical service covered under the Title XIX program;

(c) Always ensure your claim is for the actual services and/or number of services provided;

(d) OMAP may not be billed for services and/or dollars in excess of the number of services or dollars authorized.

(6) For the purposes of the Administrative Rules governing provision of Medical Transportation Services, authorization is defined to be authorization in advance of the service being accessed or provided. Retroactive authorization for medical transportation will be made only under the following circumstances:

(a) When a client has been deemed Medicaid eligible retroactively, and then only for those transports required to access covered services during the 30 calendar day period just prior to date of determination or the date of eligibility if less than 30 days;

(b) "After hours" transports to obtain urgent medical care. Medical necessity will be determined by Branch review;

(c) Secured transports provided to clients in crisis on weekends, holidays or after normal Branch office hours. Medical

necessity for secured transports will be determined by Branch/OMAP review to ensure authorization is given and/or reimbursement made only for those transports that meet criteria set forth in 410-136-0240.

(7) Authorization will not be made nor reimbursement provided to:

(a) Return a client from any foreign country to any location within the United States even though the medical care needed by the client is not available in the foreign country;

(b) Return a client to Oregon from another state unless the client was in another state for the purpose of obtaining OMAP approved services or treatment approved by OMAP or approved by the client's PHP with subsequent OMAP approval for travel.

(8) Authorization for client reimbursed transportation - For client reimbursed transportation, the client must contact the Branch office in advance of the travel. Once the transportation has been authorized, monies will be disbursed at the Branch level. Disbursement may follow the actual travel as long as the travel was authorized in advance.

(9) A DHR branch may not authorize and OMAP will not make payment for non-emergency medical transportation outside of a client's local area when the client has been non-compliant with treatment or has demonstrated other behaviors that result in a local provider or treatment facility refusing to provide further services or treatment to the client. In the event supporting documentation is submitted to OMAP that demonstrates inadequate or inappropriate services are being (or have been) provided by the local treatment facility or practitioner, transportation outside of the client's local area may be authorized on a case-by-case basis.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 7-1982, f. 1-22-82, ef. 2-1-82; AFS 21-1982(Temp), f. & ef. 3-23-82; AFS 92-1982, f. & ef. 10-8-82; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-20-021; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 9-1995, f. 3-31-95, cert. ef. 4-1-95; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; HR 10-1997, f. 3-28-97, cert. ef. 4-1-97

410-136-0320

HCFA-1500

(1) Medical transportation services must be billed on the HCFA-1500 using the billing instructions and procedure codes found in the **Medical Transportation Services Provider Guide**.

(2) Completed HCFA-1500s should be mailed to the Office of Medical Assistance Programs.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93

410-136-0340

Billing for Clients Who Have Both Medicare and Medicaid Coverage

(1) The Office of Medical Assistance Programs (OMAP) may be billed directly (on a HCFA-1500) for the following

medical transportation services:

(a) Taxi;

(b) Wheelchair Car/Van;

(c) Stretcher Car (including those provided by Ambulance);

(d) Secured Transports.

(2) Select the appropriate "Not Covered" Third Party Resource code from the list of codes printed in the Medical Transportation provider guide. Enter the code in the appropriate box on the HCFA-1500 and submit the claim directly to OMAP.

(3) All services listed above require authorization by the branch.

(4) Bill All Ambulance Services To Medicare.

(5) Medicare will process your claim for ambulance services and automatically forward it to OMAP for processing:

(a) If Medicare has not made a final payment determination on your claim, OMAP will automatically deny payment and instruct you (by EOB) to resubmit your claim to Medicare. After you have rebilled Medicare, the claim will again be transmitted to OMAP for adjudication;

(b) If Medicare has made a final payment determination on your claim, OMAP will make payment for covered services using the lesser of Medicare's allowed or OMAP's maximum allowable amount;

(c) If Medicare has denied payment for any of the services billed, and those services are covered by OMAP, resubmit your claim on the OMAP 505 with a copy of Medicare's Explanation of Benefits (EOB). Follow the OMAP 505 billing instructions in the Billing Section of the Medical Transportation provider guide;

(d) Completed OMAP 505's should be mailed to the Office of Medical Assistance Programs.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; HR 14-1996(Temp), f. & cert. ef. 7-1-96; HR 25-1996, f. 11-29-96, cert. ef. 12-1-96

410-136-0350

Billing for Base Rate -- Each Additional Client

(1) Billings must be submitted to OMAP on a separate HCFA-1500.

(2) Bill using the appropriate procedure code found in the **Procedure Code Section** of the **Medical Transportation Provider Guide**.

(3) All required billing information must be included on the claim for the additional client.

(4) Ensure a completed Transportation Order for the additional client has been forwarded by the branch for retention in the Provider Record

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 30-1993, f. & cert. ef. 10-1-93

410-136-0360

Instructions for Completing the Health Insurance Claim Form (HCFA-1500)

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another.

(2) The following fields are always required:

(a) Insured's I.D. Number: The eight-digit number found on the OMAP Medical Care Identification;

(b) Patient's Name: The name as it appears on the OMAP Medical Care Identification;

(c) Date of Service: Must be numeric. If "From - To" dates are used, a service must have been provided on each consecutive day but not more than *once* per day;

(d) Place of Service: Enter one of the following Destination Codes:

(A) E = Home to Medical Practitioner;

(B) F = Home to Hospital;

(C) G = Home to Nursing Facility;

(D) H = Home to Other (specify);

(E) J = Nursing Facility to Medical Practitioner;

(F) K = Nursing Facility to Hospital;

(G) L = Nursing Facility to Home;

(H) M = Nursing Facility to Other (specify);

(I) N = Hospital to Home;

(J) P = Hospital to Nursing Facility;

(K) Q = Hospital to Other Hospital;

(L) R = Hospital to Other (specify);

(M) S = Medical Practitioner to Hospital;

(N) T = Medical Practitioner to Nursing Facility;

(O) U = Medical Practitioner to Home;

(P) V = Medical Practitioner to Other (specify);

(Q) W = Other (document in client record) to Hospital;

(R) X = Other (document in client record) to Other (document in client record).

(e) Type of Service Codes (TOS): Enter one of the following:

(A) D = Non-Emergency Transportation;

(B) E = Emergency Transportation.

(f) Procedures, Services or Supplies: Use only the **HCPCS** or **OMAP Unique Codes** listed in the **Medical Transportation Provider Guide**;

(g) Charges: Enter a charge for each line item;

(h) Days or Units: Enter the number of services, units or miles billed. If billing for a partial mile, round up to the next mile;

(i) Total Charge: Enter the total amount for all charges listed on *this* HCFA-1500;

(j) Balance Due: Enter the balance due;

(k) Provider Number: Enter the OMAP billing or provider number here.

NOTE: Only one number may be entered in this field.

(3) The following fields are required when applicable:

(a) Other Insured's Name (TPR Information): This information is listed on the Medical Care Identification. When appropriate, use the TPR codes found in the **Appendices Section** of the **Medical Transportation Provider Guide** to indicate why payment was not made by other resources;

(b) Is Patient's Condition Related To: Complete as appropriate when an injury is involved;

(c) Reserved for Local Use (Emergency Services): Enter a "Y" in this field if the service was an emergency;

(d) Performing Provider: Enter your OMAP performing provider number here unless it is used in the provider number field;

(e) Amount Paid: Enter the total amount paid from other resources.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93

410-136-0380

Instructions on How to Complete the OMAP 505

(1) The following fields are always required:

(a) Patient's Name: The name as it appears on the Medical Care Identification form;

(b) Insured's Medicaid No.: The eight digit number from the Medical Care Identification form;

(c) Insured's Group No.: The Medicare number as it appears on the client's Medicare Card;

(d) Date of Service: Must be numeric. If a "From - Thru" date range is entered, a service must have been provided on each consecutive day but not more than once per day;

(e) Place of Service: Enter one of the following Destination Codes:

(A) E - Home to Medical Practitioner;

(B) F - Home to Hospital;

(C) G - Home to Nursing Facility;

(D) H - Home to Other (Specify);

(E) J - Nursing Facility to Medical Practitioner;

(F) K - Nursing Facility to Hospital;

(G) L - Nursing Facility to Home;

(H) M - Nursing Facility to Other (Specify);

(I) N - Hospital to Home;

(J) P - Hospital to Nursing Facility;

(K) Q - Hospital to Other Hospital;

(L) R - Hospital to Other (Specify);

(M) S - Medical Practitioner to Hospital;

(N) T - Medical Practitioner to Nursing Facility;

(O) U - Medical Practitioner to Home;

(P) V - Medical Practitioner to Other (Specify);

(Q) W - Other (Document in Client Record) to Hospital;

(R) X - Other (Document in Client Record) to Other (Document in Client Record).

(f) Procedure Code: Use only the HCPCS or OMAP unique codes identified in the Medical Transportation provider guide;

(g) Days or Units: Enter the number of services, units or miles billed. If billing for a partial mile, round up to the next mile;

(h) Type of Service Code (TOS): Enter one of the following:

(A) D = Non-emergency transportation;

(B) E = Emergency transportation.

(i) Charges Billed Medicare: Enter the total dollar amount billed to Medicare for each service;

(j) Medicare's Allowed Charges: Enter the dollar amount allowed by Medicare for each service;

(k) Provider Number: Enter the OMAP performing provider number here unless it is used in Field 34;

(l) Total Charge: Add the charges in Field 24G and enter the total dollar amount billed to Medicare;

(m) Medicare Total Payment: Enter the total dollar amount paid by Medicare;

(n) Balance Due: Subtract the amounts in Field 28 and 30 from Field 27 and enter the balance in this field. An amount must be entered in this field;

(o) Physician's or Supplier's Name, Address, Zip Code & Phone No.: Only the OMAP provider number is required.

(2) The following fields are required when applicable:

(a) Other Health Insurance Coverage: If no payment was received from Medicare, enter one of the TPR codes found in the Appendices Section of the Medical Transportation provider guide to indicate why payment was not made by Medicare. Attach a copy of the Medicare EOB to your claim;

(b) Was Condition Related to: Complete if service is related to an injury/accident;

(c) If an Emergency Check Here: If the service was performed as an emergency;

(d)Insurance Other than Medicaid/Medicare: Enter any amount paid by resource other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, enter a "0".

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

410-136-0400

Individual Adjustment Request Form

(1) Overpayments, underpayments and payments from other sources received after the Office of Medical Assistance Programs (OMAP) has paid a claim can be resolved through the adjustment process.

(2) Much of the information required on the Adjustment Request Form is printed on the Remittance Advice. Documentation may be submitted to support your request. Adjustment requests must be submitted in writing to the Office of Medical Assistance Programs.

(3) To Complete an Adjustment Request:

(a) Field 1 -- Check the appropriate box if this request is for additional payment (underpayment) or to be deducted from subsequent payments (overpayment);

(b) Field 2 -- Indicates what attachments must be submitted with the Adjustment Request Form;

(c) Field 3 -- Shows where to mail the Adjustment Request;

(d) Field 4 -- Enter the 13-digit Internal Control Number (ICN) in this space;

(e) Field 5 -- Enter the client's identification number in this space;

(f) Field 6 -- Enter the client's name in this area. Use the same name as is shown on the client's Medical Care Identification form;

(g) Field 7 -- Enter the six-digit provider number in this space;

(h) Field 8 -- This space is for the provider name;

(i) Field 9 -- Enter the date printed at the top of the RA;

(j) Field 10 -- Description -- This column contains possible areas that need to be corrected. Only check the box that needs to be changed;

(k) Place of Service -- Enter one of the Destination Codes listed in the **Appendices Section** of the M**edical Transportation Provider Guide**;

(l) Type of Service -- Use only Type of Service "D" or "E";

(m) Quantity/Unit -- The number of services, units or miles being billed;

(n) Revenue Center Code (Hospital only) -- Do not check this box. This is for hospital billings only;

(o) Procedure -- Use the codes from the **Medical Transportation Provider Guide**;

(p) Insurance Payment/Patient Liability -- The payments from other sources;

(q) Drug Name (Pharmacy Only) -- Do not check this box. This is for pharmacy billings only;

(r) Billed Amount -- The amount billed OMAP;

(s) Other -- Use this box if none of the above address your problems;

(t) Line # -- List the line number from the original claim (HCFA-1500 or OMAP 505) being adjusted;

(u) Service Date -- Enter the date the service was performed;

(v) Wrong Information -- Enter the incorrect information submitted on the original claim in this column;

(w) Right Information -- Enter the corrected information in this column;

(x) Remarks -- Use this area to provide OMAP with additional information regarding the request;

(y) Provider's Signature -- The signature of the provider or other authorized personnel *must* be in this space;

(z) Date -- Enter the date this form was completed.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93

410-136-0420

Emergency Medical Transportation

(1) Ambulance Services:

(a) Basic Life Support -- Bill using the following procedure codes:

(A) A0322 -- Ambulance service, BLS, emergency transport, supplies included, mileage separately billed;

(B) A0380 -- BLS mileage (per mile) one way;

(C) 7415Y -- Base rate for each Additional client;

(D) A0424 -- Extra ambulance attendant, BLS.

(b) Advanced Life Support -- Bill using the following procedure codes:

(A) A0330 -- Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage billed separately;

(B) A0390 -- ALS mileage (per mile) one way;

(C) 7400Y -- Base rate for each Additional client;

(D) A0424 -- Extra ambulance attendant, ALS.

(c) Neonatal Intensive Care -- Bill using the following procedure codes:

(A) A0225 -- for Base Rate;

(B) 7595Y -- for Mileage -- one way;

(C) 7445Y -- Base rate for each Additional client.

(d) Air Ambulance -- Bill procedure code A0040 for Air Ambulance (all inclusive).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 9-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1996(Temp), f. & cert. ef. 7-1-96; HR 25-1996, f. 11-29-96, cert. ef. 12-1-96

410-136-0440

Non-emergency Medical Transportation

(1) Ambulance Services -- Basic Life Support -- Bill using the following procedure codes:

(a) A0320 -- Ambulance service, BLS, non-emergency transport, supplies included, mileage billed separately;

(b) A0380 -- BLS mileage (per mile) one way;

(c) 7430Y -- Base rate for each Additional client;

(d) A0424 -- Extra ambulance attendant, BLS.

(2) Air Ambulance -- Bill using A0040 for Air Ambulance (all inclusive).

(3) Wheelchair Car/Van -- Bill using the following procedure codes:

(a) A0130 -- for Base Rate;

(b) 7625Y -- for Mileage -- one way;

(c) 7520Y -- Base rate for each Additional client;

(d) 7475Y -- for Extra Attendant.

(4) Stretcher Car -- Bill using the following procedure codes:

(a) 7490Y -- for Base Rate;

(b) 7610Y -- for Mileage -- one way;

(c) 7505Y-- Base rate for each Additional client;

(d) 7475Y -- for Extra Attendant (each);

(e) YYY15 -- Base Rate -- stretcher car service provided by an ambulance;

(f) YYY18 -- Mileage -- One way -- stretcher car service provided by an ambulance.

(5) Taxi -- Bill using A0100 (all inclusive).

(6) Secured Transport (All inclusive) -- Bill using 7509Y. A copy of the Medical Transportation Order must be attached to all billings submitted for secured transports.

(7) All non-emergency Medical Transportation requires authorization in advance of service provision.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 9-1995, f. 3-31-95, cert. ef. 4-1-95; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 137

AMBULATORY SURGICAL SERVICES

410-137-0000

Purpose

(1)The Ambulatory Surgical Services Billing and Procedures Guide is a manual designed to assist providers prepare health claims for Medicaid patients. This guide must be used in conjunction with the General Rules for Oregon Medical Assistance Programs. The guide has three sections:

(a) Instructions on completing claims forms, Administrative Rules, and examples of some completed forms are found in the first section;

(b) Procedure code and coverage policy information is contained in the second section;

(c) Forms most commonly used in billing for Medicaid patients are included in the last section. Providers may duplicate these forms for their use.

(2) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing and procedural information along with guidelines to keep pace with program changes and governmental requirements.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 2-1984, f. 1-24-84, ef. 2-1-84; HR 44-1991, f. & cert. ef. 10-1-91; Renumbered from 461-14-300

410-137-0020

Health Insurance Claim Form (HCFA-1500)

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another or attach itemized billings. HCFA-1500 forms are not provided by OMAP.

HCFA-1500 forms can be obtained through local forms suppliers. Completed HCFA-1500 forms must be sent to the Office of Medical Assistance Programs.

(2) Until further notice from OMAP, providers may bill using either the HCFA-1500 claim form dated 1/84 or the newly revised HCFA-1500, dated 12/90. If providers choose to use the 12/90 form, they must follow these instructions. If the unrevised HCFA-1500 billing form is used, providers must continue to use the instructions as they are currently shown in the provider guide. The following fields are always required:

(a) Insured's I.D. Number: The eight digit number found on the OMAP Medical Card;

(b) Patient's Name: The name as it appears on the OMAP Medical Card;

(c) Diagnosis or Nature of Illness or Injury: Enter the primary diagnosis code first and subsequent Dx as needed. Only use diagnosis codes from ICD-9;

(d) Date of Service: Must be numeric (05/03/92), If "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(e) Place of Service: Where service is provided: Enter "B" for other medical/surgical facility;

(f) Type of Service Codes (TOS): Enter "H" in this field;

(g) Procedure, Services or Supplies: Use only CPT-4, HCPCS, or OMAP uniques;

(h) Diagnosis Code: Use the one digit line reference number from the Diagnosis or Nature of Illness or Injury field;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge field minus the information in the Amount Paid field);

(m) Provider Number: Enter your Ambulatory Surgical Services provider number here.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Card. When appropriate, use the Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related to: Complete as appropriate when an injury is involved;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(e) Reserved for Local Use (Field 10d): Put a "Y" in this field if service was an emergency;

(f) Amount Paid: Enter the total amount paid from other resources.

(4) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/ Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

(I) NE -- Service Not Considered Emergency by Insurance;

(J) NP -- Service Not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/ Condition;

(L) RI -- Requested Information Not received by Insurance from Patient;

(M) RP -- Requested Information Not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- Not paid within 30 days (effective November 1, 1991);

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary Paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary Paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 2-1984, f. 1-24-84, ef. 2-1-84; AFS 55-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-14-325; HR 44-1991, f. & cert. ef. 10-1-91; Renumbered from 461-14-270; HR 12-1992, f. & cert. ef. 4-1-92

410-137-0040

Medicare/Medicaid Claims

(1) If a patient has both Medicare and Medicaid coverage, providers must bill Medicare first. Medicare will automatically forward all claims to OMAP for processing.

(2) If Medicare transmits incorrect information to OMAP, or if an out-of-state Medicare carrier or intermediary is billed, providers must bill OMAP using an OMAP 505 form. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" portion of the OMAP 505 form.

(3) If any payment is made by OMAP, an OMAP 1036, Individual Adjustment Request, must be submitted to correct payment.

(4) OMAP payment will be the lesser of Medicare's maximum allowable rate or OMAP's maximum allowable rate.

(5) Send all completed OMAP 505 forms to Office of Medical Assistance Programs (OMAP), Salem, OR 97309.

(6) How to Complete the OMAP-505 The following information must be entered on the OMAP-505:

(a) Patient's Name: The name as it appears on the OMAP Medical Card;

(b) Insured's Medicaid I.D. No.: The eight digit number from the OMAP Medical card;

(c) Insured's Group No.: The Medicare number as it appears on the client's Medicare Identification Card;

(d) Diagnosis or Nature of Illness or Injury (Dx): Enter primary diagnosis first, enter subsequent Dx as needed. Only use diagnosis from ICD-9;

(e) Date of Service: Must be numeric (10/30/91), If "From" &endash; "To" dates are used, a service must be on consecutive days and provided no more than once per day;

(f) Place of Service: Enter "B" for other medical/ surgical facility;

(g) Procedure Code: Use only CPT-4, HCPCS, or OMAP unique codes;

(h) Diagnosis Code: Use 1, 2, 3, or 4 to indicate the line reference number;

(i) Days or Units: Must match the number of days/or number of units provided;

(j) Type of Service Codes (TOS): Enter "H" in this field;

(k) Charges Billed Medicare: Enter the total dollar amount Medicare for each service provided;

(l) Medicare's Allowed Charges: Enter the dollar amount Medicare allows for each service;

(m) Total Charge: Add the charges and enter the total dollar amount billed to Medicare;

(n) Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services provided;

(o) Balance Due: Subtract the amounts paid by Medicare or other sources from the total charge and enter the balance in this field. An amount must be entered in this field;

(p) Physician's or Supplier's Name, Address, Zip Code and Phone No.: Only your OMAP provider number is required.

(7) The following information is required when applicable:

(a) This space must be completed to explain why no payment was made by Medicare. Select and enter a two digit "reason" code from the Third Party Resource (TPR) codes found in OAR 410-137-020 of this provider guide. This "reason" code is the first entry in Field 9, followed by the name of the Third Party Resource (Medicare).

EXAMPLE: Medicare paid nothing. Enter: NC -- Medicare. Do not submit your Medicare EOB with your claim.

(b) Was Condition Related to: Complete if service is related to an injury/accident;

(c) If An Emergency Check Here: If the service was performed as an emergency;

(d) Name of Referring Physician or Other Source: If this service is the result of a referral, enter the OMAP provider number of the referring provider, HMO/PCO, or the primary care physician when the patient had restricted services;

(e) Insurance Other Than Medicaid/Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, enter a "0";

(f) Your Patient's Account Number: Optional -- Enter your patient's account number for your own office records. Any combination of 12 digits (letters or numbers) you enter here will appear on your Remittance Advice next to the Internal Control Number identifying your claim.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 55-1989, f. 9-29-89, cert. ef. 10-1-89; HR 44-1991, f. & cert. ef. 10-1-91; Renumbered from 461-14-275 and 461-14-280

410-137-0060

Adjustment Requests

(1) Overpayments, underpayments, and payments received after OMAP has paid a claim can be resolved through the adjustment process. Only paid claims can be adjusted. If any item on the claim was paid by OMAP and further payment is due, submit an Individual Adjustment Request, OMAP 1036. If no payment was made, the claim must be resubmitted using a HCFA-1500 or when appropriate an OMAP 505 unless instructed otherwise by a message on the Remittance Advice. Adjustment Requests must be submitted to OMAP, Salem, Oregon.

(2) Much of the information required on the Adjustment Request form is printed on the Remittance Advice. Documentation may be submitted to support your request.

(3) How to complete an adjustment request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) Attach needed documentation;

(c) Mail your Adjustment Request to the address on the form;

(d) Enter the 13 digit Internal Control Number (ICN). This number can be found on the RA;

(e) Enter the client's OMAP identification number. This number can be found on the RA, or on the client's Medical Card;

(f) Enter the client's name. Use the same name as is shown on the Medical Card;

(g) Enter the provider number; it is always six digits;

(h) Enter the provider name;

(i) Enter the date which is printed at the top of the RA;

(j) Description -- Possible areas you might want to change are listed. Only check those you want to change;

(k) Place of Service -- Enter "B" for other medical/surgical facility;

(l) Type of Service -- Use only type of service "H";

(m) Quantity/Unit -- The number of services billed;

(n) Billed Amount -- The amount you billed OMAP;

(o) Procedure Code -- The Procedure code on the HCFA-1500 or OMAP 505 or RA;

(p) Insurance Payment/Patient Liability -- The payments from other sources, or any payments received after billing OMAP;

(q) Other -- Check if none of the above address your problems;

(r) Line # -- List the line number from the original claim (HCFA-1500) being adjusted;

(s) Service Date -- Enter the date the service was performed;

(t) Wrong Info -- Enter the incorrect information submitted on the original claim in this column;

(u) Right Info -- Enter the corrected information in this column;

(v) Remarks -- Enter any additional information regarding this request;

(w) Provider's Signature -- The provider or other authorized personnel must sign;

(x) Date -- Enter the date this form was completed.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 55-1989, f. 9-29-89, cert. ef. 10-1-89; HR 44-1991, f. & cert. ef. 10-1-91; Renumbered from 461-14-285; HR 12-1992, f. & cert. ef. 4-1-92

410-137-0080

Procedure Codes

(1) CPT-4:

(a) Providers must use the 1991 CPT-4 code book for services provided on or after October 1, 1991;

(b) Use the most applicable CPT code. Do not fragment coding when services can be included in a single code;

(c) Modifiers can be used with any codes. Always use a space or a (-) between the code and the modifier;

(d) Whenever a procedure is initiated at the ASC but is not completed for any reason (e.g., labor managed at the ASC, but patient transferred to a hospital for delivery); Do not bill under the specific procedure code; bill under an appropriate unlisted code and attach a report for payment review.

(2) HCPCS:

(a) OMAP will accept "HCPCS" billing codes;

(b) Providers may not use both CPT-4 and HCPCS codes for the same procedure. This would be duplicate billing.

(3) ICD.9.CM:

(a) Providers must use diagnosis codes from the ICD.9.CM code book;

(b) Always use the primary diagnosis code which most accurately describes the patient's condition being treated;

(c) OMAP will accept up to three additional diagnosis codes only if the claim includes charges for services related to other diagnosis.

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 2-1984, f. 1-24-84, ef. 2-1-84; AFS 55-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-14-320; HR 44-1991, f. & cert. ef. 10-1-91; Renumbered from 461-14-290

410-137-0100

Covered Services

(1) Ambulatory Surgical Center facility services are items and services furnished by an ASC in connection with a covered surgical procedure as specified in the **Medical Surgical Services** or **Dental/Denturist Services Guides**. Reimbursement will be made at all-inclusive global rates based on the surgical procedures billed. The following items and services are included in the all-inclusive global rates:

(a) Nursing services, services of technical personnel, and other related services;

(b) Any support services provided by personnel employed by the ASC facility;

(c) The use by the patient of the ASC's facilities (includes the operating room and recovery room);

(d) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment (related to the provision of care);

(e) Diagnostic or therapeutic items and services (related to the surgical procedures);

(f) Administrative, recordkeeping and housekeeping items and services;

(g) Blood, blood plasma, platelets;

(h) Materials for anesthesia; and

(i) Items not separately identified below.

(2) The following items or services are not ASC facility services and must not be billed under the ASC facility services provider number:

(a) Practitioner services such as those performed by Physicians, Physician Assistants, Nurse Practitioners, Certified Nurse Anesthetists, Dentists, and Podiatrists;

(b) The sale, lease or rental of durable medical equipment to ASC patients for use in their homes;

(c) Prosthetic devices;

(d) Ambulance services;

(e) Leg, arm, back and neck braces or other orthopedic appliances;

(f) Artificial legs, arms, and eyes;

(g) Services furnished by an independent laboratory.

(3) Ambulatory Surgical Centers will not be reimbursed for services that are normally provided by a practitioner in an office setting unless the practitioner has justified the medical necessity of using an Ambulatory Surgical Center through documentationsubmittedwiththeclaim. Practitioner's justification is subject to review by OMAP's medical consultant. If payment has been made and the practitioner fails to justify the medical necessity for using an ASC facility, the amount paid will be subject to recovery by OMAP.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Adult and Family Services Division.]

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 2-1984, f. 1-24-84, ef. 2-1-84; AFS 7-1988, f. & cert. ef. 2-1-88; AFS 55-1989, f. 9-28-89, cert. ef. 10-1-89; HR 44-1991, f. & cert. ef. 10-1-91; Renumbered from 461-14-305 and 461-14-310

410-137-0120

Payment for Multiple Procedures

Multiple Surgical Procedures performed during the same operative session will be paid these rates:

(1) The primary procedure will be paid at the lesser of the billed amount or 100 percent of OMAP's maximum rate for that procedure.

(2) The second and third procedures will be paid the lesser of the billed amount of 50 percent of OMAP's maximum rate.

(3) For each additional procedure the rate is the lesser of the billed amount or 25 percent or OMAP's maximum rate.

Stat. Auth.: ORS 184.750 & 184.770

Hist.: HR 44-1991, f. & cert. ef. 10-1-91

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 138

TARGETED CASE MANAGEMENT -- BABIES FIRST

410-138-0000

Purpose -- Effective for Services Provided on or After July 1, 1991

(1) The rules of the Babies First -- Targeted Case Management Plan define Oregon Medicaid's program to reimburse the services provided under Babies First. This program expands preventive services for all infants and pre-schoolers (0 through 3 years) covered by Medicaid who are at risk of poor health outcome as outlined in OAR 410-138-0040, Risk Factors.

(2) Services include management of non-medical services, which address health, psychosocial, economic, nutritional and other services. Home visits constitute a significant part of the delivery of services.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.085

Hist.: HR 20-1992, f. & cert. ef. 7-1-92

410-138-0020

Definitions -- Effective for Services Provided on or After July 1, 1991

(1) "Assessment" -- The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas. Data sources include interviews, existing available records, needs assessment, the use of standardized assessment tools (i.e., NCAST and Regional X Screening Standards), and contacts with the primary care provider, other professionals, and other parties on behalf of the client.

(2) "Case Management" -- Activities which will assist the client in gaining access to and effectively utilizing needed health, psychosocial, nutritional, and other services.

(3) "Intervention":

(a) Linkage -- Establishing, maintaining, and documenting a referral process with pertinent individuals and agencies which avoids duplication of services to clients. Referral must include follow-up;

(b) Planning -- Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion;

(c) Implementation -- Putting the plan into action and monitoring its effectiveness;

(d) Support -- Support is provided to assist the family reach the goals of the plan, especially, if resources are inadequate or service delivery system is non-responsive.

(4) "Screening" -- Use of a single tool(s) or procedure(s) to identify a potential problem. Screening is not designed to diagnose the problem, but to sort the target population into two groups: Those at risk for a particular problem and those not at risk.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 409.010

Hist.: HR 20-1992, f. & cert. ef. 7-1-92

410-138-0040

Risk Criteria -- Effective for Services Provided on or After October 1, 1994

(1) Medical Risk Factors:

(a) Drug exposed infant;

(b) Infant HIV Positive;

(c) Maternal PKU or HIV Positive;

(d) Intracranial hemorrhage (excludes Very High Risk Factor B16);

(e) Seizures (excludes VHR Factor B18);

(f) Perinatal asphyxia;

(g) Small for gestational age;

(h) Birth weight 1500 grams or less;

(i) Mechanical ventilation for 72 hours or more;

(j) Neonatal hyperbilirubinemia;

(k) Congenital infection (TORCH);

(l) CNS infection (e.g., meningitis);

(m) Head trauma or near drowning;

(n) Failure to thrive;

(o) Chronic illness;

(p) Suspect vision impairment;

(q) Vision impairment;

(r) Family history of childhood onset hearing loss.

(2) Social Risk Factors:

(a) Maternal age 16 years or less;

(b) Parents with disabilities or limited resources;

(c) Parental alcohol or substance abuse;

(d) At-risk caregiver;

(e) Concern of parent/provider;

(f) Other.

(3) Very High Risk Medical Factors:

(a) Inraventricular hemorrhage (grade III, IV) or cystic;

(b) Periventricular leukomalacia (PVL) or chronic subdurals;

(c) Perinatal asphyxia and seizures;

(d) Oromotor dysfunction requiring specialized feeding program (include infants with gastrostomies);

(e) Chronic lung disease on oxygen (includes infants with tracheostomies);

(f) Suspect neuromuscular disorder including abnormal neuromotor exam at NICU discharge.

(4) Established Risk Categories:

(a) Heart disease;

(b) Chronic orthopedic disorders;

(c) Neuromotor disorders including cerebral palsy and brachia nerve plasy;

(d) Cleft lip and palate and other congenital defects of the head and face;

(e) Genetic disorders including fetal alcohol syndrome;

(f) Multiple minor physical anomalies;

(g) Metabolic disorders;

(h) Spina bifida;

(i) Hydrocephalus or persistent ventriculomegaly;

(j) Microcephaly and other congenital defects of the CNS;

(k) Hemophilia;

(l) Organic speech disorders (dysarthria/ dyspraxia);

(m) Suspect hearing or hearing loss;

(n) Burns;

(o) Acquired spinal cord injury etc., paraplegia or quadriplegia.

(5) Developmental Risk Factors:

(a) Borderline developmental delay;

(b) Other.

Stat. Auth.: ORS Ch. 409

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

410-138-0060

Provider Requirements -- Effective for Services Provided on or After October 1, 1994

(1) Case management provider organizations must be certified by the single state agency as meeting the following criteria:

(a) Demonstrated capacity (including sufficient number of staff) to provide all core elements of case management services including:

(A) Comprehensive client assessment;

(B) Comprehensive care/service plan develop-ment;

(C) Linking/coordination of services;

(D) Monitoring and follow-up of services;

(E) Reassessment of the client's status and needs;

(F) Tracking the infant with follow-up across county lines to assure that no infant is lost to the case management system during the rapid growth and developmental period of the first 48 months of life.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population;

(c) Demonstrated experience with 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) Ability to link with the Title V Statewide MCH Data System or provide another statewide computerized tracking and monitoring system;

(g) Capacity to document and maintain individual case records in accordance with state and federal requirements;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.

(2) The case manager must be:

(a) A licensed registered nurse with one year of experience in community health, public health, child health nursing, or be a registered nurse or certified home visitor working under the direction of the above; and

(b) Working under the policies, procedures, and protocols of the State Title V MCH Program and Medicaid.

Stat. Auth.: ORS Ch. 409

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

410-138-0080

Billing Instructions -- Effective for Services Provided on or After October 1, 1994

Billing criteria for this program is as follows:

(1) Type of Service (TOS) Code "S" must be used.

(2) The age range for eligibility for this program is birth through three years of age.

(3) Any place of service is valid.

(4) Prior authorization is not required.

(5) Provider Type -- TC.

Stat. Auth.: ORS Ch. 409

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

410-138-0100

Procedure Codes -- Effective for Services Provided on or After October 1, 1994

The procedure code to be used is CM150 for Babies First -- Targeted Case Management. One of the three activities listed below must occur in order to bill. Maximum billing code is one time per day:

(1) Screening;

(2) Assessment;

(3) Intervention.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 20-1992, f. & cert. ef. 7-1-92; HR 11-1995, f. & cert. ef. 6-1-95

410-138-0300

Purpose -- Effective for Services Provided on or After January 1, 1992

(1) The rules of the HIV -- Targeted Case Management Plan define Oregon Medicaid's Program to reimburse the services provided under HIV -- Targeted Case Management. This program expands services to all Medicaid eligible clients in Multnomah County with symptomatic HIV disease and one or more risk factors which result in an inability to remain in a home environment without ongoing management of support services (see OAR 410-138-0340, Risk Criteria).

(2) Services include management of non-medical services, which address physical, psychosocial, nutritional, educational, and other needs. Home visits constitute a significant part of the delivery of services.

(3) These rules should be used in conjunction with the General Rules for Oregon Medical Assistance Program.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.085

Hist.: HR 42-1992, f. 12-31-92, cert. ef. 1-1-93

410-138-0320

Definitions -- Effective for Services Provided on or After January 1, 1992

(1) "Assessment" -- The systematic ongoing collection of data to determine current status and identify a client's physical, psychosocial, and educational need. An HIV nursing assessment tool will measure ability of the client to manage care at home including pain control, medication management, nutritional needs, personal care needs, home safety assessment, coping with symptoms and disease process, as well as education and service needs that might enhance the client's ability to maintain an independent lifestyle as long as possible. Data sources will include client and support person interviews, information from the referral source, communication with health care team members, and existing available records.

(2) "Case Management" -- Activities which will assist the client in gaining access to and effectively utilizing needed physical, psychosocial, nutritional, and other services.

(3) "Comprehensive Care/Services Plan Development" -- Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion. Emphasis is placed on client independence and client participation in planning of his/her own care. Natural support systems include family members, partners, and friends.

(4) "Intervention/Implementation" -- Putting the Case Management Plan into action and monitoring its status. When possible, intervention is provided in the home where client retention of information is improved, the cost of clinic space

is saved, and support persons can be included. Intervention/implementation of the Case Management Plan include identifying, referring and arranging for needed support services such as:

(a) Medication management systems, including safe levels of pain control;

(b) Nutritional support programs (teaching, Meals on Wheels, arranging for a volunteer);

(c) Care plans for the coordination of volunteers;

(d) Disease specific education of clients and caregivers;

(e) Caregiver respite;

(f) Childcare;

(g) Grief and loss counseling;

(h) Personal care decisions;

(i) Benefits eligibility;

(j) Stress reduction;

(k) Mental health assessments;

(l) Substance abuse treatment;

(m) Spiritual counseling;

(n) Emotional support to clients, partners, and family members;

(o) Facilitating early hospital discharge by assuring that support systems are in place prior to patient discharge;

(p) Coordination of client care;

(q) Coordination of home health agency and hospice nursing services.

(5) "Coordination/Linking of Services" -- Establishing and maintaining a referral process with pertinent individuals and agencies to avoid duplication of services to clients, to assist clients in accessing resources, and to solicit referrals from the community into the managed care system. Support and coordination is provided to assist the client and service providers to reach the goals of the plan; especially if resources are inadequate or service delivery system is nonresponsive.

(6) "Evaluation" -- Each visit will include a reassessment of the client's status and needs, review and update of the care plan, appropriate action and referral, and accurate record keeping.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 409.010

Hist.: HR 42-1992, f. 12-31-92, cert. ef. 1-1-93

410-138-0340

Risk Criteria -- Effective for Services Provided on or After January 1, 1992

Risk Factors:

(1) Advanced HIV-related dementia-confusion, severe memory loss, aggressive behavior.

(2) Need for assistance to ambulate and/or transfer between bed and chair.

(3) Suicidal ideation with plan for action.

(4) Need for assistance with activities of daily living based on severe fatigue and weakness.

(5) Care providers/family members overwhelmed by needs of the person with HIV disease.

(6) Uncontrolled pain.

(7) Loss of ability to manage medically prescribed care at home (medication, skin care, IVs).

(8) Significant weight loss associated with frequent diarrhea, nausea, vomiting and/or anorexia.

(9) Inability to maintain adequate nutrition.

(10) Decreased mobility -- Potential for falls.

(11) Presence of substance abuse in conjunction with advanced HIV disease.

(12) Presence of chronic mental illness in conjunction with advanced HIV disease.

(13) Complex family situations (e.g., both spouses or partners infected).

(14) Families with children affected by HIV (parent or child infected).

(15) Homelessness or inadequate housing/heat/ sanitation.

(16) Inability to manage household activities due to advanced HIV disease.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 42-1992, f. 12-31-92, cert. ef. 1-1-93

410-138-0360

Provided Requirements -- Effective for Services Provided on or After January 1, 1992

(1) Case management provider organizations must be certified by the single state agency as meeting the following criteria:

(a) Demonstrated capacity to provide all core elements of case management services including:

(A) Comprehensive nursing assessment;

(B) Comprehensive care/service plan development;

(C) Linking/coordination of services;

(D) Monitoring and follow-up of services;

(E) Reassessment of the client's status and needs.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population;

(c) Demonstrated experience with the target population;

(d) A sufficient number of staff to meet the case management service needs of the target population;

(e) An administrative capacity to ensure quality of services in accordance with state and federal requirements;

(f) A financial management capacity and system that provides documentation of services and costs;

(g) Capacity to document and maintain individual case records in accordance with state and federal requirements;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.

(2) The case manager must be:

(a) A licensed registered nurse with a minimum of one year of experience in public health or home health and HIV disease or a registered nurse working under the supervision of the above;

(b) Working under the guidelines of the qualified organization.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 42-1992, f. 12-31-92, cert. ef. 1-1-93

410-138-0380

Billing Instructions -- Effective for Services Provided on or After January 1, 1992

Billing criteria for this program is as follows:

(1) Type of Service (TOS) Code "S" must be used.

(2) Any Place of Service (POS) is valid.

(3) Prior Authorization is not required.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 42-1992, f. 12-31-92, cert. ef. 1-1-93

410-138-0400

Procedure Codes -- Effective for Services Provided on or After January 1, 1992

Use Procedure Code CM125 for HIV -- Targeted Case Management. At least one of the five activities listed below must occur during the month in order to bill. Maximum billing code is one time per calendar month:

(1) Assessment.

(2) Comprehensive Care/Services Plan Develop-ment.

(3) Intervention/Implementation.

(4) Coordination/Linking of Services.

(5) Evaluation.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 42-1992, f. 12-31-92, cert. ef. 1-1-93

410-138-0500

Purpose -- Effective for Services Provided on or After April 1, 1993

(1) The rules of the Targeted Case Management Program for Pregnant Substance Abusing Women and Women with Young Children define Oregon Medicaid's Program to reimburse the services provided under this Program. This Program expands services to Medicaid eligible women living in Marion, Polk, Linn, Benton and Yamhill Counties who are either pregnant or have children under the age of five and who are in need of treatment for the abuse of alcohol or other drugs.

(2) Services include screening and assessment, case plan development, and intervention/ implementation of non-medical services, which address health, educational, vocational, mental health, housing, child care and other services necessary to help this target group remain clean and sober.

(3) These rules are to be used in conjunction with the General Rules for Oregon Medical Assistance Programs.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.085

Hist.: HR 19-1993, f. & cert. ef. 8-13-93

410-138-0520

Definitions -- Effective for Services Provided on or After April 1, 1993

(1) "Screening and Assessment" -- The gathering of information to assess the client's need for various services, foremost being treatment for alcohol and drug abuse/addiction. Information will be gathered from the criminal justice system, the Housing Authority, and other sources as appropriate. A uniform assessment tool will be used for screening clients and identifying needed services.

(2) "Case Plan Development" -- The development of an individualized case plan utilizing the input of a treatment team that will consist of the case manager, alcohol and drug treatment counselor, criminal justice system representatives,

prenatal care provider, and others instrumental in the client's life. The case plan will include components for alcohol and other drug abuse treatment, medical care, housing, education, child care, parenting, vocational, and mental health services. Goals and objectives will be written, and resources will be identified to meet the client's needs in a coordinated, integrated fashion. The case plan will be refined, and the client's progress in meeting goals and objectives will be assessed, in periodic meetings of the treatment team as treatment progresses.

(3) "Intervention/Implementation" -- The linking of the client with appropriate community agencies and services identified in the case plan through calling or visiting these resources. The case manager will facilitate implementation of agreed-upon services through assisting the client, increasing the services and through assuring that the clients and providers fully understand how these services support the agreed-upon case plan.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.010

Hist.: HR 19-1993, f. & cert. ef. 8-13-93

410-138-0540

Provider Requirements -- Effective for Services Provided on or After April 1, 1993

(1) Case management provider organizations must be certified by the single state agency as meeting the following criteria:

(a) Demonstrated capacity to provide all core elements of case management service activities described above;

(b) Understanding and knowledge of local and state resources/services which may be needed and available to the target population;

(c) Demonstrated case management experience in coordinating and linking the needed community resources with the client and their family as required by the target population;

(d) Demonstrated experience in working with the target population;

(e) Sufficient level of staffing to meet the case management service needs of the target population;

(f) An administrative capacity sufficient to monitor and ensure quality of services in accordance with state and federal requirements;

(g) Capacity to document and maintain individual case records in accordance with state and federal requirements;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid Program; and

(i) Ability to link with the Title V statewide Maternal and Child Health Data System or provide another computerized tracing and monitoring system to assure adequate follow-up and to avoid duplication.

(2) The case manager must be:

(a) A licensed registered nurse or a licensed clinical social worker with one year of experience coordinating human services, or a licensed registered nurse or social worker without this experience who works under supervision of the above; and

(b) Working in compliance with the policies, procedures and protocols approved by state Title V MCH Program and

Medicaid.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 19-1993, f. & cert. ef. 8-13-93

410-138-0560

Billing and Procedure Codes -- Effective for Services Provided on or After April 1, 1993

(1) The procedure code to be used is CM200 for Targeted Case Management Program for Pregnant Substance Abusing Women with Young Children. Payment is to be made on a fee-for-service basis.

(2) Prior authorization is not required.

(3) Use Type of Service "S".

(4) Diagnosis and diagnosis indicator is not required.

(5) Any place of service is valid.

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 19-1993, f. & cert. ef. 8-13-93

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 139

CHIROPRACTIC SERVICES

410-139-0000

Foreword

The **Chiropractic Services Guide** shall be used in conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Medicaid Demonstration Project Administrative Rules

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Hist.: HR 30-1994, f. 9-30-94, cert. ef. 10-1-94

410-139-0020

Health Insurance Claim Form (HCFA-1500)

(1) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another or attach itemized billings. HCFA-1500 forms are not provided by OMAP. HCFA-1500 forms can be obtained through local forms suppliers. Completed HCFA-1500 forms must be sent to the Office of Medical Assistance Programs.

(2) Until further notice from OMAP, providers may bill using either the HCFA-1500 claim form dated 1/84 or the newly revised HCFA-1500, dated 12/90. If providers choose to use the 12/90 form, they must follow these instructions. If the unrevised HCFA-1500 billing form is used, providers must continue to use the instructions as they are currently shown in the provider guide. The following fields are always required:

(a) Insured's I.D. Number: The eight digit number found on the OMAP Medical Card;

(b) Patient's Name: The name as it appears on the OMAP Medical Card;

(c) Diagnosis or Nature of Illness or Injury: Enter the primary diagnosis code first and subsequent Dx as needed. Only use diagnosis codes from ICD-9;

(d) Date of Service: Must be numeric (05/03/92). if "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(e) Place of Service: Where service is provided:

(A) 3 &endash; Practitioner's office;

(B) 4 &endash; Patient's home.

(f) Type of Service Codes (TOS): Enter "S" in this field;

(g) Procedures, Services or Supplies: Use only codes from the Chiropractic Services guide;

(h) Diagnosis Code: Use the one digit line reference number from the Diagnosis or Nature of Illness or Injury field;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service field or the number of units of services provided;

(k) Total Charge: Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge field minus the information in the Amount Paid field);

(m) Provider Number: Enter the OMAP billing or provider number here.

NOTE: Only one number may be entered in this field.

(3) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Card. When appropriate, use the Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related to: Complete as appropriate when an injury is involved;

(c) Name of Referring Physician or Other Source: Enter the name of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, HMO/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(e) Reserved for Local Use &endash; (Field 10d): Put a "Y" in this field if service was an emergency;

(f) Reserved for Local Use &endash; (Field 24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(g) Amount Paid: Enter the total amount paid form other resources.

(4) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b)Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B)NC -- Service Not Covered by Insurance Policy;

(C)PN -- Patient Not Covered by Insurance Policy;

(D)IC -- Insurance Coverage Cancelled/ Terminated;

(E)IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F)IP -- Insurance Payment went to Policyholder;

(G)PP -- Insurance Payment Went to Patient;

(H)NA -- Service Not Authorized or Prior Authorized by Insurance;

(I)NE -- Service Not Considered Emergency by Insurance;

(J)NP -- Service Not Provided by Primary Care Provider/Facility;

(K)MB -- Maximum Benefits Used for Diagnosis/ Condition;

(L)RI -- Requested Information Not Received by Insurance from Patient;

(M)RP -- Requested Information Not Received by Insurance from Policyholder;

(N)MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under adminis-trative/court order through an absent parent -- Not paid within 30 days (effective November 1, 1991);

(P)OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c)Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A)MP -- PrimaryInsurancePaid-- Secondary Paid;

(B) SU -- Primary Insurance Paid -- Secondary Under Deductible;

(C)MU -- Primary and Secondary Under Deductible;

(D)PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E)SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F)SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G)ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H)SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I)SP -- Primary Paid -- Secondary Payment Went to Patient;

(J)SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K)SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L)SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M)SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provided/ Facility;

(N)SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O)SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P)SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;

(Q)MC -- Service Not Covered by Primary or Secondary Insurance;

(R)MO -- Other (if above codes do not apply, include detailed information of why no TPR pay-ment was made).

Stat. Auth.: ORS 184.750, 184.770, Ch. 411 & 414

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 12-1992, f. & cert. ef. 4-1-92; Renumbered from 461-23-520

410-139-0040

How to Complete the AFS-505

(1) The following information must be entered on the AFS-505:

(a) Patient's Name: The name as it appears on the Medicaid Medical Care Identification;

(b) Insured's Medicaid I.D. No.: The 8 digit number from the Medical Care Identification;

(c) Insured's Group No.: The medicare number as it appears on the client's Medicare Identification Card. (Example: 123456789A or 234567890C1);

(d) Diagnosis or Nature of Illness or Injury (Dx): Enter primary diagnosis first, enter subsequent Dx as needed. Only use diagnosis from ICD-9. Enter up to five codes in priority order. The codes should be carried out to their highest degree of specificity. Do not enter the decimal point or unnecessary characters;

(e) Date of Service: Must be numeric (04/30/88), or enter consecutive days if service exceeds one day;

(f) Place of Service: Where service is provided: (3 = practitioner's office, 4 = patient's home, 7 = intermediate care facility, 8 = skilled nursing facility);

(g) Procedure Code: Use only codes from your Chiropractic Services Guide;

(h) Diagnosis Code: Use 1, 2, 3, or 4 to indicate the line reference number. Use a single diagnosis reference number;

(i) Days or Units: Must match the number of days/units in date of service;

(j) Type of Service Codes (TOS): Enter "S" in this field;

(k) Charges Billed Medicare: Enter the total dollar amount you billed Medicare for the service you provided;

(l) Medicare's Allowed Charges: Enter the dollar amount Medicare allows for this service;

(m) Provider Number: Enter your AFS provider number here unless it is used in subsection (q) of this section;

(n) Total Charge: Add the charges in Field 24G and enter the total dollar amount you billed Medicare;

(o) Medicare Total Payment: Enter the total dollar amount paid by Medicare for the services you provided;

(p) Balance Due: Subtract the amounts in Fields 28 and 30 from Field 27 and enter the balance in this field. You must put an amount in this field;

(q) Physician's or Supplier's Name, Address, Zip code & Phone No.: Only your AFS provider number is required.

(2) The following information is required when applicable:

(a) Other Health Insurance Coverage: If you received no payment from medicare, you must use this space to tell why no payment was made. Select a 2 digit "reason" code from the Third Party Resource (TPR) codes listed in your provider guide, and put it in this field. Be sure that this "reason" code is the first entry, followed by the name of the Third Party Resource (Medicare). Example: Nothing was paid because Medicare did not cover the service. Use "reason code" NC, Not Covered. Enter: NC - Medicare. Do not mail in your Medicare EOB with your claims;

(b) Was Condition Related to: Complete if service is related to an injury/accident;

(c) If an Emergency Check Here: If the service was performed as an emergency;

(d) Name of Referring Physician or Other Source: If this service is the result of a referral, enter the OMAP provider number of the referring (requesting) practitioner. If this service is the result of an HMO or PCO referral, enter the OMAP provider number of the HMO/PCO Plan (not the practitioner) here;

(e) Insurance Other Than Medicaid/Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "O";

(f) Your Patient's Account No.: Optional -- Enter your patient's account number for your own office records. Any combination of 12 digits (letters or numbers) you enter here will appear on your Remittance Advice next to the Internal Control Number identifying your claim.

Stat. Auth.: ORS Ch.184

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-540

410-139-0080

Individual Adjustment Requests (OMAP 1036)

(1) If any payment is made by the Office of Medical Assistance Programs (OMAP) on a claim, submit an Individual Adjustment Request to correct payment, if necessary.

(2) Complete an Individual Adjustment Request:

(a) To correct an overpayment;

(b) To correct an underpayment;

(c) To report payments received from other resources after OMAP has paid a claim.

(3) Do not submit a new claim to make corrections.

(4) Only paid claims can be adjusted. Billers must have a Remittance Advice for the claim in order to fill out the form. If no payment at all was made on a claim, resubmit the claim using a HCFA-1500, or when appropriate, an OMAP 505 unless instructed otherwise by the message on the Remittance Advice.

(5) Submit Individual Adjustment Request to OMAP.

(6) How to complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much), unless instructed otherwise by the message on the Remittance Advice;

(b) Attach needed documentation;

(c) Mail your Adjustment Request to the address on the form;

(d) Enter the 13 digit Internal Control Number (ICN). This number can be found on the RA;

(e) Enter the client's recipient identification number. This number can be found on the RA, or on the client's OMAP 1417;

(f) Enter the client's name. Use the same name as is shown on the OMAP 1417;

(g) Enter your provider number; it is always six digits;

(h) Enter your provider name;

(i) Enter the date which is printed at the top of the RA;

(j) Description -- Possible areas which may need to be changed are listed. Only check those that need to be changed;

(k) Place of Service -- Enter place where service is provided: 3 = practitioner's office or 4 = patient's home;

(l) Type of Service -- Use only OMAP type of service indicators;

(m) Quantity/Unit -- The number of services being billed;

(n) Billed amount -- The amount billed to OMAP;

(o) Insurance Payment/Patient Liability -- The payments from other sources;

(p) Other -- Check if none address the problems;

(q) Line # -- List the line number from the original claim (HCFA-1500) or OMAP 505 being adjusted;

(r) Service Date -- Enter the date the service was performed;

(s) Wrong Info -- Enter the incorrect information submitted on the original claim in this column;

(t) Right Info -- Enter the corrected information in this column;

(u) Remarks -- Enter any additional information regarding the request;

(v) Provider's Signature -- The provider or other authorized personnel must sign;

(w) Date -- Enter the date the form was completed.

Stat. Auth.: ORS Ch. 409

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 12-1992, f. & cert. ef. 41-192; Renumbered from 461-23-550; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94

410-139-0100

Procedures and Coverage

(1) OMAP covers chiropractic services for the following:

(a) Patients under 21 years of age with the Standard Medicaid Package or Qualified Medicare Beneficiary (QMB) + Standard package listed on their OMAP 1417;

(b) Patients with the Basic Health Care Package listed on their OMAP 1417. Because coverage for these patients is governed by the Oregon Health Plan prioritized list of health care services, procedures are covered only when both the patient's diagnosis and the treatment are covered. For more information, see the Oregon Health Plan Administrative Rules.

(2) When billing OMAP, use only the procedure codes listed in the **Chiropractic Services Provider Guide** which most accurately identify the service(s) performed.

(3) Provider must not fragment billings under multiple procedure codes when the total array of services performed is included in the identification for a single procedure code.

(4) Billing for laboratory services must be in accordance with the following criteria:

(a) Charges may only be billed by and paid to the performing provider;

(b) Pass-along charges from the performing provider to another provider for billing do not qualify for reimbursement, and cannot be billed to OMAP.

(5) OMAP will not pay for items normally included in the provision of services, e.g., sterile set ups, cleaning agents, examination utensils, lubricants, anesthetics, and bandages.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Hist.: AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-23-206; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-560

410-139-0120

Visits - Examinations - Effective for Services Provided On or After August 1, 1997

(1) OMAP will pay a chiropractor to provide treatment by means of manual manipulation of the spine:

(a) 98940, Chiropractic manipulative treatment (CMT); spinal, one to two regions;

(b) 98941, Chiropractic manipulative treatment (CMT); spinal, three to four regions;

(c) 98942, Chiropractic manipulative treatment (CMT); spinal, five regions.

(2) Diagnostic Visits:

(a) 99202, Office visit for the evaluation and management of a new patient (diagnostic visit);

(b) 99212 Office visit for the evaluation and management of an established patient (diagnostic visit);

(c) Visits include services pertaining to the evaluation of a problem including an interval history and examination, the review of effectiveness of past treatment, the evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or treatment.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-023-0570; HR 19-1997, f. & cert. ef. 8-15-97

410-139-0140

Urinalysis

OMAP will pay a chiropractor to perform the following urinalysis tests:

(1) 81000-- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constitutents; with microscopy

(2) 81002-- Without microscopy, non-automated

(3) 81003 -- Without microscopy, automated

(4) 81005-- Urinalysis, qualitative, or semiquantitative, except immunoassays

(5) 81007 -- Bacteriuria screen, by non-culture technique, commercial kit (specify type)

(6) 81015 -- Microscopic only

Stat. Auth.: ORS Ch.409

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-580

410-139-0160

Hematology

OMAP will pay a chiropractor for the following blood tests:

(1) 85009-- Blood count; differential WBC count, buffy coat

(2) 85018-- Hemoglobin

(3) 85022-- Hemogram, automated, and manual differ-ential WBC count (CBC)

(4) 85031-- Hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)

(5) 85041-- Red blood cell (RBC) only

(6) 85048-- White blood cell (WBC)

(7) 85651-- Sedimentation rate, erythrocyte, non-automated

Stat. Auth.: ORS Ch. 409

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-590

410-139-0180

Chemistry and Toxicology

OMAP will pay a chiropractor for the following tests:

(1) 82947-- Glucose; quantitative

(2) 82948-- Blood, reagent strip

(3) 84520-- Urea nitrogen, quantitative

(4) 84525-- Semiquantitative (eg. reagent strip test)

Stat. Auth.: ORS 409

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-600

410-139-0200

Radiology

(1) Radiology codes include both the technical component and professional interpretation.

(2) Head and Neck:

(a) 70010 -- Myleography, posterior fossa, radiological supervision and interpretation

(b) 70110 -- Radiologic examination, mandible; complete, minimum of four views

(c) 70120 -- Radiologic examination, mastoids; less than three views per side

(d) 70130 -- Complete, minimum of three views per side

(e) 70140 -- Radiologic examination, facial bones; less than three views

(f) 70150 -- Complete, minimum of three views

(g) 70190 -- Radiologic examination; optic foramina

(h) 70220 -- Radiologic examination, sinuses, paranasal, complete, minimum of three views

(i) 70250 -- Radiologic examination, skull; less than four views, with or without stereo

(j) 70260 -- Complete, minimum of four views, with or without stereo

(k) 70328 -- Radiologic examination, temporomandibular joint, open and closed mouth; unilateral

(l) 70330 -- Bilateral

(3) Chest:

(a) 71010 -- Radiologic examination, chest; single view, frontal

(b) 71020 -- Radiologic examination, chest, two views, frontal and lateral

(c) 71030 -- Radiologic examination, chest complete, minimum of four views

(d) 71034 -- With fluoroscopy

(e) 71100 -- Radiologic examination, ribs, unilateral; two views

(f) 71101 -- Including posteroanterior chest, minimum of three views

(g) 71110 -- Radiologic examination, ribs, bilateral; three views

(h) 71120 -- Radiologic examination, sternum, minimum of two views

(i) 71130 -- sternoclavicular joint or joints, minimum of three views

(4) Spine and Pelvis:

(a) 72010 -- Radiologic examination, spine, entire, survey study, anteroposterior and lateral

(b) 72040 -- Radiologic examination, spine, cervical; anteroposterior and lateral

(c) 72050 -- Minimum of four views

(d) 72052 -- Complete, including oblique and flexion and/or extension studies

(e) 72070 -- Radiologic examination, spine; thoracic, anteroposterior and lateral

(f) 72072 -- Thoracic, anteroposterior and lateral, including swimmer's view of the cervicothoracic junction

(g) 72080 -- Thoracolumbar, anteroposterior and lateral

(h) 72090 -- Scoliosis study, including supine and erect studies

(i) 72100 -- Radiologic examination, spine, lumboscral; anteroposterior and lateral

(j) 72110 -- Complete, with oblique views

(k) 72114 -- Complete, including bending views

(l) 72120 -- Radiologic examination, spine, lumbosacral, bending views only, minimum of four views

(m) 72170 -- Radiologic examination, pelvis; anteroposterior only

(n) 72202 -- Radiologic examination, sacroiliac joints; three or more views

(o) 72220 -- Radiologic examination, sacrum and coccyx, minimum of two views

(5) Upper Extremities:

(a) 73010 -- Radiologic examination; scapula, complete

(b) 73030 -- Radiologic examination, shoulder, complete, minimum of two views

(c) 73040-- Radiologic examination, shoulder, arthrography, radiological supervision and interpretation

(d) 73060-- Radiologic examination; humerus, minimum of two views

(e) 73070-- Radiologic examination, elbow, anterposterior and lateral views

(f) 73080-- Complete, minimum of three views

(g) 73090-- Radiologic examination; forearm, anteroposterior and lateral views

(h) 73100-- Radiologic examination, wrist; anteroposterior and lateral views

(i) 73110-- Complete, minimum of three views

(j) 73120-- Radiologic examination, hand; two views

(k) 73130-- Minimum of three views

(l) 73140 -- Radiologic examination, finger or fingers, minimum of two views

(6) Lower Extremities:

(a) 73510 -- Radiologic examination, hip, complete, minimum of two views

(b) 73520-- Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis

(c) 73550-- Radiologic examination, femur, anteroposterior and lateral views

(d) 73560-- Radiologic examination, knee, antero-posterior and lateral views

(e) 73562 -- Anteroposterior and lateral, with oblique(s), minimum of three views

(f) 73600-- Radiologic examination, ankle; anteroposterior and lateral views

(g) 73610-- Complete, minimum of three views

(h) 73620-- Radiologic examination, foot; anteroposterior and lateral views

(i) 73630 -- Complete, minimum of three views

(j) 73650-- Radiologic examination; calcaneus, minimum of two views

(7) Abdomen:

(a) 74000-- Radiologic examination, abdomen; single anteroposterior view

(b) 74010-- Anteroposterior and additional oblique and cone views

(8) Gastrointestinal Tract:

(a) 74210-- Radiologic examination; pharynx and/or cervical esophagus

(b) 74220-- Esophagus

(c) 74245-- Radiologic examination, gastrointestinal tract, upper, with small bowel, includes multiple serial films

(d) 74270-- Radiologic examination, colon; barium enema, with or without KUB

(e) 74280-- Air contrast with specific high density barium, with or without glucagon

(f) 74290-- Cholecystography, oral contrast

(g) 74291-- Additional or repeat examination or multiple day examination

Stat. Auth.: ORS Ch. 409

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-610

410-139-0220

Miscellaneous

The Office of Medical Assistance Programs (OMAP) will pay a chiropractor for the following consultation:

76140 -- Consultation on x-ray examination made elsewhere, written report

Stat. Auth.: ORS Ch. 409

Hist.: AFS 57-1989, f. 9-28-89, cert. ef. 10-1-89; HR 30-1994, f. 9-30-94, cert. ef. 10-1-94; Renumbered from 461-23-620

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 140

VISUAL SERVICES

410-140-0000

Foreword

(1) The **Visual Services Provider Guide** is a user's manual designed to assist providers in preparing claims for Medical Assistance clients. This guide should be used in conjunction with the General Rules for Oregon Medical Assistance Programs and the Oregon Health Plan Administrative Rules.

(2) Instructions on completing claim forms, Administrative Rules and examples of some forms are included in this guide. A section listing procedure codes is also included.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: HR 15-1992, f. & cert. ef. 6-1-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96

410-140-0020

Prepaid Health Plans

(1) OMAP has contracted with Fully Capitated Health Plans (FCHPs), Primary Care Case Managers (PCCMs) and Physician Care Organizations (PCOs) for certain medical services on a prepaid basis for clients whose Medical Care Identification shows coverage under the "Basic Health Care" Benefit package.

(2) FCHPs provide a comprehensive package of health care benefits including physician, laboratory, X-ray, Medicheck

(EPSDT), hospital, pharmacy, all vision services and case management services.

(3) If a client is enrolled with an FCHP, the FCHP covers all vision services, (including routine vision exams, fitting, repairs, therapies and materials) provided by ophthalmologists, optometrists and opticians. These services must be obtained through the FCHP.

(4) PCOs provide physician, laboratory, X-ray, Medicheck (EPSDT), pharmacy, all vision services and case management services. If a client is enrolled with a PCO, the PCO covers all vision services (including routine vision exams, fittings, repairs, therapies and materials) provided by ophthalmologists, optometrists and opticians. These services must be obtained through the Plan.

(5) Services covered by an FCHP/PCO will not be reimbursed by OMAP; reimbursement is a matter between the FCHP/PCO and the provider. If a managed care plan utilizes the OMAP Visual Materials Contractor for visual materials and supplies, all issues must be resolved between the managed care plan and the Contractor.

(6) All services by ophthalmologists and optometrists require referrals from the PCCM except for routine vision exams, fittings, repairs and materials. Bill OMAP for all services referred by the PCCM and for routine vision exams, fittings, repairs and materials.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15, 1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-160; 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

410-140-0040

Prior Authorization

(1) Prior authorization is approval by the Office of Medical Assistance Programs (OMAP) to make payment for services which are medically necessary prior to provision of services. In the Vision Services Program, prior authorization can only be obtained through OMAP for clients who are not enrolled in managed care. If a client is enrolled in managed care, call the managed care plan for criteria on vision services.

(2) A prior authorization number must be present on the billing for visual services with a "PA" indicator, or the claim will reject.

(3) All dispensings of ophthalmic materials by a provider other than a physician or optometrist require a written prescription signed by a physician or optometrist.

(4) Prior authorization does not guarantee eligibility. Always check for eligibility on the date of service.

(5) Prior authorization does not guarantee payment.

(6) OMAP will review documentation to determine if payment can be made. Requests for payment for services which do not meet the rule criteria will be denied.

(7) To determine client eligibility, check the client's Medical Care ID or call AIS for client eligibility information.

(8) A copy of the signed request is sent to OMAP . The following information is needed:

(a) The client's name and client identification number from the Medical Care ID;

(b) Provider's name and OMAP provider number;

(c) A description of the needed item or service. Use the appropriate procedure code and acquisition cost of the item, if applicable;

(d) A statement of medical necessity showing the need for the item or service and why other options are inappropriate. Include diopter information and appropriate ICD-9-CM diagnosis codes;

(e) Any other clinical data or evidence, including medical history, which provides additional information or may simplify the review process.

(9) Providers will receive an OMAP 1072, Prior Authorization form, specifying services authorized. Always enter the nine digit prior authorization number in the appropriate field on the HCFA-1500.

(10) Eligibility:

(a) The Vision Program requires two types of eligibility issues to be verified. The first is general eligibility -- the provider must verify if the client is eligible for Medicaid services and if the client is enrolled in managed care (either an FCHP or PCO). The second is service eligibility -- some vision services (comprehensive eye exams and glasses/ contacts) are limited to once every 24 months. The provider must verify if the client has received these services within the limitation period of OMAP or the client's managed care plan;

(b) Verify Medicaid Eligibility & Managed Care Status:

(A) Check the client's OMAP Medical Care Identification; or

(B) Call AIS to verify eligibility.

(c) Verify Service Eligibility:

(A) Check to see if there are any limitations on the services. The OMAP policy for comprehensive exams and glasses/contacts is once every two years for adults regardless of whether they are in a managed care plan or receive services on a fee-for-service basis. If the client is not in managed care, call AIS to see if the client has received limited services within the last 24 months;

(B) FCHPs and PCOs may decide to allow exams and glasses/contacts more frequently. If the client is in managed care, call the FCHP or PCO to find out what their policy is and if the client is eligible for these services;

(C) OMAP and several managed care plans contract with Sweep Optical to provide vision materials. Sweep will refuse to fill an order if the client has received these services in the past 24 months. When this happens:

(i) If the client is currently not in managed care, OMAP will not pay for another pair of glasses/contacts (except when the client has had cataract surgery within the last 120 days);

(ii) If the client is currently in managed care - If the client received glasses/contacts through OMAP Fee-For-Service or was previously enrolled in a different FCHP/PCO, call the FCHP/PCO the client is currently enrolled with and give them the last date of service for the comprehensive eye exam and glasses/contacts. The FCHP/PCO will decide whether or not to pay for an additional pair of glasses/contacts.

(d) It is the responsibility of the provider to verify eligibility for vision services prior to the initiation of the service. If any services are provided by Sweep Optical and the client is not eligible, the provider is responsible for payment to Sweep Optical (See section on Contracted Services in the Visual Services provider guide);

(e) After eligibility has been verified, check to see if the service requires prior authorization:

(A) If the client is not in managed care - obtain prior authorization from OMAP if it is required for the procedure;

(B) Clients in managed care - Obtain prior authorization from the managed care plan, if it is required by the plan.

(f) AIS can verify client eligibility for the Medicaid program for past and present dates. AIS can only verify vision service history for a client in Fee-For-Service and only for the day the provider accesses AIS. AIS does not verify vision history for managed care clients. This information shall be obtained from the managed care plan the client is enrolled in.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

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 461-18-010; HR 15- 1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-170; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96

410-140-0060

Health Insurance Claim Form (HCFA-1500)

(1) Opticians always bill on the HCFA-1500. Optometrists and ophthalmologists bill using the HCFA-1500. Optometrists and ophthalmologists use OMAP 505 for those clients who have Medicare/Medicaid. Opticians cannot bill Medicare.

(2) The HCFA-1500 is a required billing form. Each HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another or attach itemized billings. HCFA-1500 forms are not provided by OMAP. HCFA-1500 forms can be obtained through local forms suppliers. Completed HCFA-1500 forms must be sent to the Office of Medical Assistance Programs.

(3) The following fields are always required to be completed:

(a) Insured's I.D. Number: The eight digit number found on the OMAP Medical Care ID;

(b) Patient's Name: The name as it appears on the OMAP Medical Care ID;

(c) Diagnosis or Nature of Illness or Injury: Ophthalmologists and optometrists must enter the appropriate ICD-9-CM primary diagnosis code to the 4th or 5th digit, where they exist. List up to three additional diagnosis codes only if the claim includes charges for services related to other diagnoses. Use the following primary diagnosis codes for:

(A) Medicheck Screening - V20.2;

(B) Administrative Medical Records and/or Examinations - V68.89;

(C) Child Abuse - 995.5 or E967;

(D) For glasses provided within 120 days following cataract surgery use an appropriate cataract diagnosis code (codes 366 through 366.9).

(d) Date of Service: Must be numeric. If "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(e) Place of Service: Where service is provided:

(A) 1 - inpatient hospital;

(B) 2 - outpatient hospital/OP Dept./ER;

(C) 3 - practitioner's office;

(D) 4 - patient's home;

(E) 7 - nursing home.

(f) Type of Service Codes (TOS):

(A) 1 = Ophthalmologist;

(B) F = Optometrist;

(C) S = Optician;

(D) K = Complete Radiological Services;

(E) P = Professional Radiological Services;

(F) T = Technical Radiological Services.

(g) Procedures, Services or Supplies: Use only CPT, OMAP Uniques or HCPCS;

(h) Diagnosis Code: Use the one digit line reference number from the Diagnosis or Nature of Illness or Injury field;

(i) Charges: Enter a charge for each line item;

(j) Days or Units: This number must match the number of days in the Date of Service field or the number of units of services provided;

(k) Total Charge: Enter the total amounts for all charges listed on this HCFA-1500;

(l) Balance Due: Enter the balance (the information in the Total Charge field minus the information in the Amount Paid field);

(m) Provider Number: Enter the OMAP billing or provider number here. Note: Only one number may be entered in this field.

(4) The following fields are required, when applicable:

(a) Other Insured's Name: This information is listed on the Medical Care ID. When appropriate, use the Third Party Resource (TPR) codes found in the Billing Section to indicate response received from other resources;

(b) Is Patient's Condition Related to: Complete as appropriate when an injury is involved;

(c) Name of Referring Physician or Other Source: Enter the name of referring provider, FCHP/PCO (if the client is in a prepaid health plan), or the primary care physician if the patient is restricted. This entry is required for the following:

(A) Only when restricted clients are referred to ophthalmologists. Restriction is listed on the Medical Care ID;

(B) All services provided by dispensing opticians.

(d) ID Number of Referring Physician: Enter the OMAP provider number of the referring provider, FCHP/PCO (if the

client is in a prepaid health plan), or the primary care physician if the patient is restricted;

(e) Prior Authorization Number: If required, enter the Prior Authorization number here;

(f) Reserved for Local Use (Field 10d): Put a "Y" in this field if service was an emergency;

(g) Reserved for Local Use - (24K): Enter the OMAP performing provider number here, unless it is used in the Provider Number Field;

(h) Amount Paid: Enter the total amount paid from other resources.

(5) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/ Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

(I) NE -- Service Not Considered Emergency by Insurance;

(J) NP -- Service Not Provided by Primary Care Provider/Facility;

(K) MB -- Maximum Benefits Used for Diagnosis/Condition;

(L) RI -- Requested Information Not Received by Insurance from Patient;

(M) RP -- Requested Information Not Received by Insurance from Policyholder;

(N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;

(O) AP -- Insurance mandated under administrative/court order through an absent parent -- not paid within 30 days;

(P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).

(c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:

(A) MP -- Primary Insurance Paid -- Secondary paid;

(B) SU -- Primary Insurance Paid -- Secondary under Deductible;

(C) MU -- Primary and Secondary Under Deductible;

(D) PU -- Primary Insurance Under Deductible -- Secondary Paid;

(E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;

(F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;

(G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

(H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;

(I) SP -- Primary paid -- Secondary Payment Went to Patient;

(J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;

(K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;

(L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;

(M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/Facility;

(N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;

(O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;

(P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from patient;

(Q) MC -- Service Not Covered by Primary or Secondary Insurance;

(R) MO -- Other (if above codes do not apply, include detailed information of why not TPR payment was made).

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 12-1992, f. & cert. ef. 4-1-92; Renumbered from 461-18-180; HR 15-1992, f. & cert. ef. 6-1-92; 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

410-140-0080

Medicare/Medicaid Claims

(1) When an individual has both Medicare and Medicaid coverage, optometrists and ophthalmologists must bill Medicare first. This must be done for all vision services.

(2) The Office of Medical Assistance (OMAP) payment will be based on either Medicare's maximum allowable rate or OMAP's maximum allowable rate, whichever is the lesser.

(3) Medicare will automatically forward all Medicare/Medicaid claims to the State. The OMAP 505 must be used if Medicare sends incorrect claim information to the State and no payment is made on the entire claim, if an out-of-state

Medicare carrier or intermediary was billed or, if Medicare does not cover the service. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" portion of the OMAP-505. Be sure to enter the Medicare Maximum Allowable in field 24H. If any billing corrections are required and payment is made by OMAP, an Adjustment Request must be submitted to correct payment, if necessary. Send all completed OMAP-505 forms to OMAP.

(4) How to complete the OMAP-505. Opticians do not bill on this form:

(a) Patient's Name: The name as it appears on the Medical Care ID;

(b) Insured's Medicaid I.D. No.: The 8 digit number from the Medical Care ID;

(c) Insured's Group No.: The Medicare number as it appears on the client's Medicare Identification Card;

(d) Diagnosis or Nature of Illness or Injury: Ophthalmologists and optometrist must enter the appropriate ICD-9-CM diagnosis code to the 4th or 5th digit, where they exist. The primary diagnosis code is required and must be listed on the first line. List up to three additional diagnosis codes only if the claim includes chages for services related to other diagnoses. Use the following primary diagnosis codes for:

(A) Medicheck Screening - V20.2;

(B) Administrative Medical Reports and/or Examinations - V68.89;

(C) Child Abuse - 999.5 or E967;

(D) For glasses provided within 120 days following cataract surgery use an appropriate cataract diagnosis code (codes 366 through 366.9).

(e) Date of Service: Must be numeric and in six digit format, or enter consecutive days when service exceeds one day;

(f)Place of Service:

(A) 1 = inpatient hospital;

(B) 2 = outpatient hospital/OP Dept./ER;

(C) 3 = practitioner's office;

(D) 4 = patient's home;

(E) 7 = nursing home.

(g) Procedure Codes: Use only CPT, HCPCS or OMAP unique codes found in the Visual Service Guide;

(h) Days or Units: Must match the number of days/units in (e);

(i) Type of Service Codes (TOS):

(A) 1 = Ophthalmologist;

(B) F = Optometrist;

(C) S = Optician;

(D) P = Professional Radiological Services;

(E) T = Technical Radiological Services;

(F) K = Complete Radiological Services.

(j) Charges Billed Medicare: Enter the total dollar amount billed to Medicare for the service provided;

(k) Provider Number: Enter the OMAP provider number unless it is used in (o);

(l) Total Charge: Enter the total dollar amount billed to Medicare;

(m) Medicare Total Payment: Enter the total dollar amount paid by Medicare for these services provided;

(n) Balance Due: Subtract the amounts for Medicaid and insurance from the total billed. There must be an amount in this Field;

(o) Physician's or Supplier's Name, Address, Zip Code & Phone No.: Only the OMAP provider number is required in this field.

(5) The following information is required when applicable:

(a) Other Health Insurance Coverage: If no payment was received from Medicare, enter the reason no payment was made. Select a two-digit code from the Third Party Resource Section;

(b) Was Condition Related to: Complete if service is related to an injury/accident;

(c) If An Emergency Check Here: If the service was performed as an emergency;

(d) Name of Referring Physician or Other Source: Enter the OMAP provider number and name of referring provider. This entry is required only when a restricted client is referred to an ophthalmologist. Restriction is listed on the Medical Care ID;

(e) Prior Authorization: If Prior Authorization is required enter the 9 digit prior authorized number;

(f) Medicare's Allowed Charges: Enter the dollar amount Medicare allows (not the amount paid) for this service. Enter "O" if the amount was zero;

(g) Insurance Other Than Medicaid/Medicare: Enter any amount paid by another resource, other than Medicare, such as other health insurance, or "Spend-Down" (client responsibility). If the amount is zero, put in a "O".

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

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410-140-0100

Adjustment Requests

(1) Overpayments, underpayments and payments received from other resources after OMAP has paid a claim must be resolved through the adjustment process. If a claim has been paid incorrectly, request an adjustment by completing an Adjustment Request Form (OMAP 1036).

(2) An adjustment is only requested for a paid claim. If no payment was made, the claim must be resubmitted using a HCFA-1500 or an OMAP-505 for Medicare claims.

(3) Much of the information required on the Adjustment Request is printed on the Remittance Advice. Claims will process faster if a copy of the Remittance Advice is attached. Submit any documentation that supports the statement of the underpayment or overpayment.

(4) Adjustments cannot be accepted by phone. Send all Adjustment Requests to OMAP.

(5) How to complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) Attach needed documentation;

(c) Mail your Adjustment Request to the address on the form;

(d) Enter the 13 digit Internal Control Number (ICN). This number can be found on the Remittance Advice;

(e) Enter the client's identification number in this space. This number can be found on the Remittance Advice, or on the client's Medical Care ID;

(f) Enter the client's name. Use the same name as is shown on the Medical Care ID;

(g) Enter the provider number; it is always six digits;

(h) Enter the provide name;

(i) Enter the date which is printed at the top of the Remittance Advice;

(j) Description -- Possible areas you might want to change. Only check the box you want to change;

(k) Place of Service -- Enter place where services are provided: 1 -- inpatient hospital, 2 -- outpatient hospital/OP Dept./ER, 3 -- practitioner's office, 4 -- patient's home, 7 -- intermediate care facility;

(l) Type of Service -- Use only OMAP type of service indicators;

(m) Quantity/Unit -- The number of services being billed;

(n) Billed Amount -- The amount billed;

(o) NDC/Procedure Code -- Only CPT codes from the most current CPT codebook found in the Visual Services Guide, HCPCS or OMAP Unique Codes may be used;

(p) Insurance Payment/Patient Liability -- The payments from other sources;

(q) Other -- Check if none of the above address the problem;

(r) Line # -- List the line number from the original claim (HCFA-1500) being adjusted;

(s) Service Date -- Enter the date the service was performed;

(t) Wrong Info -- Enter the incorrect information submitted on the original claim in this column;

(u) Right Info -- Enter the corrected information in this column;

(v) Remarks -- Enter any additional information or explain your request;

(w) Provider's Signature -- The provider or other authorized personnel must sign;

(x) Date -- Enter the date this form was completed.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 12-1992, f. & cert. ef. 4-1-92; Renumbered from 461-18-200; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96

410-140-0120

Procedure Codes

(1) Providers billing CPT codes must bill using the most current CPT Code Book. The CPT codes most commonly used by optometrists and opticians are listed in the Visual Services guide. Ophthalmologists should refer to the Medical-Surgical guide for additional coverage information:

(a) Always use the most applicable CPT code. Do not fragment coding when services can be included in a single code;

(b) Always read the definition to verify the level of service.

(2) Evaluation and Management codes in the CPT cannot be used when performing a comprehensive eye exam or vision therapy. Evaluation and Management codes from CPT cannot be used in lieu of the intermediate, comprehensive or vision therapy exam codes listed in the Ophthalmology section of CPT.

(3) All ophthalmological services and materials must be medically necessary, and documented in the client's clinical record. Specific coverage and restrictions can be found in the Procedure Codes Section of the Visual Services guide.

(4) Documentation in the patient's file must support the level of service billed.

(5) Modifiers can be used with any code. OMAP will recognize Modifiers from CPT, HCPCS and Oregon Medicare.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-210; 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

410-140-0140

Ophthalmological Diagnostic and Treatment Services Coverage

(1) Adults (age 21 and over). Reimbursement for ophthalmological examinations for the purpose of glasses is limited to one complete examination which includes the refractive state every 24 months for adults. Diagnostic evaluations and examinations may be reimbursed more frequently if documentation in the physician's or optometrist's clinical record justifies the medical need.

(2) Children (birth through age 20). All Ophthalmological examinations are covered when documentation in the clinical record justifies the medical need.

(3) Reimbursement for determination of the refractive state is included in an ophthalmological examinations and may not be billed as a separate servic. Determination of the refractive state is limited to once every 24 months for adults age 21 and over.

(4) See Definitions under Ophthalmology Section in the current CPT book for definitions and examples of levels of service.

(5) General Ophthalmological services:

Table 1

New Patient: A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

92002 -- Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate new patient

92004 -- comprehensive, new patient, one or more visits

Established Patient: An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

92012 -- Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient;

92014 -- Comprehensive, established patient, one or more visits

Special Ophthalmological Services

92015 -- Determination of refractive state

92018 -- Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete (Note: Payable to ophthalmologists only).

92019 -- limited (Note: Payable to ophthalmologists only).

92020 -- Gonioscopy with medical diagnostic evaluation (separate procedure)

92060 -- Sensorimotor examination with multiple measurement of ocular deviation and medical diagnostic evaluation procedure

92070 -- Fitting of contact lens for treatment of disease, including supply of lens. Use for Medical bandage for acute injury or disease only -- see Contact lens Section for visual corrections and treatment of Keratoconus.

92081 -- Visual field examination, unilateral or bilateral, with medical diagnostic evaluation; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octupus 3 or 7 equivalent).

92082 -- Intermediate examination (eg, at least two isopters on Goldmann perimeter or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33).

92083 -- Extended examination, (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30_ or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2 or 30/60-2) (Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately)

92100 -- Serial tonometry (separate procedures), with multiple measurements of intraocular pressure over an extended time period with medical diagnostic evaluation, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)

92120 -- Tonography with medical diagnostic evaluations, recording indentation tonometer method or perilimbal suction method.

92130 -- Tonography with water provocation.

92140 -- Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography.

Ophthalmoscopy: Routine ophthalmoscopy is part of general and special ophthalmologic services, whenever indicated. It is a non-itemized service and is not reported separately.

92225 -- Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch and/or fundus biomicroscopy), with medical diagnostic evaluation; initial

92226 -- Subsequent

92230 -- Ophthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)

92235 -- With fluorescein angiography (includes multiframe photography)

92250 -- Ophthalmoscopy, with medical diagnostic evaluation; with fundus photography

92260 -- With ophthalmodynamometry

Other Specialized Services

92265 -- Oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation

92270 -- Electro-oculography, with medical diagnostic evaluation

92275 -- Electroretinography, with medical diagnostic evaluation

92283 -- Color vision examination, extended, eg, anomaloscope or equivalent (Color vision testing with pseudoisochromatic plates (such as HRR or Ishihara) is not reported separately. It is included in the appropriate general or ophthalmological service.)

92284 -- Dark adaptation examination, with medical diagnostic evaluation

92285 -- Extended ocular photography with medical diagnostic evaluation for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)

92286 -- Special anterior segment photography with medical diagnostic evaluation; with speciular endothelial microscopy and cell count

95930 -- Visual evoked potential (VEP) testing central nervous system, checkerboard or flash

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 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 461-18-012; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-220; 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

410-140-0160

Contact Lens Services

(1) The Office of Medical Assistance Programs (OMAP) contracts for contact lens services. Include the brand name with prescription information when ordering contact lenses. If a prior authorization is required, this should also be mailed or faxed to the Contractor. Coverage for Contact Lens Services - Adults (age 21 and older):

(a) 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) Aphakia;

(E) Nystagmus;

(F) Irregular astigmatism.

(b) Prescription and fitting of contact lenses is limited to once every 24 months and requires prior authorization. This limitation is for contacts only. See Purchase of Ophthalmic Materials for limitations on eyeglasses;

(c) Replacement of contact lenses is limited to a total of two contacts every 12 months and does not require prior

authorization;

(d) Corneoscleral lenses are not covered.

(2) Coverage for Contact Lens Services - Children (birth through age 20):

(a) Contact lenses for children are covered when it is documented in the clinical record that glasses cannot 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) Nystagmus;

(E) Irregular asitmatism;

(F) Aphakia.

(b) Prescription and fitting of contacts is limited to once every 24 months and does not require prior authorization;

(c) Replacement of contact lenses is covered when documented as a medical necessity in the clinical record;

(d) Replacement lenses do not require prior authorization;

(e) Corneoscleral lenses are not covered.

(3) The prescription of contact lens includes specifying the optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is *not* part of the general ophthalmological services (such as eye examinations).

(4) Fitting contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

(5) Follow-up of successfully fitted extended wear lenses is part of the general ophthalmological service (such as office visits).

(6) Contact Lens Services:

(a) 92310 -- Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes; except for aphakia. Does not include the cost of the contact lenses. Prior authorization required for adults only;

(b) 92311 -- corneal lens for aphakia, one eye. Does not include the cost of the contact lenses;

(c) 92312 -- corneal lens for aphakia, both eyes. Does not include the cost of the contact lenses;

(d) 92325 -- Modification of contact lens (separate procedure), with medical supervision of adaptation.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-230; 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

410-140-0180

Ocular Prosthetics, Artificial Eye

(1) 823390 -- Prescription, fitting and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation. Limited to one prosthesis every five years after age 20.

(2) 92335 -- Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation. Limited to one prosthesis every five years after age 20.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-240; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96

410-140-0200

Fitting and Repair

(1) Prescription of glasses, when required, is a part of general ophthalmological services (eye exams) and is not reported separately. It includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

(2) The fitting of glasses is a separate service. The fitting can be billed using only the codes listed below. Fitting of glasses is covered only when glasses are provided by the contractor. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. Presence of physician or optometrist is not required.

(3) Supply of frames and lenses is a separate service component; it is not part of the service of fitting spectacles.

(4) Fitting of glasses is limited to once every 24 months for adult (age 21 years and older), except when dispensing glasses within 120 days of cataract surgery. When billing for fitting within 120 days following cataract surgery use an appropriate cataract diagnosis code and document on the claim the date of the cataract surgery. Fitting of glasses is not limited for children (birth through age 20) when documented in the patient's record as medically necessary.

(5) Use fitting codes 92340 - 92353 only when a complete pair of glasses is dispensed. Repair codes 92370 and 92371 must be billed when replacing parts and can only be billed when the parts have been ordered through the Contractor. A delivery invoice will be included with the parts order. Keep a copy of the delivery invoice in the client's records or document the delivery invoice number in the client's records.

(6) Fitting of spectacle mounted low vision aids, single element systems, telescopic or other compound lens systems is not covered.

(7) Periodic adjustment of frames (including tightening of screws) is included in the dispensing fee and is not covered.

(8) Either the date of order or date of dispensing may be used in the "Date of Service" field; however, glasses must be dispensed prior to billing OMAP. Note: Providers may bill for a fitting or repair on undispensed glasses under the following conditions:

(a) Death of the client prior to dispensing;

(b) Client failure to pick up ordered glasses. Documentation in the client's record must show that serous efforts were made by the provider to contact the client.

(9) All frames have a limited warranty. Check specific frame styles for time limits. All defective frames must be returned to the Contractor.

Table 2

CPT Code -- Description

92340 -- Fitting of spectacles, (except for aphakia); monofocal

92341 -- bifocal

92342 -- multifocal

92352 -- Fitting of spectacle prosthesis, (for aphakia;) monofocal

92353 -- multifocal

92358 -- Prosthesis service for aphakia, temporary (disposable or loan, including materials)

92370 -- Repair and refitting spectacles; (except for aphakia)

92371 -- spectacle prosthesis for aphakia\

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-250; 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

410-140-0220

Other Procedures

CPT Code 92499 By Report - Requires prior authorization.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-260; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96

410-140-0240

Prescription Required

Dispensing of glasses by opticians must be supported by proper written order of a physician or optometrist. The order must specify the correction required.

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 9-1978, f. & ef. 2-1-78; AFS 75-1989, f. & cert. ef. 12-15-89; Renumbered from 461-18-005; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-270

410-140-0260

Purchase of Ophthalmic Materials

(1) The Office of Medical Assistance Programs (OMAP) buys all materials i.e. frames, lenses, contact lenses, specialty frames and miscellaneous items) through SWEEP Optical. Rates for materials are negotiated by the Oregon Department of Administrative Services. All frames listed in the Visual Services provider guide and the lenses and miscellaneous items fitted into these frames are to be provided only by SWEEP Optical. It is the responsibility of the provider to verify eligibility of the client before ordering materials from the Contractor.

(2) Adults (age 21 and older) are limited to one complete pair of glasses (frame and lenses) every 24 months.

(3) One pair of additional glasses is covered within 120 days following cataract surgery. When ordering glasses from SWEEP Optical for post-cataract surgery mark the appropriate box indicating surgery was performed within 120 days.

(4) Children (through age 20) are covered for glasses when it is documented in the physician/ optometrist's clinical record as a medical necessity.

(5) Not Covered Ophthalmic Materials include but are not limited to:

(a) Two pairs of glasses in lieu of bifocals or trifocals in a single frame;

(b) Hand-held, low vision aids;

(c) Nonspectacle mounted aids;

(d) Single lens spectacle mounted low vision aids;

(e) Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system;

(f) Extra or spare pairs of glasses;

(g) Anti-reflective lens coating;

(h) U-V lens;

(i) Sunglasses;

(j) Progressive and blended lenses;

(k) Bifocals and trifocals segments over 28 mm including Executive;

(l) Aniseikonic lenses.

(6) Contractor Services:

(a) All materials and supplies must be provided by SWEEP Optical;

(b) Materials provided by SWEEP Optical which require prior authorization (must be medically necessary) and are subject to the following limitations:

(A) Frames not listed in the Vision Services provider guide;

(B) Safety frames and lenses (safety lenses must be in safety frames to meet ANSI standards);

(C) Replacement frame fronts and temples for frames not listed in the Vision Services provider guide;

(D) Tints - limited to albinism and pupillary defects;

(E) Photochromic lenses - limited to albinism and pupillary defects;

(F) Other medically necessary items for a contract frames, i.e., cable temples, head strap frame;

(G) Contact lenses;

(H) Nonprescription glasses - covered only when no correction is necessary; however, there is blindness in one eye; for the purpose of protecting the functional eye;

(I) High Index lenses:

(i) Power is -10 or greater in any meridian in either eye;

(ii) Prism diopters are 10 or more diopters in either lens.

(c) Prior authorization will be sent to the requesting provider who then must forward a copy of the prior authorization to be sent to SWEEP Optical;

(d) Use Type of Service (TOS) "F" for glass lenses and TOS "S" for all other materials;

(e) Reimbursement for frame cases is included in the reimbursement for the frames;

(f) Either the date of order or date of shipping may be used in the "Date of Service" field on the claim form; however, the services may not be billed to OMAP until the order is completed and shipped

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 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 461-18-011; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-280; 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

410-140-0280

Vision Therapy Services

(1) Vision therapy is not covered for adults (age 21 and older).

(2) Vision therapy is covered for children (through age 20), but is limited to a total of five sessions per calendar year without prior authorization (additional therapy sessions require prior authorization). The therapy treatment plan and regimen will be taught to the patient, family, foster parents and/or caregiver during the therapy treatments. No extra treatments will be authorized for teaching. Therapy that can be provided by the patient, family, foster parents, and/or caregiver is not a reimbursable service. Include the following additional information on the OMAP 3071 (request for prior authorization):

(a) Client's name, Medicaid recipient number and date of birth;

(b) Provider number;

(c) Procedure code;

(d) Medical justification;

(e) Diagnosis and ICD-9-CM code (to the highest specificity);

(f) Development diagnostic exam result;

(g) Goals and objectives.

(3) Vision Therapy Services are limited to the following codes. Evaluation and Management CPT codes cannot be used to bill OMAP for vision therapy services:

(a) Examinations -- 98317 -- This code has been deleted -- use VTP01. VTP01, Vision therapy development diagnostic exam;

(b) Therapy -- 92065 -- Orthoptic and/or pleoptic training with continuing medical direction and evaluation. Limited to five sessions per calendar year. More than five sessions require prior authorization.

Stat. Auth.: ORS Chapter 049

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92; Renumbered from 461-18-290; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96

410-140-0300

Postsurgical Care

The office of Medical Assistance Programs (OMAP) will pay optometrists for post-operative care which is within their scope of practice. The ophthalmologist performing the surgery must indicate on the claim, by the use of an appropriate modifier, that only the surgical procedure is being billed, not the follow-up care:

(1) Ophthalmologists and optometrists will be paid a percentage of the maximum allowable for the surgical procedure.

(2) Optometrists must bill using the first post-operative date of service and the same CPT procedure code as the surgeon. Follow-up care includes all visits and examinations provided within 90 days following the date of surgery. Claims for evaluation and management services and ophthalmological examinations will be denied if billed within the 90 days follow-up period.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 15-1992, f. & cert. ef. 6-1-92

410-140-0320

Radiological Services

Radiological Services are covered within scope of practice of an optometrist or an ophthalmologist. Bill the most appropriate CPT code, using Type of Service "K" for a complete service; "T" for technical service only and "P" for professional service only.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: 414.065

Hist.: HR 15-1992, f. & cert. ef. 6-1-92

410-140-0380

Administrative Exam Services Authorized by the Branch Office -- Effective for Services Provided on or After December 15, 1992

(1) The following service is covered only when requested by an AFS, SDSD, MHDDSD, or CSD branch office.

(2) Use **Diagnosis Code V68.89** when billing.

(3) Send Form OMAP 729C to the requesting branch office.

(4) Retain a copy of the OMAP 729 for your records.

(5) Send the completed HCFA-1500 claim form to OMAP at the address shown in the **Visual Services Provider Guide**.

(6) Bill using **OMAP Unique Code 2002M**, **Ophthalmic/Optometric Examination** with completion of form OMAP 729C. This code is covered for adults and children.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: 414.065

Hist.: HR 37-1992, f. & cert. ef. 12-18-92

410-140-0400

Contractor Services

(1) The Office of Medical Assistance Programs (OMAP) contracts with SWEEP Optical Laboratories to provide vision materials. It is the responsibility of the requesting provider to check client eligibility prior to mailing or faxing an order to the Contractor. Order forms can be obtained from SWEEP Optical. A copy of the order form is included, for your

information in the Visual Services provider guide. Written orders should be mailed or faxed to SWEEP Optical using the address and fax number shown in the provider guide. Orders may not be given over the phone. A phone number is listed in the provide guide for order inquiries or general information.

(2) Clients may choose any frame regardless of category listed (i.e. women may choose "Girls" frames).

(3) Contractor responsibilities:

(a) Turn-around time shall be seven calendar days from receipt of the order by the contractor until delivery to the ordering provider;

(b) Ordering provider must be notified within two days of receipt of order whenever there is a delay. Delayed orders must be delivered within a reasonable time;

(c) Document the reason for delay and the date the ordering provider was notified;

(d) Provide the order as specified by the ordering provider;

(e) Contractor must pay for postage via US mail or UPS for all returned orders which are not to specifications of the order or that are damaged in shipping;

(f) Contractor will not accept phone orders for the initial orders. Contractor must accept phone calls or faxed messages if orders are not to specifications and must begin remaking the product before receiving the materials not to specifications. The ordering provider must return the product to the contractor with a note stating the problem and date contact was made with the contractor to remake the order.

(4) Neither the Contractor nor OMAP are responsible for expenses incurred due to "doctor's error" or "re-do's".

(5) Eyeglass cases are to be included with every frame. Cases will not be included in orders for only lenses, temples or frame fronts.

(6) Contractor may use the date of order as the date of service (DOS) but may not bill OMAP until the order has been completed and shipped.

(7) Contractor must bill OMAP using HCPCS or OMAP Unque Codes listed in the Contract agreement. Payment will be at contracted rates.

(8) Contractors must use Type of Service (TOS) Code "S" when billing for plastic lenses, frames and

miscellaneous items and TOS "F" when billing for glass lenses.

(9) Contractor will provide display frames to the ordering provider at a cost not to exceed the contract cost.

(10) All brands of contacts will be available through the Contractor. When requesting contacts, include the brand in addition to the prescription. The Contractor cannot mail contacts directly to the client. All contacts, including replacement lenses, must be dispensed to the client by the Ophthalmologist or Optometrist.

(11) The following Unisex frame styles for men, women, girls or boys are available through this contractor: See Table 1.

[ED. NOTE: Table 1 referred to in this rule is not printed in the OAR Compilation. Copies are available from the Department of Human Resources.]

Stat. Auth.: ORS Chapter 409

Stats. Implemented: 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 37-1992, f. & cert. ef. 12-18-92, Renumbered from 461-18-300; 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

The 1998 Compilation contains Oregon Administrative Rules **filed through November 14, 1997.**

Updates? Use the **OAR Revision Cumulative Index** found in the Oregon Bulletin to access the full text of rulemaking actions after November 14, 1997.

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Oregon Administrative Rules
1998 Compilation

DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 141

OREGON HEALTH PLAN

410-141-0000

Definitions

(1) Administrative Hearing -- A hearing related to a denial, reduction, or termination of benefits which is held when requested by the OHP Client or OMAP Member. A hearing may also be held when requested by an OHP Client or OMAP Member who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(2) Adult and Family Services Division (AFSD) -- The Division with primary responsibility to assist poor families in meeting basic needs and to help them become more self sufficient. To achieve these outcomes, the Division provides income maintenance payments to poor families; contracts with providers for employment training and placement of eligible clients; provides payments for supportive services, such as day care and transportation, and provides eligibility determination for the Oregon Health Plan.

(3) Advance Directive -- A form that allows a person to have another person make health care decisions when he/she cannot make the decision and tells a doctor that the person does not want any life sustaining help if he/she is near death.

(4) Aged -- Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of age.

(5) Americans with Disabilities Act (ADA) -- Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(6) Alternative Care Settings -- Sites or groups of practitioners which provide care to OMAP Members under contract with the PHP. Alternative Care Settings include but are not limited to urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, outpatient surgicenters.

(7) Ancillary Services -- Those medical services under the Oregon Health Plan not identified in the definition of a Condition/Treatment Pair under the OHP Benefit Package, but Medically Appropriate to support a service covered under the OHP benefit package. A list of ancillary services and limitations is identified in OAR 410-141-0520,

Prioritized List of Health Services, or specified in the Ancillary Services Criteria Guide.

(8) Automated Information System (AIS) -- A computer system that provides information on the current eligibility status for clients under the Medical Assistance Program.

(9) Blind -- Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(10) Capitated Services -- Those services that a PHP or Primary Care Case Manager agrees to provide for a Capitation Payment under an OMAP Oregon Health Plan contract.

(11) Capitation Payment -- Monthly prepayment to a PHP for the provision of all Capitated Services needed by OHP Clients who are enrolled with the PHP. Monthly prepayment to a Primary Care Case Manager to provide Primary Care Case Management Services for an OHP Client who is enrolled with the PCCM. Payment is made on a per client, per month basis.

(12) Chemical Dependency Organization (CDO) -- In Deschutes County only, a Prepaid Health Plan that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the Oregon Health Plan. All chemical dependency services covered under the Oregon Health Plan are covered as Capitated Services by the CDO in Deschutes County. The CDO is a limited demonstration project to test the effectiveness of chemical dependency services as part of services to children and families.

(13) Chemical Dependency Services --Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria".

(14) Children Receiving SOSCF or OYA Services-- Individuals who are receiving medical assistance under ORS 414.025(2)(f),(i),(j),(k) and (o), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of the State Office for Services to Children and Families, Department of Human Resources, or Oregon Youth Authority who are in placement outside of their homes.

(15) Clinical Recod -- The Clinical Record includes the medical, dental, or mental health records of an OHP Client or OMAP Member. These records include the PCP's record, the inpatient and outpatient hospital records and the ENCC, Complaint and Disenrollment for Cause records which may reside in the PHP's administrative offices.

(16) Comfort Care -- The provision of medical services or items that give comfort and/or pain relief to an individual who has a Terminal Illness. Comfort care includes 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. Comfort Care includes but is not limited to care provided through a hospice program (see Hospice Guide), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort Care includes nutrition, hydration and medication for disabled infants with life-threatening conditions that are not covered under Condition/ Treatment Pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 - Patient Self-Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(17) Community Mental Health Program (CMHP) -- The organization of all services for persons with mental or emotional disorders and developmental disabilities 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 Mental Health and Developmental Disability Services Division.

(18) Comorbid Condition -- A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or

more other current and existing conditions/diagnoses in the same patient. See OAR 410-141-0480 (7).

(19) Complaint -- An OMAP Member's, a PCCM Member's, or a Member's Representative's clear expression of dissatisfaction with the Prepaid Health Plan or the Primary Care Case Manager which addresses issues that are part of the Prepaid Health Plan or Primary Care Case Manager contractual responsibility. The expression may be in whatever form of communication or language that is used by the Member or the Member's Representative but must state the reason for the dissatisfaction.

(20) Community Standard -- Typical expectations for access to the health care delivery system in the OMAP Member's or PCCM Member's community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, OMAP requires that the health care delivery system available to OMAP Members in Prepaid Health Plans and to PCCM Members with Primary Care Case Managers take into consideration the Community Standard and be adequate to meet the needs of OMAP and PCCM Members.

(21) Condition/Treatment Pair -- Diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9 CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or Mental Health and Developmental Services Division Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

(22) Continuing Treatment Benefit -- A benefit for OHP Clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to the OHP Benefit Package of Covered Services and that treatment is not covered under the OHP Benefit Package of Covered Services.

(23) Dentally Appropriate -- 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 Oregon Health Plan Member or a provider of the service;

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

(24) Dental Care Organization (DCO) -- A Prepaid Health Plan that provides and coordinates capitated dental services. All dental services covered under the Oregon Health Plan are covered as Capitated Services by the DCO; no dental services are paid by OMAP on a fee-for-service basis for Oregon Health Plan Clients enrolled with a DCO provider.

(25) Dental Case Management Services -- Services provided to ensure that OMAP Members obtain dental services including a comprehensive, ongoing assessment of the dental and medical needs related to dental care of the Member plus the development and implementation of a plan to ensure that OMAP Members obtain Capitated Services.

(26) Dental Practitioner -- A practitioner who provides dental services to OMAP Members under an agreement with a DCO, or is a Fee-For-Service Health Care Practitioner. Dental practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.

(27) Department of Human Resources (DHR) -- The Department comprised of seven divisions and two major program offices: Adult and Family Services Division; State Office for Services to Children and Families; Health Division; Mental Health and Developmental Disability Services Division; Senior and Disabled Services Division; Vocational Rehabilitation Division; and the Office of the Director, which includes the Office of Medical Assistance Programs and

the Office of Alcohol and Drug Abuse Programs.

(28) Diagnostic Services -- 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.

(29) Disabled -- Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of Medical Assistance because of a disability.

(30) Disenrollment -- The act of discharging an Oregon Health Plan Client from a Prepaid Health Plan's or Primary Care Case Manager's responsibility. After the effective date of Disenrollment an Oregon Health Plan Client is no longer required to obtain Capitated Services from the Prepaid Health Plan or Primary Care Case Manager, nor be referred by the Prepaid Health Plan for Medical Case Managed Services or by the Primary Care Case Manager for PCCM Case Managed Services.

(31) Dual Eligible -- OHP Clients who are receiving both Medicaid and Medicare benefits.

(32) Emergency Services -- Covered services that are needed immediately or reasonably appear to the OMAP or PCCM Member to be needed immediately because of an injury, sudden illness, or exacerbation of an illness that would have meant a risk of permanent damage to the PCCM Member's or OMAP Member's health. Covered services provided by an appropriate source other than a Primary Care Case Manager or a PHP or its subcontractors are considered Emergency Services if the time required to reach the Primary Care Case Manager or PHP's providers or suppliers (or alternatives authorized by the PHP) involves a risk of permanent damage to the PCCM Member's or OMAP Member's health. These services are considered to be Emergency Services as long as transfer of the PCCM Member or OMAP Member to the Primary Care Case Manager's or PHP's source of health care or the PHP's designated alternative is precluded because of risk to the PCCM Member's or OMAP Member's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition. Dental emergency services may include, but are not limited to, severe tooth pain, unusual swelling of the face or gums, and a tooth that has been knocked out.

(33) Enrollment -- Oregon Health Plan Clients, subject to OAR 410-141-0060, Client Enrollment, become OMAP Members of a Prepaid Health Plan or PCCM Members of a Primary Care Case Manager that contracts with OMAP to provide Capitated Services. An OHP Client's Enrollment with a PHP indicates that the OMAP Member must obtain or be referred by the PHP for all Capitated Services and referred by the PHP for all Medical Case Managed Services subsequent to the effective date of Enrollment. An Oregon Health Plan Client's Enrollment with a Primary Care Case Manager indicates that the PCCM Member must obtain or be referred by the Primary Care Case Manager for preventive and primary care and referred by the Primary Care Case Manager for all PCCM Case Managed Services subsequent to the effective date of Enrollment.

(34) Enrollment Year -- A twelve month period beginning the first day of the month of Enrollment of the Oregon Health Plan Client in a PHP and, for any subsequent year(s) of continuous Enrollment, beginning that same day in each such year(s). The Enrollment Year of Oregon Health Plan Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(35) End Stage Renal Disease (ESRD) -- End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.

(36) Exceptional Needs Care Coordination (ENCC)-- A specialized case management service provided by Fully Capitated Health Plans to OMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405, Oregon Health Plan Prepaid Health Plan Exceptional Needs Care Coordination (ENCC). ENCC includes:

(a) Early identification of those Aged, Blind or Disabled OMAP Members that have disabilities or 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.

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

(38) Fee-for-Service Health Care Providers -- Health care providers who bill for each service provided and are paid by OMAP for services as described in OMAP provider guides. Certain services are covered but are not provided by Prepaid Health Plans or by Primary Care Case Managers. The client may seek such services from an appropriate Fee-For-Service provider. Primary Care Case Managers provide primary care services on a fee-for-service basis and might also refer PCCM Members to specialists and other providers for fee-for-service care. In some parts of the state, the State may not enter into contracts with any managed care providers. OHP Clients in these areas will receive all services from Fee-For-Service providers.

(39) Free-Standing Mental Health Organization (MHO) -- The single MHO in each county that provides only mental health services and is not affiliated with a Fully Capitated Health Plan for that service area. In most cases this "carve-out" MHO is a county Community Mental Health Program or a consortium of Community Mental Health Programs, but may be a private behavioral health care company.

(40) Fully Capitated Health Plan (FCHP) -- Prepaid Health Plans that contract with OMAP to provide capitated services under the Oregon Health Plan. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(41) Health Care Financing Administration (HCFA) -- The federal agency under the Department of Health and Human Services, responsible for approving the waiver request to operate the Oregon Health Plan Medicaid Demonstration Project.

(42) Health Care Professionals --Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental`profession, which include but are not limited to: Medical Doctors (including Psychiatrists), Dentists, Osteopathic Physicians, Psychologists, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Medical Assistants, Physicians Assistants, Qualified Mental Health Professionals (QMHPs), and Qualified Mental Health Associates (QMHAs), Dental Hygienists, Denturists, and Certified Dental Assistants. These professionals may conduct health, mental health or dental assessments of OMAP members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification.

(43) Health Management Unit (HMU) -- The OMAP unit responsible for adjustments to enrollments, retroactive disenrollment and enrollment of newborns.

(44) Health Plan New/Noncategorical Client (HPN) -- A person who was born before October 1, 1983, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an Oregon Health Plan Client.

(45) Health Services Commission -- An eleven 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.

(46) Hospice Services -- A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

(47) Line Items -- Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the Oregon Health Plan Medicaid Demonstration Project.

(48) Local and Regional Allied Agencies -- Local and Regional Allied Agencies include the following: local Mental Health Authority; Community Mental Health Programs; local offices of DHR agencies (AFSD, SOSCF, and SDSD); Commission on Children and Families; OYA; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.

(49) Medicaid -- A federal and state funded portion of the Medical Assistance Program established by Title X1X of the Social Security Act, as amended, and administered in Oregon by the Department of Human Resources.

(50) Medical Care Identification -- The preferred term for what is commonly called the "medical card". It is a letter-sized document issued monthly to Medicaid clients to verify their eligibility for services and enrollment in PHPs.

(51) Medical Case Management Services -- Medical Case Management Services are services provided to ensure that OMAP Members obtain health care services necessary to maintain physical and emotional development and health. Medical Case Management Services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are Capitated Services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.

(52) Medically Appropriate -- Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

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

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

(c) Not solely for the convenience of an Oregon Health Plan 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 an OMAP Member or PCCM Member in the PHP's or Primary Care Case Manager's judgment.

(53) Medicare -- The federal health insurance program for the aged and disabled administered by the Health Care Financing Administration under Title XVIII of the Social Security Act.

(54) Medicare HMO -- A capitated health plan that meets specific referral guidelines and contracts with HCFA to provide Medicare benefits to Medicare enrollees.

(55) Mental Health and Developmental Disability Services Division (MHDDSD) -- The Department of Human Resources agency responsible for the administration of the state's mental health and developmental disability services.

(56) Mental Health Assessment -- The determination of an OMAP Member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a Member's mental status, psychosocial history and current problems through interview, observation and testing.

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

(58) Mental Health Organization (MHO) -- A Prepaid Health Plan under contract with the Mental Health and Developmental Disability Services Division (HDDSD) that provides mental health services as capitated services under the Oregon Health Plan. MHOs can be Fully Capitated Health Plans, community mental health programs or private behavioral organizations or combinations thereof.

(59) Non-Capitated Services -- Those OHP-covered services which are paid for on a fee-for-service basis and for which a capitation payment has not been made to a PHP.

(60) Non Covered Services -- Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the Oregon Health Plan. Non-Covered Services for the Oregon Health Plan are identified in:

(a) OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual provider guides.

(61) Non-Participating Provider -- A provider who does not have a contractual relationship with the Prepaid Health Plan, i.e. is not on their panel of providers.

(62) Office of Alcohol and Drug Abuse Programs (OADAP) -- The DHR agency that coordinates policy and programs for the state's chemical dependency prevention, intervention, and treatment services.

(63) Office of Medical Assistance Programs (OMAP) -- The Office of the Department of Human Resources responsible for coordinating Medicaid medical services, including the OHP Medicaid Demonstration, in Oregon. OMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays Medicaid providers.

(64) OMAP Member -- An Oregon Health Plan Client enrolled with a Prepaid Health Plan.

(65) Ombudsman Services -- Services provided by OMAP to Aged, Blind and Disabled Oregon Health Plan Clients by OMAP ombudsman staff who may serve as the Oregon Health Plan Client's advocate whenever the Oregon Health Plan Client, Representative, a physician or other medical personnel, or other personal advocate serving the Oregon Health Plan Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the Oregon Health Plan. Ombudsman Services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about Oregon Health Plan systems.

(66) Oregon Health Plan (OHP) -- The Medicaid demonstration project which expands Medicaid eligibility to Oregon residents with an income of less than 100% of the Federal Poverty Level and pregnant women and children under age six with incomes up to 133% of the Federal Poverty Level. The Oregon Health Plan relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(67) Oregon Health Plan Client -- An individual found eligible by a DHR Division to receive services under the Oregon Health Plan. The individual might or might not be enrolled in a Prepaid Health Plan or with a Primary Care Case Manager. The 14 OHP categories eligible to enroll in Prepaid Health Plans are defined as follows:

(a) Aid to Families with Dependent Children (AFDC) are categorical eligibles with income under current eligibility rules;

(b) PLM (Poverty Level Medical) Adults under 100% Federal Poverty Level (FPL) are OHP recipients who are pregnant women with income under 100% of FPL;

(c) PLM Adults over 100% FPL are OHP recipients who are pregnant women with income between 100% and 133% of

the FPL;

(d) PLM Children under 100% FPL are OHP recipients who were born after September 30, 1983 with income under 100% FPL;

(e) PLM Children over 100% of the FPL are OHP recipientswho are less than six years of age with income between 100% and 133% of the FPL;

(f) OHP Adults and Couples are OHP recipients with income below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(g) OHP Families are OHP recipients with income below 100% of FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under the age of 19 in the household;

(h) GA (General Assistance) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(i) AB/AD (Assistance to Blind and Disabled) with Medicare Eligibles are OHP recipients with concurrent Medicare eligibility with income under current eligibility rules;

(j) AB/AD without Medicare Eligibles are OHP recipients without Medicare with income under current eligibility rules;

(k) OAA (Old Age Assistance) with Medicare Eligibles are OHP recipients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(l) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(m) OAA without Medicare Eligibles are OHP recipients without Medicare with income under current eligibility rules; and

(n) SOSCF Children are OHP recipients who are children with medical eligibility determined by the State Office for Services to Children and Families or the Oregon Youth Authority.receiving OHP under ORS 414.025(2)(f), (I), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of the State Office for Services to Children and Families or the Oregon Youth Authority who are in placement outside of their homes.

(68) Oregon Youth Authority -- 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.

(69) Participating Provider -- An individual, facility, corporate entity, or other organization which supplies medical, dental, or mental health services or items who have agreed to provide those services or items and to bill in accordance with a signed agreement with a PHP.

(70) PCCM Case Managed Services -- PCCM Case Managed Services include the following: Preventive Services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, Community Mental Health Programs, Mental Health Organizations; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(71) PCCM Member -- An Oregon Health Plan Client enrolled with a Primary Care Case Manager.

(72) Post Hospital Extended Care Benefit -- A 20 day benefit for non-Medicare OMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(73) Practitioner -- A person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(74) Prepaid Health Plan (PHP) -- A managed health, dental, or mental health care organization that contracts with OMAP and/or MHDDSD on a case managed, prepaid, capitated basis under the Oregon Health Plan. Prepaid Health Plans may be Dental Care Organizations (DCOs), Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), or Chemical Dependency Organizations (CDOs).

(75) Preventive Services -- Those services as defined under Expanded Definition of Preventive Services for Oregon Health Plan clients in OAR 410-141-0480, The Oregon Health Plan Benefit Package of Covered Services, and OAR 410-141-0520, Prioritized List of Health Services.

(76) Primary Care Case Management Services -- Primary Care Case Management Services are services provided to ensure PCCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care Case Management Services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are preventive or primary care services or PCCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(77) Primary Care Case Manager (PCCM) -- A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician back-up, who agrees to provide Primary Care Case Management Services as defined in rule to PCCM Members. Primary Care Case Managers may also be hospital primary care clinics, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCCM provides Primary Care Case Management Services to PCCM Members for a Capitation Payment. The PCCM provides preventive and primary care services on a fee-for-service basis.

(78) Primary Care Provider (PCP) -- A practitioner who has responsibility for supervising, coordinating initial and primary care within their scope of practice for OMAP Members, Primary care providers initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically or dentally appropriate care.

(79) Prioritized List of Health Services -- The listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan Demonstration Project. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of condition and treatment pairs.

(80) Proof of Indian Heritage -- Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service - services provided by Indian Health Service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.

(81) Provider -- An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(82) Quality Improvement -- Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(83) Representative -- A person who can make Oregon Health Plan related decisions for Oregon Health Plan Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is designated as the Oregon Health Plan Client's health care representative, a court-appointed guardian, a

spouse, or other family member as designated by the Oregon Health Plan client, the Individual Service Plan Team (for developmentally disabled clients), a DHR case manager or other DHR designee.

(84) Senior and Disabled Services Division (SDSD) -- The Division responsible for providing three types of services: (1) assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program; (2) cash assistance grants for persons with long-term disabilities through General Assistance and the Oregon Supplemental Income Program (OSIP); and (3) administration of the federal Older Americans Act.

(85) Service Agreement --The agreement between the State of Oregon, acting by and through its Department of Human Resources, Office of Medical Assistance Programs (OMAP) and a Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), or a Chemical Dependency Organization (CDO) for the provision of Covered Services to OMAP Members for a Capitation Payment.

(86) State Office for Services to Children and Families (SOSCF) -- The Division serving as Oregon's child welfare agency. Child Protective Services staff assess reports of child abuse and neglect, work with families to try to keep children in the home, and place children in foster care or residential treatment if their need for safety and other services requires substitute care. The Adoption Assistance Program serves children previously under SOSCF guardianship who have been adopted.

(87) Terminal Illness -- An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

(88) Triage --Evaluations conducted to determine whether or not an emergency condition exists, and to direct the OMAP Member to the most appropriate setting for Medically Appropriate care.

(89) Urgent Care Services -- Covered services required in order to prevent a serious deterioration of an OMAP Member's or PCCM Member's health that results from an unforeseen illness or an injury and for dental services necessary to treat such conditions as lost fillings or crowns. Services that can be foreseen by the individual are not considered Urgent Services.

(90) Valid Claim -- An invoice received by the PHP for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party;

(b) Has been received within the time limitations prescribed in these Rules; and

(c) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

(91) Valid Pre-Authorization -- A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.610 & 414.620

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & 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 25-1997, f. & cert. ef. 10-1-97

410-141-0020

Administration of Oregon Health Plan Regulation and Rule Precedence

(1) OMAP may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Oregon Health Plan subject to the rulemaking requirements of Oregon statute and Oregon Administrative Rule procedures.

(2) In the event that OMAP policies, procedures, rules and interpretations are not complementary, the following order of precedence is to be followed:

(a) Federal law, regulation and waivers granted OMAP by the Health Care Financing Administration to operate the Oregon Health Plan;

(b) Oregon state law;

(c) OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules, inclusive;

(d) OAR 410-120-1100 through 410-120-9999, Office of Medical Assistance Programs General Rules, inclusive;

(e) Any other duly promulgated rules issued by OMAP and other offices and Divisions within the Department of Human Resources necessary to administer the State of Oregon's Medical Assistance Program.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94

410-141-0060

Oregon Health Plan Managed Care Enrollment Requirements

(1) Enrollment of an Oregon Health Plan (OHP) Client, excluding the New/Noncategorical Client (HPN) in Prepaid Health Plans shall be mandatory unless exempted from enrollment by the Department of Human Resources (DHR), or unless the OHP Client resides in a service area where there is inadequate capacity to provide access to capitated services for all OHP Clients through Prepaid Health Plans (PHPs) or Primary Care Case Managers (PCCMs). PHPs include Fully Capitated Health Plans (FCHPs), Dental Care Organizations (DCOs) and Mental Health Organizations (MHOs),and Chemical Dependency Organizations (CDOs).

(2) Enrollment of the New/Noncategorical Client (HPN) in PHPs shall be mandatory unless exempted from enrollment by DHR under the term in 410-141-0060(4). Selection of (PHPs) in accordance with this rule is a condition of eligibility for HPN Clients. If, upon reapplication, an HPN Client does not select PHPs in accordance with this rule, PHPs will be selected for the HPN Client by DHR. This selection will be made based on the PHPs in which the HPN Client was previously enrolled.

(3) OHP Clients, except the HPN Clients shall be enrolled with PHPs or PCCMs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of FCHPs and PCCMs shall be called mandatory FCHP/PCCM service areas. An OHP Client shall select a FCHP unless exempted from enrollment in a FCHP, in which case they shall choose a PCCM in a mandatory FCHP/PCCM service area;

(b) Areas with sufficient physical health service capacity through PCCMs alone shall be called mandatory PCCM service areas. An OHP Client shall select a PCCM in a mandatory PCCM service area;

(c) Areas without sufficient physical health service capacity through FCHPs and PCCMs shall be called voluntary FCHP/PCCM service areas. An OHP Client may choose to select a FCHP or PCCM in voluntary FCHP/PCCM service areas if the FCHP or PCCM is open for enrollment, or may choose to remain in the Medicaid fee-for-service (FFS) physical health care delivery system;

(d) Areas with sufficient dental care service capacity through DCOs shall be called mandatory DCO service areas. An OHP Client shall select a DCO in a mandatory DCO service area;

(e) Areas without sufficient dental care service capacity through DCOs shall be called voluntary DCO service areas. An OHP Client may choose to select a DCO in a voluntary DCO service area if the DCO is open for enrollment, or may choose to remain in the Medicaid FFS dental care delivery system;

(f) Areas with sufficient mental health service capacity through MHOs shall be called mandatory MHO service areas. An OHP Client shall select an MHO in a mandatory MHO service area; and

(g) Areas without sufficient mental health service capacity through MHOs shall be called voluntary MHO service areas. An OHP Client may choose to select an MHO in voluntary MHO service areas if the MHO is open for enrollment, or may choose to remain in the Medicaid FFS mental health care delivery system.

(4) The following are exemptions to mandatory enrollment in PHPs which allow OHP Clients, including HPN Clients, to enroll with a PCCM or remain in the Medicaid FFS delivery systems for physical, dental and/or mental health care:

(a) The OHP Client is covered under a major medical insurance policy, Medicare supplemental policy, Medicare employer group policy or other third party resource which covers the cost of services to be provided by a PHP. The OHP Client shall enroll with a PCCM if the insurance policy is not a private HMO;

(b) The OHP Client has an established relationship with a Medicaid enrolled Practitioner who is not a member of the provider panel of the PHP, and it would be detrimental to the health of the OHP Client as determined by DHR to change Practitioners; and the PHP cannot negotiate a treatment plan or reimbursement arrangement consistent with the contracting practices of the PHP with the Practitioner to provide for continuity of care:

(A) When the Practitioner is a Primary Care Practitioner (PCP) enrolled with OMAP as a PCCM, the OHP Client shall enroll with this Practitioner as a PCCM;

(B) Exemptions from mandatory enrollment in PHPs for this reason may be granted for a period of four months. Extensions may be granted by DHR upon request, subject to review of unique circumstances. A 12 month exemption may be granted if the reason for the exemption is not likely to change or is due to a chronic or permanent condition or disability.

(c) The OHP Client is a Native American or Alaskan Native with Proof of Indian Heritage and chooses to receive services from an Indian Health Service facility or tribal health clinic;

(d) The OHP Client is a child in the legal custody of either the Oregon Youth Authority (OYA) or State Office for Services to Children and Families (SOSCF), and the child is expected to be in a substitute care placement for less than 30 calendar days;

(e) The OHP Client is in the third trimester of her pregnancy when first determined eligible for OHP, or at redetermination, and she wishes to continue obtaining maternity services from a Practitioner who is not a Participating Provider with an FCHP in the service area:

(A) In order to qualify for such exemption at the time of redetermination, the OHP Client must not have been enrolled with an FCHP during the three months preceding redetermination;

(B) If the OHP Client moves out of the PHP service area during the third trimester, the client may be exempted from enrollment in the new service area for continuity of care if the client wants to continue OB-care with her previous physician, and that physician is within the travel time or distance indicated in 410-141-0220(1) (a) Oregon Health Plan PHP Accessibility;

(C) If the Practitioner is a PCCM, the OHP Client shall enroll with that Practitioner as a PCCM;

(D) If the Practitioner is not enrolled with OMAP as a PCCM, then the OHP Client may remain in the Medicaid FFS delivery system until 60 days after the birth of her child. After the 60-day period, the OHP Client must enroll in a FCHP.

(f) The OHP Client has End Stage Renal Disease (ESRD). The OHP Client shall not enroll in an FCHP but shall enroll with a PCCM unless exempt for some other reason listed in Section 4 of this rule;

(g) The OHP Client has been accepted by the Medically Fragile Children's Unit of the Mental Health and Developmental Disability Services Division (MHDDSD);

(h) The OHP Client is a Medicare beneficiary and is in a hospice program. The OHP Client shall not enroll with any PHPs but shall enroll with a PCCM unless exempt for some other reason listed in Section 4 of this rule;

(i) The OHP Client is enrolled in Medicare and the only FCHP in the service area is a Medicare HMO. The OHP Client may be exempted from Enrollment in the FCHP if they choose not to enroll;

(j) Other just causes as determined by DHR, at its sole discretion. which include the following factors:

(A) The cause is beyond the control of the client;

(B) The cause is in existence at the time that the client first becomes eligible for OHP;

(C) Enrollment would pose a serious health risk; and

(D) The lack of reasonable alternatives.

(5) The primary person in the household group and benefit group as defined in OAR 461-110-0110, OAR 461-110-0210, and OAR 461-110-0720, respectively, shall select PHPs or PCCMs on behalf of all OHP Clients in the benefit group. PHP or PCCM selection shall occur at the time of application for the OHP in accordance with Section 1 of this rule:

(a) All individuals in the benefit group shall enroll in the same PHP for each benefit type (physical, dental or mental health care) unless exempted under the conditions stated above in Section 2. If PCCM selection is an option, individuals in the benefit group may select different PCCMs;

(b) If the OHP Client is not able to choose PHPs or PCCMs on his or her own, such selection shall be made by the Representative of the OHP Client. The hierarchy used for making enrollment decisions shall be in descending order as defined under Representative:

(A) If the OHP form 7208, Health Plan Enrollment, is signed by someone other than the OHP Client, or if the OHP Client signs with a mark, then the OHP Client's Representative must complete and sign an OHP form 7208A, Addendum to OHP Health Plan Enrollment;

(B) If the OHP Client is a Medicare beneficiary who is capable of making enrollment decisions, the Representative shall not have authority to select FCHPs which have corresponding Medicare HMO components.

(c) The SOSCF or OYA shall select PHPs or a PCCM for a child receiving SOSCF or OYA Services, with the exception of children in subsidized adoptions;

(d) Erollment in a FCHP of an OHP Client who is receiving Medicare and who resides in a service area served by PHPs or PCCMs shall be as follows:

(A) If the OHP Client selects a FCHP that has a corresponding Medicare HMO, the OHP Client shall also enroll in the Medicare HMO;

(B) If the OHP Client is enrolled as a private member of a Medicare HMO, the OHP Client may choose to remain enrolled as a private member or to enroll in the FCHP that corresponds to the Medicare HMO:

(i) If the OHP Client chooses to remain as a private member in the Medicare HMO, the Member shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;

(ii) If the OHP Client chooses to discontinue the Medicare HMO enrollment and then, within 60 calendar days of disenrollment from the Medicare HMO, chooses the FCHP that corresponds to the Medicare HMO that was discontinued, the OHP Client shall be allowed to enroll in that FCHP even if the FCHP is not open for Enrollment to other OHP Clients;

(iii) A Dual Eligible (DE) OHP Client who has been exempted from enrollment in an MHO shall not be enrolled in a FCHP that has a corresponding Medicare HMO unless the exemption was done for a provider who is on the FCHP's panel.

(e) MHO enrollment options shall be based on the OHP Client's county of residence, the FCHP selected by the OHP Client, and whether the FCHP selected serves as a MHO:

(A) If the OHP Client selects a FCHP that is not a MHO, then the OHP Client shall enroll in the MHO designated as the free-standing MHO for that county;

(B) If the OHP Client selects a FCHP that is a MHO, then the OHP Client shall receive the OHP mental health benefit through that FCHP.

(6) If the OHP Client resides in a mandatory service area and fails to select a DCO, MHO, and/or FCHP or a PCCM at the time of application for the OHP, OMAP may enroll the OHP Client with a DCO, MHO, and/or FCHP or a PCCM:

(a) The OHP Client shall be assigned to and enrolled with a DCO, MHO, and FCHP or PCCM which meet the following requirements:

(A) Is open for enrollment;

(B) Serves the county in which the OHP Client resides;

(C) Has Practitioners located within the Community Standard distance for average travel time for the OHP Client.

(b) Assignment shall be made first to a FCHP and second to a PCCM;

(c) DHR shall send a notice to the OHP Client informing the OHP 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, and FCHP or PCCM open for enrollment in the county in which the OHP Client resides;

(d) Enrollments resulting from assignments shall be effective the first of the month or week after DHR enrolls the OHP Client and notifies the client of Enrollment and the name of the PHP or PCCM: If enrollment is initiated by a DHR worker on or before Wednesday, the date of enrollment shall be the following Monday. If enrollment is initiated by a DHR 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 FCHP, MHO or DCO shall be initiated by an auto-enrollment program of DHR with effective dates the first of the month following the month-end cutoff. Monthly enrollment in service areas where there is a choice of FCHPs, MHOs or DCOs, shall be done by OMAP's Health

Management Unit (HMU) according to established assignment protocols.

(7) The provision of Capitated Services to an OHP Client enrolled with a DCO, MHO, and/or FCHP or a PCCM shall begin on the first day of enrollment with the DCO, MHO, and/or FCHP or a PCCM 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 with a FCHP or MHO shall be the first possible enrollment date after the date the individual is discharged from inpatient hospital services and the date of Enrollment with a PCCM shall be the first of the month for which Capitation Payment is made;

(c) Persons who are reenrolled within 30 calendar days of Disenrollment. The date of Enrollment shall be the date specified by DHR which may be retroactive to the date of Disenrollment;

(d)Adopted children or children placed in an adoptive placement. The date of Enrollment shall be the date specified by DHR.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0080

Oregon Health Plan Disenrollment from Prepaid Health Plans

(1) Client Requests for Disenrollment:

(a) All Oregon Health Plan Client-initiated requests for Disenrollment from Prepaid Health Plans (PHP) must be initiated by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and OAR 461-110-0720, respectively. For OHP Clients who are not able to request Disenrollment on their own, the request may be initiated by the OHP Client's Representative;

(b) Primary person or Representative requests for Disenrollment shall be honored:

(A) After six months of OMAP Member's Enrollment without cause. The effective date of Disenrollment shall be the end of the month following the request for Disenrollment;

(B) Whenever OMAP Member eligibility is redetermined by DHR and the Primary Person requests Disenrollment without cause. The effective date of Disenrollment shall be the end of the month following the date that the OMAP Member's eligibility is redetermined by DHR;

(C) OMAP Members who disenroll from a Medicare HMO shall also be Disenrolled from the corresponding PHP. The effective date of Disenrollment shall be the same date that their Medicare HMO disenrollment is effective;

(D) OMAP Members who are receiving Medicare and who are enrolled in a PHP that has a corresponding Medicare HMO may Disenroll from the PHP at any time if they also request disenrollment from the Medicare HMO. The effective date of Disenrollment from the PHP shall be the end of the month following the date of request for Disenriollment;

(E) At any other time with cause:

(i) OMAP shall determine if sufficient cause exists to honor the request for Disenrollment. The determination shall be made within ten working days;

(ii) Examples of sufficient cause include but are not limited to:

(I) The OMAP Member moves out of the PHP's service area;

(II) It would be detrimental to the OMAP Member's health to remain enrolled in the PHP;

(III) The OMAP 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 delivery system;

(IV) Continuity of care that is not in conflict with any section of 410-141-0060 or 410-141-0080.

(c) In addition to the Disenrollment constraints listed in (b), above, OMAP Member Disenrollment requests are subject to the following requirements:

(A) The OMAP Member shall join another PHP, unless the OMAP Member resides in a service area where Enrollment is voluntary, or the OMAP Member meets the exemptions to enrollment as stated in 410-141-0060(4);

(B) If the only PHP available in a mandatory service area is the plan from which the OMAP Member wishes to disenroll, the OMAP Member may not disenroll without cause;

(C) The effective date of Disenrollment shall be the end of the month in which Disenrollment was requested unless retroactive Disenrollment is approved by OMAP.

(2) Prepaid Health Plan requests for Disenrollment:

(a) Causes for Disenrollment:

(A) OMAP may Disenroll OMAP Members for cause when requested by the PHP subject to ADA requirements and approval by HCFA if a Medicare Member is enrolled in a PHP's Medicare HMO. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of appointments are to be established by provider or PHP. The number must be the same as for commercial members or patients. The provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the Member in receiving services. This rule does not apply to Medicare Members who are enrolled in a PHP's Medicare HMO;

(ii) Member's behavior is disruptive, unruly, or abusive to the point that his/her enrollment seriously impairs the provider's ability to furnish services to either the Member or other members;

(iii) Member commits or threatens an act of physical violence directed at a medical provider or property, the provider's staff, or other patients, or the PHP's staff;

(iv) Member commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts committed in any provider's or Prepaid Health Plan's premises. The PHP shall report any illegal acts to law enforcement authorities or to the Adult & Family Services Fraud Unit as appropriate.

(B) OMAP Members shall not be disenrolled solely for the following reasons:

(i) Because of a physical or mental disability;

(ii) Because of an adverse change in the Member's health;

(iii) Because of the Member's utilization of services, either excessive or lack thereof;

(iv) Because the Member requests a hearing;

(v) Because the Member has been diagnosed with end-stage renal disease or placed in a hospice after the date of enrollment;

(vi) Because the Member exercises his/her option to make decisions regarding his/her medical care with which the plan disagrees.

(C) Requests by the PHP for Disenrollment of specific OMAP Members shall be submitted in writing to their PHP Coordinator for approval. The PHP must 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 must be followed prior to requesting disenrollment of an OMAP Member (except in cases of threats or acts of physical violence, and fraudulent or illegal acts). In cases of threats or acts of physical violence, OMAP will consider an oral request for Disenrollment, with written documentation to follow: In cases of fraudulent or illegal acts, the PHP must submit written documentation for review by the PHP Coordinators:

(i) There shall be notification from the provider to the PHP at the time the problem is identified. The notification must describe the problem and allow time for appropriate intervention by the PHP. Such notification shall be documented in Member's clinical record. The PHP shall conduct provider education regarding the need for early intervention and the services they can offer the provider;

(ii) The PHP shall contact the Member either verbally or in writing, depending on the severity of the problem, to develop an agreement regarding the issue(s). If contact is verbal, it shall be documented in the Member's record. The PHP shall inform the Member that his/her continued behavior may result in disenrollment from the PHP;

(iii) The PHP shall provide individual education, counseling, and/or other intervention's in a serious effort to resolve the problem;

(iv) The PHP shall contact the Member's DHR caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution;

(v) If the severity of the problem and intervention warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and/or coordinate a case conference. Involvement of provider, caseworker, Member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain a release of information to providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it must be documented in the Member's record;

(vi) If a Primary Care Provider (PCP) terminates the patient/provider relationship, 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 a release of information in order to share the information necessary for a new provider to evaluate if they can treat the Member. All terminations of provider/patient relationships shall be according to the PHP's policies and must be consistent with PHP's or PCP's policies for commercial members.

(D) If the problem persists, the PHP may request disenrollment of the Member by submitting a written request to disenroll the Member to the plans' PHP Coordinator, with a copy to the Member's caseworker. Documentation with the request shall include the following:

(i) The reason the PHP is requesting disenrollment; a summary of the PHP's efforts to resolve the problem and other options attempted before requesting disenrollment;

(ii) Documentation should be objective, with as much specific details and direct quotes as possible when problems

involve disruptive, unruly, abusive or threatening behaviors;

(iii) Where appropriate, background documentation including a description of Member's age, diagnosis, mental status (including their level of understanding of the problem and situation), functional status (their level of independence) and social support system;

(iv) Where appropriate, separate statements from PCPs, caseworker and other agencies, providers or individuals involved;

(v) If reason for the request is related to the OMAP Member's substance abuse treatment, the PHP shall notify the OHP Coordinator in the Office of Alcohol and Drug Abuse Services;

(vi) If Member is disabled, the following documentation shall also be submitted as appropriate:

(I) A written assessment of the relationship of the behavior to the disability including: 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;

(II) An interdisciplinary team review that includes a mental health professional and/or behavioral specialists to assess the behavior, its history, and previous history of efforts to manage behavior;

(III) If warranted, a clinical assessment that the behavior will not respond to reasonable clinical or social interventions;

(IV) Documentation of any accommodations that have been attempted;

(V) Any additional information or assessments requested by the PHP Coordinators.

(E) Requests will be reviewed according to the following process:

(i) If there is sufficient documentation, the request will be evaluated by a team of PHP Coordinators who may request additional information from Ombudsman, mental health or other agencies as needed;

(ii) If there is not sufficient documentation, the PHP Coordinator will notify the PHP what additional documentation is required before the request can be considered;

(iii) The PHP Coordinators will review the request and notify the PHP of the decision within ten working days of receipt. Written decisions, including reasons for denials, will be sent to the PHP within 15 working days from receipt of request;

(iv) If the request is approved, the Disenrollment date is 30 days after the date of approval, except as provided in (f) and (G) below. The PHP must send the Member a letter within 14 days after the request was approved, with a copy to the Member's DHR caseworker and OMAP's Health Management Unit (HMU), except in cases where the Member is also enrolled in a PHP's Medicare HMO. The letter must give the disenrollment date, the reason for disenrollment, and the notice of Member's right to an Administrative Hearing;

(v) In cases where the Member is also enrolled in a PHP's Medicare HMO, the letter shall be sent after the approval by HCFA and the date of disenrollment shall be the date of disenrollment as approved by HCFA. If HCFA does not approve the disenrollment, the Member shall not be disenrolled from the PHP's OHP Plan;

(vi) If Member requests a hearing, the Member will continue to be Disenrolled until a hearing decision reversing that disenrollment has been mailed to the Member and the PHP;

(vii) The PHP Coordinators will determine when enrollment in another PHP or with a PCCM is appropriate. PHP Coordinator will contact Member's DHR caseworker to arrange enrollment;

(viii) When the disenrollment date has been determined, HMU sends a letter to the Member with a copy to the Member's DHR caseworker and the PHP. The letter shall inform Member of the requirement to be enrolled in another PHP.

(F) If the PHP Coordinators approve a PHP's request for Disenrollment because the OMAP Member threatens or commits an act of physical violence directed at a medical provider, the provider's staff, or other patients, the following procedures shall apply:

(i) OMAP shall inform the Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for disenrollment;

(iii) All OMAP Members in the OMAP Member's benefit group, as defined in OAR 461-110-0720, may be Disenrolled if the PHP requests;

(iv) OMAP may require the OMAP Member and/or the benefit group to obtain services from fee-for-service providers or a PCCM until such time as they can be enrolled in another PHP;

(v) At the time of enrollment in another PHP, OMAP shall notify the new PHP that the Member and/or benefit group were previously Disenrolled from another PHP at that Plan's request.

(G) If the PHP Coordinator approves the PHP's request for Disenrollment because the OMAP Member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a)(A)(iv), the following procedures shall apply:

(i) The PHP shall inform the OMAP Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for disenrollment;

(iii) At the time of enrollment in another PHP, OMAP shall notify the new PHP that the Member and/or benefit group were previously Disenrolled from another PHP at that Plan's request.

(b) Other Reasons for the PHP's Requests for Disenrollment include the following:

(A) The Member is hospitalized on the date their enrollment is effective with the PHP;

(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 Member is in the third trimester of her pregnancy when first determined eligible for OHP, or at redetermination and has not been enrolled in a FCHP within the past 3 months and she wishes to continue obtaining maternity services from a Non-Participating provider;

(D) The Medicare Member was in a hospice at the time of enrollment in the PHP;

(E) The Member had End Stage Renal Disease at the time of enrollment in the PHP;

(F) The PHP determines that the OMAP Member has a third party insurer. If after contacting The Third Party Resource Unit, the Disenrollment is not effective the following month, PHP may contact HMU to request Disenrollment;

(G) The Member moves out of the PHP's service area(s). If after contacting the caseworker, the Disenrollment will not be effective the following month, the PHP may then contact HMU to request Disenrollment;

(H) The Member is legally confined to a correctional facility such as jail, penitentiary, or juvenile detention center, or is temporarily released from a correctional facility to perform court-imposed community service work;

(I) The Member is in a state psychiatric institution.

(3) OMAP Initiated Disenrollments:

(a) OMAP may initiate and disenroll OMAP Members as follows:

(A) If OMAP determines that the OMAP Member has sufficient third party resources such that health care and services may be cost effectively provided on a fee-for-service basis, OMAP may disenroll the OMAP Member. The effective date of Disenrollment shall be the end of the month in which OMAP makes such a determination. In cases where the third party resource is a Health Maintenance Organization (HMO), the date of Disenrollment shall be the effective date of coverage with the HMO or enrollment in the PHP, whichever is first. OMAP may specify a retroactive effective date of Disenrollment if the OMAP Member's third party coverage is through the PHP, or in other situations agreed to by the PHP and OMAP;

(B) If the OMAP Member moves out of the PHP's service area(s), the effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment;

(C) If the OMAP Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project, the effective date of Disenrollment shall be the date specified by OMAP;

(D) If the OMAP Member dies, the effective date of Disenrollment shall be the end of the month following the date of death;

(E) When a non-Medicare Contracting PHP is assumed by another PHP that is a Medicare HMO, OMAP Members with Medicare shall be disenrolled from the existing PHP. The effective date of Disenrollment shall be the day prior to the month the new PHP assumes the existing PHP.

(b) Unless specified otherwise in these rules or in the OMAP notification of Disenrollment to the PHP, all Disenrollments are effective the end of the month after the request for Disenrollment is approved by OMAP;

(c) OMAP shall inform the Members of the Disenrollment decision in writing, including the right to request an Administrative Hearing. Oregon Health Plan Members may request an OMAP hearing if they dispute a Disenrollment decision by OMAP;

(d) If Member requests a hearing, the Member will continue to be disenrolled until a hearing decision reversing that Disenrollment has been mailed to the Member.

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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

410-141-0085

Oregon Health Plan Disenrollment from Primary Care Case Managers

(1) PCCM member requests for disenrollment:

(A) All PCCM member-initiated requests for disenrollment from Primary Care Case Managers must be initiated by the primary person in the benefit group, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For Oregon Health Plan Clients who are not able to request Disenrollment on their own, the

request may be initiated by the Oregon Health Plan Client's Representative;

(b) Primary Person or Representative requests for disenroll-ment shall be honored:

(A) During the first 30 days of enrollment without cause. The effective date of disenrollment shall be the first of the month following PCCM member notification to DHR;

(B) After six months of PCCM member's enrollment without cause. The effective date of disenrollment shall be the first of the month following PCCM member notification to DHR;

(C) Whenever PCCM member eligibility is redetermined by DHR and the primary person requests disenrollment without cause. The effective date of disenrollment shall be the first of the month following the date that PCCM member eligibility is redetermined by DHR;

(D) At any other time with cause:

(i) OMAP shall determine if sufficient cause exists to honor the request for disenrollment;

(ii) Examples of sufficient cause include but are not limited to:

(I) The PCCM member moves out of the Primary Care Case Manager's service area;

(II) It would be detrimental to the PCCM member's health to remain enrolled with the Primary Care Case Manager;

(III) The PCCM 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 delivery system.

(c) In addition to the disenrollment constraints listed in subsection (b) of this section, PCCM member disenrollment requests are subject to the following requirements:

(A) The PCCM member shall select another Primary Care Case Manager or Prepaid Health Plan, unless the PCCM member resides in a service area where enrollment is voluntary;

(B) If the only Primary Care Case Manager or Prepaid Health Plan available in a PHP, PHP/ PCCM or PCCM mandatory service area is the PCCM from which the PCCM member wishes to disenroll, the PCCM member may not disenroll without cause.

(2) Primary Care Case Manager requests for disenrollment:

(a) Procedures for Primary Care Case Manager requests for disenrollment are as follows:

(A) Requests by the Primary Care Case Manager for disenrollment of specific PCCM members shall be submitted in writing to OMAP for approval prior to disenrollment. The Primary Care Case Manager shall document the reason for the request, provide other records to support the request, and certify that the request is not due to an adverse change in the PCCM member's health. If the situation warrants, OMAP shall consider an oral request for disenrollment,with written documentation to follow. OMAP shall approve Primary Care Case Manager requests for disenrollment that meet OMAP criteria;

(B) OMAP shall respond to Primary Care Case Manager requests in a timely manner and in no event greater than 30 calendar days;

(C) The Primary Care Case Manager shall not disenroll or request disenrollment of any PCCM member because of an adverse change in the PCCM member's health.

(b) OMAP may disenroll PCCM members for cause when requested by the Primary Care Case Manager:

(A) OMAP shall inform the PCCM member of:

(i) An approved disenrollment decision;

(ii) Any requirement to select another Primary Care Case Manager;

(iii) Right to request an OMAP hearing if the disenrollment decision by OMAP is disputed.

(B) Examples of cause include, but are no limited to the following:

(i) The PCCM member refuses to accept medically appropriate treatment and/or follow medically appropriate guidelines;

(ii) The PCCM member is unruly or abusive to others or threatens or commits an act of physical violence directed at a medical provider, the provider's staff or other patients;

(iii) The PCCM member has permitted the use of his or her OMAP Medical Care Identification by another person or used another person's Medical Care Identification;

(iv) The PCCM member has missed three appointments without cancelling and/or without explanation and the Primary Care Case Manager has documented attempts to accommodate the PCCM member's needs and to counsel with or educate the PCCM member.

(c) If OMAP approves the Primary Care Case Manager's request for disenrollment of a PCCM member because the PCCM member is abusive to others or threatens or commits an act of phsical violence, the following procedures shall apply:

(A) OMAP shall inform the PCCM member of the disenrollment decision;

(B) The PCCM member shall be disenrolled. All PCCM members in the PCCM member's benefit group, as defined in OAR 461-110-720, may be disenrolled;

(C) The effective date of disenrollment shall be the date of the Primary Care Case Manager's request for disenrollment;

(D) OMAP shall require the PCCM member and/or the Benefit Group to obtain services from fee-for-service providers for six months;

(E) After six months the PCCM member and/or the Benefit Group shall be required to select another Primary Care Case Manager, if available in the service area;

(F) OMAP shall notify the new Primary Care Case Manager that the PCCM member and/or benefit group was previously disenrolled from another Primary Care Case Manager at the Primary Care Case Manager's request.

(3) OMAP may initiate and disenroll PCCM members as follows:

(a) If OMAP determines the PCCM member has third party resources through a private HMO, OMAP may disenroll the PCCM member. The effective date of disenrollment shall be specified by OMAP and shall be the first of the month after OMAP determines the PCCM member should be disenrolled;

(b) If the PCCM member moves out of the Primary Care Case Manager's service area, the effective date of disenrollment shall be the date specified by OMAP, which may be retroactive up to one month prior to the month OMAP notifies the Primary Care Case Manager;

(c) If the PCCM member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project, the effective date of disenrollment shall be the date specified by OMAP;

(d) If the PCCM member dies, the effective date of disenrollment shall be the date of death.

(4) Unless specified otherwise in this rule or at the time of notification of disenrollment to the Primary Care Case Manager by OMAP all disenrollments are effective the first of the month after the request for disenrollment is approved by OMAP.

(5) Oregon Health Plan clients may request an OMAP hearing if they dispute a disenrollment decision by OMAP.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & 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

410-141-0110

Oregon Health Plan Prepaid Health Plan Member Satisfaction Survey

(1) OMAP shall conduct a statistically valid OMAP member satisfaction survey each calendar year to survey OMAP members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General OMAP member satisfaction.

(2) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94

410-141-0115

Oregon Health Plan Primary Care Case Manager Member Satisfaction Survey

(1) OMAP shall conduct a statistically valid PCCM member satisfaction survey each calendar year to survey PCCM members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General PCCM member satisfaction.

(2) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0120

Oregon Health Plan 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 and Emergency Services, Preventive Services and Ancillary Services, in those categories of services included in agreements with OMAP and/or MHDDSD. 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 providers providing capitated services to OMAP Members are credentialed upon initial contract with the PHP and recredentialed no less frequently than biennially 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 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 results of professional Quality improvement review activity. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall retain responsibility for delegated activities, including oversight of processes:

(A) PHPs shall ensure that services are provided within the scope of license or certification of the provider or facility and that providers are appropriately supervised according to their scope of practice;

(B) PHPs shall provide training for plan staff and providers and their staff regarding the delivery of capitated services, OHP Administrative Rules, and the PHP's administrative policies under the OHP Medicaid demonstration project;

(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;

(D) PHPs shall not refer OMAP Members to or use providers who have been suspended or terminated from the Oregon Medical Assistance Program or excluded as Medicare/Medicaid providers by HCFA and/or by any lawful Court in this state. PHPs shall not accept billings for services to OMAP Members provided after the date of such provider's suspension or termination.

(b) PHPs shall have written procedures that allow and encourage choice of a Primary Care Provider (PCP) for physical health, mental health and dental health services by each OMAP Member. These procedures shall enable an OMAP Member to choose a participating PCP or clinic (when a choice is available) to provide services within the scope of practice to that OMAP Member. Information about which providers are currently accepting new patients (except for staff models) shall be provided by the PHP to newly enrolled Members: PHPs shall encourage choice of primary practitioners;

(c) If the OMAP Member does not choose a PCP within 30 calendar days from the date of enrollment, then PHPs which assign OMAP Members to PCPs shall document unsuccessful efforts to elicit the OMAP Member's choice before assigning an OMAP Member to a PCP or clinic. PHPs who assign PCPs before 30 calendar days after enrollment, must notify the OMAP Member of the assignment and allow the OMAP Member 30 calendar days after assignment to change the assigned PCP.

(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 OMAP's satisfaction why such an agreement is not feasible, FCHPs 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) OMAP Members may receive the following services from appropriate Nonparticipating Medicaid providers. If the following services are not referred by the FCHP in accordance with the FCHP's referral process (except as provided for under 410-141-0420 Billing and Payment under the Oregon Health Plan), OMAP 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 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 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/or planning committees;

(e) FCHPs shall report to OMAP 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 a semi-annual basis. This report will be completed as part of the Exhibit D of the Service Agreement.

(3) FCHPs shall ensure a newly enrolled OMAP Member receives timely, adequate and appropriate health care services necessary to establish and maintain the health of the OMAP Member. An FCHP's liability covers the period between the OMAP Member's enrollment and disenrollment with the FCHP, unless the OMAP Member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the OMAP Member in accordance with Part II of the Service Agreement. The FCHP shall have written procedures which describe how it shall comply with this obligation.

(4) The OMAP 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.

(5) FCHPs with a Medicare HMO component and MHOs have significant and shared responsibility for prepaid services, and shall coordinate benefits for shared OMAP Members to ensure that the OMAP Member receives all Medically Appropriate services covered under respective Capitation Payments. If the Dual Eligible OMAP Member is enrolled in a FCHP with a Medicare HMO component the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or upon referral by the FCHP;

(b) Mental health services which are not covered by the FCHP that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(6) PHPs shall coordinate services for each OMAP 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, and/or dental care for that OMAP Member on an ongoing basis except as provided for in Section (6)(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 OMAP Members to Divisions or Offices of the Department of Human Resources and Local and Regional Allied Agencies which may offer services not covered under the Capitation Payment;

(c) FCHPs shall not require OMAP Members to obtain the approval of a PCP in order to gain access to mental health assessment and evaluation services. OMAP Members may refer themselves to MHO services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0140

Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services

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 OMAP Members. 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:

(1) 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 to determine the nature of the situation and the OMAP Member's immediate need for services;

(b) Capacity to conduct the elements of an assessment that are 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 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 OMAP Member, and whether or not the Practitioner will meet the OMAP Member at the emergency room; and

(f) Provision for notifying other providers requesting approval to treat OMAP Members of the determination.

(2) PHPs shall ensure the availability of an after-hours call-in system adequate to Triage urgent care and emergency calls from OMAP Members. Urgent calls shall be returned 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 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;

(3) PHPs shall have methods for tracking inappropriate use of emergency care and shall take action, including individual 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 Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0160

Oregon Health Plan Prepaid Health Plan Continuity of Care

(1) PHPs shall have written policies and procedures and monitoring systems that ensure the provision of Case Management Services for all OMAP Members, 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 OMAP Member's Clinical Record Exceptional Needs Care Coordination for Aged, Blind and Disabled OMAP Members described in 410-141-0405 is a service available through Fully Capitated Health Plans (FCHPs) that is separate from and in addition to Case Management Services. FCHPs 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 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 agreements with OMAP and/or MHDDSD. 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 OMAP 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 OHP Client shall obtain all covered services, either directly or upon referral, from the PHP or PCCM responsible for the service from the date of Enrollment through the date of Disenrollment, except when the OHP Client is enrolled in a Medicare HMO:

(A) FCHPs with a Medicare HMO component and MHOs have significant and shared responsibility for prepaid services, and shall coordinate benefits for the OHP Client to ensure that the OHP Client receives all medically appropriate services covered under respective Capitation Payments;

(B) If the OHP Client is enrolled in a FCHP with a Medicare HMO component, then Medicare covered mental health services shall be obtained from the FCHP or upon referral by the FCHP. Mental health services which are not covered by the FCHP, 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 which ensure adequate prior notice of the referral to referral providers and adequate documentation of the referral in the OMAP 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 which ensure that relevant medical, mental health, and/or dental information is obtained from referral providers, including telephone referrals. These procedures shall include:

(A) Review of information by the referring provider;

(B) Entry of information into the OMAP Member's Clinical Record;

(C) 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, and the staff in alternative care, settings, and 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 which ensure that an appropriate staff person responds to calls from other providers requesting approval to provide care to OMAP 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 shall have written policies and procedures to ensure information on all emergency department visits is entered into the OMAP Member's appropriate PCP's Clinical Record. FCHPs 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 an OMAP Member is hospitalized in an inpatient or outpatient setting for a Capitated Service, PHPs shall ensure that:

(A) A notation is made in the OMAP Member's appropriate PCP's Clinical Rrecord of the reason, date, and expected duration of the hospitalization;

(B) Upon discharge, a notation is made in the OMAP Member's appropriate PCP's Clinical Record of the actual duration of the hospitalization and follow-up plans, including appointments for provider visits; and

(C) Pertinent reports from the hospitalization are entered in the OMAP 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 OMAP Members living in residential facilities or homes providing ongoing care, PHPs shall work with the appropriate staff person identified by the facility to ensure that the OMAP Member has timely and appropriate access to Capitated 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 OMAP Members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.

(3) For OMAP Members living in residential facilities or homes providing ongoing care, FCHPs shall provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, which meets state dispensing laws. FCHPs shall provide emergency prescriptions on a 24-hour basis.

(4) For OMAP Members who are discharged to Post Hospital Extended Care, the FCHP shall notify the appropriate DHR office at the time of admission to the skilled nursing facility and begin appropriate discharge planning. The FCHP is not responsible for the Post Hospital Extended Care Benefit unless the OMAP Member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the OMAP Member no later than two full working days prior to discharge from Post Hospital Extended Care. For OMAP Members who are discharged to Medicare Skilled Care, the appropriate DHR 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 DHR office.

(5) PHPs shall coordinate and consult with providers of physical health services, mental health services, chemical dependency services and dental services about an OMAP Member's care as Medically Appropriate and within laws governing confidentiality.

(6) When an OHP Client's care is being transferred from one PHP to another or from fee-for-service to a PHP, the PHP shall make every reasonable effort within the laws governing confidentiality to coordinate transfer of the OHP Client into the care of a PHP participating provider.

(7) PHPs shall make attempts to contact targeted OMAP population(s) by mail, telephone, in person or through the DHR agency 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 OMAP Member to his/her PCP or other resources as indicated by the assessment. Targeted OMAP population(s) shall be determined by the PHP and approved by OMAP.

(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 OMAP Member access to mental health services which are not provided under the Capitation Payment.

(9) MHOs shall ensure that OMAP 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 OMAP Members experiencing a mental health crisis.

(11) MHOs shall use a multi-disciplinary team service planning and case management approach for OMAP 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 to help assure that mental health conditions of OMAP Members are identified early so that intervention and prevention strategies can begin as soon as possible.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0180

Oregon Health Plan Prepaid Health Plan Record Keeping

(1) Maintenance and Security: PHPs shall have written policies and procedures that ensure maintenance of a record keeping system that includes complete Clinical Records that document the care received by OMAP Members from the PHP's primary care and referral providers. 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. 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: PHPs shall have written policies and procedures to ensure that Clinical Records related to OMAP Members receiving services are kept confidential in accordance with ORS 179.505 through ORS 179.507, ORS 411.320, ORS 433.045 (3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50. If the PHP is a public body within the meaning of the Oregon public records law, such policies and procedures shall ensure that OMAP Member privacy is maintained in accordance with ORS 192.502 (2), ORS 192.502 (8) (Confidential under Oregon law) and ORS 192.502 (9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their providers shall not release or disclose any information concerning an OMAP Member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the OMAP Member;

(b) Except in an emergency, PHPs' providers shall obtain a written consent from the OMAP Member or the legal guardian, or the legal Power of Attorney for Health Care Decisions of the OMAP Member before releasing information. The written consent shall specify the type of information to be released and the recipient of the information, and shall be placed in the OMAP 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 OMAP Member;

(c) PHPs may consider an OMAP Member, age 14 or older competent to authorize or prevent disclosure of mental health and alcohol and drug treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the OMAP Member's clinical treatment requirements.

(3) Access to Clinical Records:

(a) Provider Access to Clinical Records:

(A) PHPs shall release health service information requested by a provider involved in the care of an OMAP Member within ten working days of receiving a signed release;

(B) 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 an OMAP Member's mental health record when necessary for use in the diagnosis or treatment of the OMAP Member. Such access is permitted under ORS 179.505 (6).

(b) OMAP Member Access to Clinical Records: Except as provided in ORS 179.505 (9), PHPs' providers shall upon request, provide the OMAP Member access to his/her own Clinical Record and provide copies within ten working days of the request. PHPs' providers may charge the OMAP Member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' providers shall upon written consent of the OMAP Member provide access to member's Clinical Record. PHPs' providers may charge for reasonable duplication costs;

(d) DHR Access to Records: PHPs shall cooperate with OMAP, OADAP, the Medicaid Fraud Unit, and/or MHDDSD representatives for the purposes of audits, inspection and examination of OMAP Members' Clinical and Administrative

Records.

(4) 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 must be retained until all issues arising out of the action are resolved.

(5) 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 which fully documents the OMAP Member's condition, and the Capitated and Non-Capitated services received from PHPs' Participating or referred providers. 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) A Clinical Record shall be maintained for each OMAP Member receiving services that documents all types of care needed or delivered in all settings whether such 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. Incorrect data shall be crossed through with a single line. Correct and legible data shall be added followed by the date corrected and initials of the person making the correction. Removal or obliteration of errors shall be prohibited;

(d) The Clinical Record shall reflect a signed and dated consent of the OMAP Member, his/her legal guardian or the Power of Attorney for Health Care Decisions for any invasive treatments;

(e) The PCP's Clinical Record shall include data that forms the basis of the diagnostic impression of the OMAP Member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP's Clinical Record of the OMAP Members receiving services shall include the following information as applicable:

(A) OMAP Member's 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 psycho-social history as appropriate;

(D) Dates of service;

(E) Names and titles of persons 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 OMAP Member was jointly involved in the development of his/her mental health treatment plan;

(iii) For inpatient and outpatient hospitalizations, history and physical, dictated consultations, and discharge summary;

(iv) Emergency Room and Screening Services reports;

(v) Consultation reports;

(vi) Medical education and medical social services provided.

(N) Copies of signed release of information forms;

(O) Copies of medical and/or mental health directives.

(f) Based on written policies and procedures, the Clinical Record keeping system developed and maintained by PHPs' 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 OMAP Member. The system shall conform with accepted professional practice and facilitate an adequate system for follow up treatment;

(g) Other Records: PHPs' shall maintain other records in either the Clinical Record or within the PHP's administrative offices. Such records shall include the following:

(A) Names and phone numbers of the OMAP Member's prepaid health plans, primary care physician, primary dentist and mental health Practitioner, if any in the MHO records;

(B) Copies of Client Process Monitoring System (CPMS) 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 OMAP Member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;

(E) Evidence that the OMAP Member has been informed of his or her rights and responsibilities in the MHO records;

(F) ENCC records in the FCHP's records;

(G) Complaint records;

(H) Disenrollment Requests for Cause and the supporting documentation.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0200

Oregon Health Plan Prepaid Health Plan Quality Improvement System

(1) PHP's except MHO's shall have a planned, systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to OMAP Members. MHOs shall abide by the Quality Assurance Requirements as stated in the MHO Agreement. This process shall: Include an internal Quality Improvement program based on written policies, standards and procedures that are in accordance with relevant law, the community standards for dental care, and/or with accepted medical practice, whichever is applicable, and with accepted professional standards.

(2) Monitor for appropriate utilization. FCHPs, DCOs and CDOs Quality committee shall include, but is not limited to, the following: the Medical or Dental Director, the Quality Improvement Coordinator, and other health professionals who are representative of the scope of the services delivered by the FCHP, DCO or CDO Membership of the Quality Improvement committee shall include or have access to consultation from individuals, including consumers, with knowledge of all populations served by the FCHP, DCO, or CDO.

(3) FCHPs, DCOs and CDOs shall designate a Quality Improvement Coordinator who shall develop and coordinate systems to facilitate the work of the Quality Improvement committee. The Quality Improvement Coordinator shall be qualified to assess the care of people who are Aged, Blind, Disabled and Children receiving SOSCF or OYA Services, or shall be able to retain consultation from individuals who are so qualified. The Quality Improvement Coordinator is generally responsible for the operations of the Quality Improvement program and must have the management authority to implement changes to the Quality Improvement program as directed by the Quality Improvement committee.

(4) The Quality Improvement committee shall conduct meetings at least every two months.

(5) FCHPs and CDOs shall establish written procedures for monitoring and written protocols and criteria for conducting review activities to assess the quality of OMAP Members' care and shall establish or adopt criteria for adequate medical care for conditions and treatments identified by the Quality Improvement committee as in need of study or improvement.

(6) DCOs shall establish written criteria and standards for assessing dental quality and professional performance which meet the relevant law and the community standards for care.

(7) The FCHP's, CDO's and DCO's Quality Improvement committee shall include in its deliberations the following:

(a) Annual review for appropriateness and currency of the FCHP's, DCO's or CDO's written procedures, protocols and criteria for OMAP Member care;

(b) Annual review of OMAP Member care as measured against the FCHP's, DCO's or CDO's written procedures and protocols of OMAP Member care;

(c) Annual review of medical or dental records of the PCP's specialists, outpatient hospitalizations, and inpatient hospitalizations as appropriate;

(d) Annual review of other aspects of the FCHP's, DCO's or CDO's performance, including, but not limited to: preventive care, adequacy of clinical recordkeeping; operation and outcome of referral procedures; medication reviews; the appointment system; the after-hours call-in system; arrangements for Emergency Services; denials of service; plan-initiated disenrollments; out-of-plan utilization; OMAP access plan as defined under OAR 410-141-0220; encounter data management; timeliness and appropriateness of referrals;

(e) Annual review by FCHPs of the quality of Exceptional Needs Care Coordination program;

(f) Quarterly review and analysis of all complaints received by the FCHP, DCO, or CDO and review of persistent and

significant OMAP Member Complaints (those Complaints that indicate consistent trends or are indicators of quality of care or service problems which might adversely affect Members' health) identified through the FCHP's, DCO's or CDO's Complaint procedures, including review of persistent and significant complaints from OMAP Members (or their Representatives) who are Aged, Blind, Disabled or Children Receiving SOSCF or OYA Services;

(g) Annual review of Quality Improvement program, including policies, standards, and written procedures to ensure that the standards used in the Quality Improvement process adequately address the needs of OMAP Members who are Aged, Blind, Disabled or Children Receiving SOSCF or OYA Services;

(h) Review of whether comorbidities and complications are assessed before denial of a service or prior authorization;

(i) Annual review of appropriateness of utilization of, at least, preventive, primary and specialty services, including any relationship to adverse or unexpected outcomes for OMAP Members. Review shall include utilization of preventive services for adults and children and focus on utilization of services and adverse outcomes specific to the OMAP Members who are Aged, Blind, Disabled or Children Receiving SOSCF or OYA Services;

(j) Annual review of OMAP Member educational plans and modifications, as appropriate. Reviews of educational plans and modifications shall address the needs of OMAP Members, including the Aged, Blind, Disabled and Children Receiving SOSCF or OYA Services. Educational plans shall address access, urgent care and emergency issues, and such services as preventive and maternity services;

(k) Annual review of whether PCP's are receiving emergency department and hospitalization records, are including these records within the PCP's Clinical Record, and are reviewing the information as Medically Appropriate.

(8) FCHP's, DCO's and CDO's Quality Improvement committee meetings, shall include:

(a) Adequate documentation of all deliberations, including dated minutes signed by the Quality Improvement Coordinator, Chairperson of the Committee or person designated by the Board of Directors, and reviewed and approved at the next meeting;

(b) Recommendations regarding corrective actions to address issues identified through the Quality Improvement committee review process; and

(c) Review of results, progress, and effectiveness of corrective actions recommended at previous meetings.

(9) The FCHP's, DCO's and CDO's Quality Improvement committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. At the least, the Quality Improvement Committee should have authority, accountability, and responsibility as required by the current edition of standards published by NCQA or the NCQA Standards under which an FCHP, DCO or CDO was last reviewed. The standards on governance of Quality Improvement committees of this publication are, hereby, adopted by reference. If any Quality Improvement functions are delegated, the Quality Improvement committee shall maintain oversight and accountability for those delegated functions.

(10) FCHPs, DCOs and CDOs shall ensure that the positions of Medical or Dental Director and the Quality Improvement Coordinator have the qualifications, responsibility experience, authority, and accountability necessary to assure compliance with this rule.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0220

Oregon Health Plan Prepaid Health Plan Accessibility

(1) PHPs shall have written policies and procedures that ensure access to all Capitated Services for all OMAP Members. 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. PHPs shall not discriminate between OMAP Members and non-OMAP members as it relates to benefits and services to which they are both entitled:

(a) FCHPs, DCOs, and CDOs shall have written policies and procedures which ensure that for 90% of their OMAP 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 providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by OMAP:

(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 provider panels sufficient to ensure adequate service capacity to provide availability of, and timely access to, Medically Appropriate covered services for OMAP Members:

(A) FCHPs, DCOs, CDOs shall ensure that ratio of Medicaid enrollees to PCPs shall not exceed 25% of the Community Standard, unless an alternative plan for staffing is approved by OMAP;

(B) 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 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;

(C) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to OMAP Members in terms of timeliness, amount, duration and scope as those services are to non-OMAP persons within the same service area. If the PHP is unable to provide those services locally, it must so demonstrate to OMAP and shall provide reasonable alternatives for Members to access care that must be approved by OMAP. PHPs shall have a monitoring system that will demonstrate to OMAP or MHDDSD, as applicable, that the plan has surveyed and monitored for equal access of OMAP Members to referral providers pharmacy, hospital, vision and ancillary services;

(D) PHPs shall have written policies and procedures and a monitoring system to ensure that OMAP Members who are Aged, Blind, or Disabled or who are children receiving SOSCF 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 OMAP Members, including emotional disturbance and behavioral responses, and combined or multiple diagnoses.

(2) Prepaid Health Plans and Primary Care Case Managers Enrollment Standards:

(a) PHPs and PCCMs shall remain open for Enrollment unless DHR has closed Enrollment because the PHP or PCCM has exceeded their enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by OMAP or MHDDSD, as appropriate, and the PHP or PCCM;

(b) PHPs enrollment may also be closed by OMAP or MHDDSD, as appropriate due to sanction provisions;

(c) PHPs and PCCMs shall accept all OHP Clients, regardless of health status at the time of Enrollment, subject to the stipulations in agreements with DHR to provide Capitated Services or Primary Care Case Management services;

(d) PHPs and PCCMs may confirm the Enrollment status of an OHP Client by one of the following:

(A) The individual's name appears on the monthly or weekly Enrollment list produced by OMAP;

(B) The individual presents a valid Medical Care Identification that shows he or she is enrolled with the PHP or PCCM;

(C) The Automated Information System (AIS) verifies that the individual is currently eligible and enrolled with the PHP or PCCM;

(D) An appropriately authorized staff member of DHR states that the individual is currently eligible and enrolled with the PHP or PCCM.

(e) FCHPs and DCOs shall have open enrollment for 30 continuous calendar days during each twelve month period of October through September, regardless of the FCHPs or DCO's 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, OMAP Members shall be automatically enrolled in the succeeding PHP. The OMAP Member will have 30 calendar days to request disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare HMO, those OMAP 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 provider or provider group which has significant impact on access in that service area and necessitates either transferring OMAP Members to other providers or the PHP withdrawing from part or all of a service area, the PHP shall rovide DHR 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 days notice to DHR upon approval by DHR when the PHP must terminate a provider or group due to problems that could compromise OMAP Member care, or when such a provider or group terminates its contract with the PHP and refuses to provide the required 90 calendar days notice;

(b) If DHR must notify OMAP Members of a change in providers or PHPs, the PHP shall provide DHR with the name, prime number, and address label of the OMAP Members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide OMAP Members with at least 30 calendar days notice of such changes.

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of OMAP 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 OMAP Members have access to appointments according to the following standards:

(A) FCHPs:

(i) Emergency Care -- The OMAP Member shall be seen immediately or referred to an Emergency Room depending on Member's condition;

(ii) Urgent Care -- The OMAP Member shall be seen within 48 hours; and

(iii) Well Care -- The OMAP Member shall be seen within 4 weeks or within the Community Standard.

(B) DCOs:

(i) Emergency Care -- The OMAP Member shall be seen or treated within 24 hours;

(ii) Urgent Care -- The OMAP Member shall be seen within one to two weeks depending on Member's condition; and

(iii) Routine Care -- The OMAP Member shall be seen within twelve weeks or the Community Standard whichever is less.

(C) MHOs and CDO's:

(i) Emergency Care -- Member shall be seen within 24 hours or as indicated in initial screening;

(ii) Urgent Care -- Member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care -- Member shall be seen for an intake assessment within 2 weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of OMAP Members through the office such that OMAP Members are not kept waiting longer than non-OMAP Member patients, under normal circumstances. If OMAP Members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointments is anticipated, OMAP Members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through complaint reviews, OMAP 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 OMAP Member(s) when providers have notified the PHP that the Member(s) 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 or non-clinical Rrecord of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the OMAP Member's diagnosis or disability or is due to lack of transportation to the PHP clinic, PHPs shall provide outreach services as Medically Appropriate;

(d) PHPs shall have policies and procedures that ensure Participating Providers will attempt to contact OMAP 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 OMAP Members who walk to the PCP's office 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) OMAP Members with non-emergent conditions who walk into the PCP's office 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 onsite or through call sharing or an answering service, unless this requirement is waived in writing by OMAP and/or MHDDSD 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 call-back for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs shall have an adequate on-call PCP back-up system covering Internal Medicine, Family Practice, OB/Gyn, and Pediatrics, as an operative element of FCHP's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate Clinical Record of the OMAP 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 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 providers) have sufficient communication skills and training to reassure OMAP 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 OMAP 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 which 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 OMAP 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 plan administrative offices, especially those of Member Services and Complaint 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 persons with hearing impairment or in the primary language of non-English speaking OMAP Members. Such interpreters shall be capable of communicating in English and the primary language of the OMAP Member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to be able to understand the OMAP Member's complaint; to make a diagnosis; respond to Member's questions and concerns; and to communicate instructions to the OMAP Member;

(c) PHPs shall educate contracted providers and their staff regarding the requirements to provide qualified interpreter services and the procedures for obtaining these services for OMAP Members, including after hours calls, monitor compliance with these policies and procedures, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee;

(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 Capitated Services for all OMAP 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 plan shall include procedures to determine whether OMAP Members are receiving accommodations for access and to determine what will be done to remove existing barriers and/or to accommodate the needs of OMAP Members;

(C) This plan shall include the assurance of appropriate physical access to obtain Capitated Services for all OMAP Members including, but not limited to, the following:

(i) Street level access or accessible ramp into facility;

(ii) Wheelchair access to lavatory;

(iii) Wheelchair access to examination room; and

(iv) Doors with levered hardware or other special adaptations for whelchair access.

(e) PHPs shall ensure that providers, their facilities and personnel are prepared to meet the special needs of OMAP Members who require accommodations because of a disability:

(A) PHPs shall have a written plan for meeting the needs of OMAP Members;

(B) PHPs shall monitor providers for compliance with the access plan and take corrective action, when necessary.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0260

Oregon Health Plan Prepaid Health Plan Complaint Procedures

(1) This rule will apply to all PHPs except MHOs. MHOs shall abide by the complaint requirments as stated in the MHO Agreement.

(2) FCHPs, DCOs and CDOs shall have written policies and procedures that ensure that they meet the requirements of sections OAR 410-141-0260 to OAR 410-141-0266.

(3) FCHPs, DCOs and CDOs shall keep all information concerning an OMAP member's Complaint confidential as specified in OAR 410-141-0261.

(4) FCHPs, DCOs and CDOs must have a written procedure to handle complaints from OMAP members or their representatives. At a minimum, the procedure must meet the requirements of OAR 410-141-0261.

(5) FCHPs, DCOs and CDOs shall afford OMAP Members the full use of the Complaint procedures, and shall cooperate if the OMAP Member decides to pursue a remedy through the Administrative Hhearing process.

(6) Hearing requests made outside of the Complaint process or without previous use of the Complaint process shall be reviewed by the FCHP, DCO or CDO through the FCHP's, DCO's or CDO's Complaint process upon notification by OMAP as provided for in OAR 410-141-0264.

(7) Under no circumstances may FCHP. DCO or CDO discourage an OMAP Member's use of the Administrative Hearing process. The FCHP, DCO or CDO may, however, explain to the OMAP Member the potential benefits of using the Complaint procedure.

(8) Neither implementation of an OMAP hearing decision nor an OMAP Member's request for a hearing may be a basis for a request by the FCHP, DCO or CDO for Disenrollment of an OMAP Member.

(9) FCHPs, CDOs and CDOs shall make available a supply of blank Complaint forms (OMAP 3001) in all plan administrative offices and in those medical/dental offices where staff have been designated by the FCHP, DCO or CDO to respond to Complaints.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0261

Complaint Procedures

(1) FCHPs, DCOs, and CDOs shall have written procedures for the receipt, disposition and documentation of all Complaints from OMAP Members. The FCHP's, DCO's, and CDO's written procedures for handling complaints, shall, at a minimum:

(a) Address how contractor will accept, process and respond to all Complaints from OMAP Members or their Representatives;

(b) Address the resolution of all Complaints which OMAP Members identify as needing resolution;

(c) Describe how the FCHP, DCO, or CDO informs OMAP Members, both orally and in writing, about FCHP's, DCO's, or CDO's Complaint procedures. Information provided to the member shall include at least:

(A) Written material describing the Complaint process; and

(B)Assurance in all written, oral, and posted material of OMAP Member confidentiality in the Complaint process.

(d) Designate the FCHP, DCO, or CDO staff member(s) or a designee who will be responsible for receiving, processing, directing, and responding to Complaints;

(e) Ensure that clients who indicate dissatisfaction or concern are informed of their right to file a Complaint and how to do so;

(f) Include a requirement for a log to be maintained by the FCHP, DCO, or CDO that is in compliance with OAR 410-141-0266.

(2) The FCHP, DCO, or CDO shall assure members that complaints are handled in confidence and shall safeguard the client's right to confidentiality of information about the Complaint as follows:

(a) FCHPs, DCOs, and CDOs shall, implement and monitor written policies and procedures that ensure that all information concerning an OMAP Member's Complaint is kept confidential, except that OMAP has a right to this information without a signed release from the OMAP Member;

(b) If an OMAP Member makes a Complaint or files a hearing request, and wishes the Complaint to be resolved, FCHPs, DCOs, and CDOs shall ask the OMAP Member to consent verbally to the release of information regarding the Complaint to individuals who are directly involved in the Complaint:

(A) Before any information related to the Complaint is released, the FCHP, DCO, or CDO shall have a release of information documented in the Complaint file;

(B) FCHPs, DCOs, and CDOs shall inform the OMAP Member if failure to consent may make it impossible to resolve the Complaint;

(C) FCHPs' DCOs' and CDOs'written procedures shall describe how complaints will be resolved and reviewed should OMAP Member decline to provide a release;

(D) An OMAP Member's consent to release information related to the Complaint does not constitute consent to release medical information unrelated to the Complaint.

(3) The FCHP, DCO, or CDO shall assure that a member's expression of dissatisfaction, or Complaint is recognized by FCHP, DCO, or CDO staff as follows:

(a) The expression may be in whatever form of communication or language that is used by the OMAP Member or the Member's Representative:

(A) An OMAP Member may relate any incident or concern to a practitioner or other staff person by indicating or expressing dissatisfaction or concern or by stating this is a Complaint that needs resolution;

(B) If the OMAP Member indicates dissatisfaction or concern, the practitioner or staff person shall advise the OMAP Member that he or she may make a Complaint using the FCHP's, DCO's, or CDO's Complaint process.

(b) A Complaint requires resolution as follows:

(A) The OMAP Member or the Member's Representative identifies the expression of dissatisfaction as a Complaint which must be addressed by the FCHP, DCO, or CDO;

(B) The OMAP Member or Member's Representative's intent is unclear to the FCHP, DCO, or CDO or the FCHP's, DCO's, or CDO's designee. The FCHP, DCO, or CDO or the FCHP's, DCO's, or CDO's designee shall confirm that the expression of dissatisfaction is a Complaint in need of resolution by asking the OMAP Member or the Member's Representative if the expression of dissatisfaction is something that needs resolution;

(C) Complaints may also be termed concerns, problems, or issues by the OMAP Member or the Member's Representative and may or may not be identified by the Member or the Member's Representative as needing resolution.

(4) The FCHP's, DCO's, and CDO's procedures shall provide for the resolution of complaints as follows:

(a) The practitioner or staff person shall either resolve the Complaint and communicate the Complaint and its resolution to the FCHP's, DCO's, CDO's; or direct the OMAP Member to the FCHP's, DCO's, or CDO's staff person designated for receiving Complaints, as identified in FCHP's, DCO's, or CDO's OMAP Member Handbook;

(b) If an OMAP Member makes a Complaint to the FCHP's, DCO's, or CDO's staff person designated for receiving Complaints, the staff person shall notify the OMAP Member that the OMAP Member has the right to make a Complaint either orally or in writing;

(c) If the OMAP Member does not wish to attempt to resolve the Complaint through the use of the FCHP's, DCO's, or CDO's internal Complaint procedure, the staff person shall notify the OMAP Member that the member has the right to seek resolution through another process within the plan or through a state process, such as the the Administrative Hearing process or OMAP Ombudsman;

(d) If the OMAP Member chooses to pursue the Complaint orally or in writing through FCHP's, DCO's, or CDO's internal Complaint procedure, shall within 5 working days from the date either:

(A) Make a decision on the Complaint; or

(B) Notify the OMAP Member in writing that a delay in FCHP's, DCO's, or CDO's decision of up to 30 calendar days from the date the Complaint was received by the FCHP, DCO, or CDO is necessary to resolve the Complaint. Contractor shall specify the reasons the additional time is necessary.

(5) Complaints concerning denial of service or service coverage shall be handled as Complaints as described in this section. In addition, FCHPs, DCOs, or CDOs shall immediately issue notice and provide OMAP Members with a notice of Hearing Rights (OMAP 3030) and an Administrative Hearing Request (AFS 443) as described in OAR 410-141-0263, upon receipt of a Complaint concerning denial of service or service coverage.

(6) The FCHP's, DCO's, or CDO's staff person, who is designated to receive complaints, shall begin to establish the

facts concerning the Complaint, upon receipt of the Complaint regardless of whether the OMAP Member seeks an Administrative Hhearing and/or elects the Complaint process.

(7) FCHP's, DCO's, or CDOs decision, shall be communicated to the OMAP Member orally or in writing no later than 30 calendar days from the date of receipt of the Complaint:

(a) An oral decision shall address each aspect of the client's Complaint and explain the reason for the contractor's decision. The oral decision shall include informing the OMAP Member of his/her rights to an Administrative Hhearing;

(b) A written decision must be made if the Complaint was received in writing, or if the Complaint involves a denial of services or service coverage:

(A) The written decision on the Complaint shall review each element of the OMAP Member's Complaint and address each of those concerns specifically, including the reasons for the FCHP's, DCO's, or CDO's decision;

(B) The written decision shall have both the Notice of Hearing Rights (OMAP 3030) and the AFS 443, Hearing Request, attached;

(C) A written decision which involves denial of service or service coverage must conform to the requirements for notice in OAR 410-141-0263.

(8) All Complaints made to the FCHP's, DCO's, or CDO's staff person designated to receive Complaints shall be entered into a log and addressed in the context of Quality Assurance activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(9) All Complaints that the member chooses to resolve through another process, and that the FCHP, DCO, or CDO is notified of, shall be noted in the Complaint log.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0262

PHP's Additional Review of Complaint

(1) The FCHP, DCO, or CDO may provide for additional review of a client's Complaint, as follows:

(a) If the OMAP Member indicates dissatisfaction with the decision on the Member's complaint, the FCHP, DCO, or CDO may also provide the OMAP Member with another review, in addition to the notice of hearing rights and hearing request;

(b) This review may be offered by the FCHP, DCO, or CDO based on expression of further dissatisfaction by the OMAP Member but shall not release the FCHP, DCO, or CDO from the obligations to notify the member of member's right to an Administrative Hearing and to provide a copy of AFS 443;

(c) The request for additional FCHP, DCO, or CDO review of the Complaint may be conveyed by the OMAP Member, the OMAP Member's Representative or FCHP's, DCO's, or CDO's designee, upon the request of the OMAP Member.

(2) The additional FCHP, DCO, or CDO review of the Complaint shall be reviewed, investigated, considered or heard by either:

(a) The FCHP's, DCO's, or CDO's medical or dental director or administrator; or

(b) A person or group, such as the Quality Improvement Committee or board of directors, responsible for internal review with the authority to make a final clinical or administrative decision at the FCHP, DCO, or CDO level.

(3) A written decision shall be made on the additional FCHP's, DCO's, or CDO's review of the OMAP Member's Complaint:

(a) The decision shall be sent to the OMAP Member no later than 30 calendar days from the date of receipt of the request for additional FCHP, DCO, or CDO review of the Complaint, unless further time is needed for the receipt of information requested from or submitted by the OMAP Member and the new time frame is communicated to the member in writing;

(b) If the OMAP Member fails to provide the requested information within 30 calendar days of the request by the FCHP, DCO, or CDO, or another mutually agreed upon timeframe, the Complaint may be resolved against the OMAP Member;

(c) The decision on the additional FCHP, DCO, or CDO review of the OMAP Member's Complaint shall review each element of the OMAP Member's Complaint and address each of those concerns specifically, including the reasons for the FCHP's, DCO's, or CDO's decision.

(4) The FCHP's, DCO's, or CDO's decision on the additional FCHP, DCO, or CDO review of the OMAP Member's Complaint shall have an additional Notice of Hearing Rights (OMAP 3030) attached.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0263

Denial of Services

(1) All denials of service or service coverage by the FCHP, DCO, or CDO shall be in writing. If the FCHP, DCO, or CDO denies the request for a service, the response shall inform the OMAP Member of the following:

(a) That the service is denied;

(b) The basis for the denial;

(c) The OMAP Member's right to a hearing;

(d) The method by which the OMAP Member may obtain a hearing, including a statement that the Member has a right to request an Administrative Hearing, and that in order to request such a hearing the OMAP Member must submit an Administrative Hearing Request form (AFS 443) to the OMAP Member's local DHR office within 45 calendar days of the date of the FCHP's, DCO's, or CDO's decision on the Complaint concerning denial of service or service coverage;

(e) That the OMAP Member does not need to be represented at the hearing but may be represented by legal counsel, a relative, a friend, or any other person;

(f) That additional information about the hearing may be found on the Administrative Hearing Request, (form AFS 443);

(g) That the OMAP Member shall submit the hearing request to the DHR Office;

(h) A statement that an Administrative Hearing request may be made in addition to using the FCHP's, DCO's, or CDO's Complaint procedure, if the OMAP Member so chooses.

(2) A Complaint made to the FCHP's, DCO's, or CDO's staff person designated to receive Complaints that concern a denial of service or service coverage decision must be recognized by the FCHP, DCO, or CDO and answered in writing:

(a) The FCHP's, DCO's, or CDO's staff person shall notify the OMAP Member in writing of the decision that denied the service or coverage within 5 working days. The decision letter shall include at least the elements included in (1) above;

(b) A copy of the Notice of Hearing Rights (OMAP 3030) and Administrative Hearing Request (AFS 443) shall be attached.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0264

Administrative Hearings

(1) OMAP Members are entitled to an Administrative Hearing regarding Medicaid services. Client hearings are governed by OAR 461-025-0300 and following.

(2) FCHPs, DCOs, and CDOs shall immediately transmit to OMAP any hearing request submitted on behalf of a client.

(3) If an Administrative Hearing is requested by an OMAP Member, the FCHP, DCO, or CDO shall cooperate in the hearing process and shall make available, as determined necessary by OMAP, all persons with relevant information, including the staff person who attempted resolution of the complaint. The FCHP, DCO, or CDO shall also provide all pertinent files and medical or dental records, as well as the results of the review by the FCHP, DCO, or CDO of the hearing request and any attempts at resolution by the contractor.

(4) If the OMAP Member files a request for an Administrative Hearing, OMAP shall immediately notify the FCHP, DCO, or CDO. The FCHP, DCO, or CDO shall review the Hearing Request as a Complaint as described below.

(5) OMAP Members may request a delay in the Administrative Hearing in writing. This delay shall not relieve the FCHP, DCO, or CDO of resolving the compliant that was referred to them by the Hearings Representative within 30 days.

(6) FCHPs, DCOs, and CDOs shall review the Hearing Request, which has not been previously received or reviewed as a complaint, using the FCHP's, DCO's, or CDO's Complaint process as follows:

(a) The Complaint shall be reviewed immediately and shall be resolved, if possible, within 30 days of receipt of the request for hearing in OMAP;

(b) The FCHP's, DCO's, or CDO's decision shall be in writing and shall be provided to OMAP, and to the OMAP Member;

(c) If the Complaint is not resolved within 30 days, or the member does not accept resolution proposed by the FCHP, DCO, or CDO on the hearing request, the FCHP, DCO, or CDO shall provide the OMAP Hearings Representative with all pertinent material and documentation within 30 days from the date of the transmittal of the request for hearing from

OMAP. Complaints are defined in OAR 410-141-0000, Definitions.

(7) If the OMAP Member chooses to use the FCHP's, DCO's, or CDO's Complaint procedure as well as the Administrative Hearing process, the FCHP, DCO, or CDO shall ensure that the Complaint procedure is completed within 30 days of receipt of the Complaint.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0265

Request for Expedited Hearing

(1) An OMAP Member who feels his or her medical or dental problem cannot wait for the normal FCHP, DCO, or CDO review process, including the FCHP's, DCO's, or CDO's final resolution, may be entitled to an expedited hearing. FCHPs, DCOs, or CDOs shall inform OMAP members of the Members' rights to request an expedited hearing and provide members with a copy of AFS Form 443 and Notice of Hearing Rights.

(2) Expedited hearings are requested using AFS Form 443.

(3) The FCHP, DCO, or CDO shall submit relevant documentation to OMAP's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. OMAP's Medical Director shall decide within, as nearly as possible, 2 working days from date of request, if that OMAP Member is entitled to an expedited OMAP hearing.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0266

The FCHP's, DCO's, or CDO's Responsibility for Documentation and Quality Improvement Review of Complaints

(1) The FCHP's, DCO's, or DCO's documentation shall include, at the minimum:

(a) The log of all Complaints and concerns. The log shall identify the OMAP Member, the date of the Complaint, the nature of the Complaint, the resolution and the date of resolution;

(b) A file of Complaints and records of their review or investigation and resolution, including all written decisions and copies of correspondence with the OMAP Member.

(2) The FCHPs, DCOs, and CDOs shall retain documentation of complaints for the term of the Medicaid Reform demonstration plus two years to permit evaluation.

(3) The FCHPs, DCOs, and CDOs shall have written procedures for the review and analysis of all Complaints received by the FCHP, DCO, or CDO. The analysis of Complaints shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards.

(4) FCHPs, DCOs, and CDOs shall monitor the written log, on a monthly basis, for receipt, disposition and documentation of complaints.

(5) Monitoring of Complaints shall review at a minimum: completeness, accuracy, timeliness of documentation, and compliance with plan procedures for receipt, disposition, and documentation of Complaints.

(6) FCHPs, DCOs, and CDOs shall have written procedures to review the operation of the entire Complaint process.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0280

Oregon Health Plan Prepaid Health Plan Informational Requirements

(1) Prepaid Health Plans (PHPs) shall develop informational materials for potential OMAP Members:

(a) PHPs shall provide OMAP and/or MHDDSD with informational materials sufficient for the potential OMAP Member to make an informed decision about PHP selection and Enrollment. Information about which providers are currently accepting new patients shall be provided either orally or in writing by the PHP. Informational materials may be included in the application packet for potential OMAP Members;

(b) Marketing by subcontracts is limited to the posting of a sign listing all OHP Plans to which the provider belongs;

(c) PHPs shall ensure that all staff who have contact with potential OMAP Members are fully informed of PHP and OMAP and/or MHDDSD policies, including Enrollment, Disenrollment and Complaint policies and the provision of interpreter services including which providers' offices have bilingual capacity.

(2) Informational materials for OMAP Members that PHPs develop shall meet the language requirements of, and be culturally sensitive to the OMAP Membership:

(a) PHPs shall produce informational materials, which at a minimum shall include the Member Handbook and information about complaints and grievances in the primary language of each substantial population of non-English speaking OMAP Members and in alternate forms for vision and hearing impaired OMAP Members. A substantial population is 35 non-English speaking households enrolled with the PHP which have the same language. Alternate forms may include, but are not limited to, audio tapes, close-captioned videos, large type and braille;

(b) Form correspondence sent to OMAP Members, including but not limited to, enrollment information, choice and member counseling letters and denial of service notices shall include instructions in the appropriate languages of each substantial population of non-English speaking OMAP Members on how to receive an oral translation of the material;

(c) All written informational materials distributed to OMAP Members shall be written at the sixth grade reading level and printed in 12 point print or larger;

(d) No written information shall be provided to potential OMAP Members that has not been approved by OMAP and/or MHDDSD. Any written communication by the PHP or its subcontractors and providers which is intended solely for OMAP Members and pertains to provider requirements for obtaining services, care at service sites, or benefits must be approved by OMAP and/or MHDDSD prior to distribution;

(e) PHPs shall provide written notice to affected OMAP Members of any significant changes in program or service sites that impacts the OMAP Members' ability to access care or services from PHP's providers. Such notice shall be provided

at least 14 calendar days prior to the effective date of that change, or as soon as possible if the provider has not given the PHP sufficient notification to meet the 14 days notice requirement. OMAP and/or MHDDSD will review and approve such materials within two working days.

Stat. Auth.: ORS Ch. 409

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

410-141-0300

Oregon Health Plan Prepaid Health Plan Member Education

(1) Prepaid Health Plans (PHPs) shall have an ongoing process of OMAP Member education and information sharing that includes orientation to the PHP, a Member Handbook and health education. Member education shall include, the availability of Exceptional Needs Care Coordination through FCHPs for Aged, Blind and Disabled OMAP Members, the appropriate use of the delivery system, including a proactive and effective education of OMAP Members on how to access Emergency Care and Urgent Care Services appropriately.

(2) PHPs shall offer plan orientation to new OMAP Members by mail, phone, or in person within 30 days of enrollment unless no address can be obtained, a telephone number is not provided by OMAP, and a DHR agency is unable to assist in delivering the information to the OMAP Member.

(3) Member Handbook Materials:

(a) The Member Handbook shall be made available as described in OAR 410-141-0280, Oregon Health Plan PHP Informational Requirements. and shall be distributed within 14 calendar days of the OMAP Member's effective date of coverage with PHP;

(b) At a minimum the information in the Member Handbook shall contain the following elements:

(A) Location(s) and office hours of PHP and PHP's PCPs;

(B) Telephone number(s) to call for more information and telephone numbers relating to information listed below;

(C) Choice and use of PCPs and policies on changing PCPs;

(D) Use of the appointment system;

(E) Use of the referral system, including what services must be pre-authorized and how to obtain a referral;

(F) How to access Urgent Care Services and advice;

(G) How and when to use Emergency Services;

(H) Information on the Complaint process, including confidentiality and requesting an OMAP Administrative Hearing;

(I) How to access interpreter services including sign interpreters;

(J) OMAP Member rights and responsibilities;

(K) OMAP Member's possible responsibility for charges including Medicare deductibles and coinsurances if they go outside of plan for non-emergent care, and charges for Non-Covered Services (including missed appointments);

(L) The transitional procedures for new OMAP Members to obtain prescriptions, supplies and other necessary items and/or services in the first month of enrollment with PHP if they are unable see a PCP or obtain new orders during that period, and if applicable;

(M) Information on the availability of Exceptional Needs Care Coordination through FCHPs for Aged, Blind and Disabled OMAP Members;

(N) What services can be self referred to both Participating and Non-Participating Providers;

(O) How to obtain mental health and Chemical Dependency Services;

(P) Information on Advance Directives.

(c) If the Member Handbook is returned with a new address, the PHP shall remail the Handbook or use the telephone number provided by DHR to reach the OMAP Member. If the PHP is unable to reach the OMAP Member by either mail or telephone, the PHP shall send the Handbook to the DHR agency for distribution to the appropriate OMAP Member(s);

(d) PHPs shall, at a minimum, upon request provide Member Handbooks to clinical offices for distribution to Members;

(e) The Member Handbook shall be reviewed by PHP for accuracy at least yearly and updated with new or corrected information as needed to reflect the PHP's internal changes and regulatory changes. If changes impact the OMAP Members' ability to use services or benefits, the updated materials shall be distributed to all OMAP Members.

(4) PHPs shall have written procedures and criteria for health education of OMAP Members. Health education shall include: 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. Health education may be provided by PHP's Practitioner(s) or other individual(s) or program(s) approved by the PHP. PHPs shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from nondominant cultures: PHPs shall ensure development and maintenance of an individualized health educational plan for OMAP Members who have been identified by their Practitioner as requiring specific educational intervention. The Department of Human Resources may assist in developing materials which address specifically identified health education problems to the population in need.

(5) PHPs shall provide an identification card to OMAP Members, unless waived by OMAP and/or MHDDSD, which contains simple, readable and usable information on how to access care in an urgent or emergency situation. Such identification cards shall confer no rights to services or other benefits under the Oregon Health Plan and are solely for the convenience of the PHP's, OMAP Members and providers.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

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 OMAP 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 OMAP Member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) OMAP Members 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 choose a PHP or PCCM as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a practitioner 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 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 his/her treatment plan;

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

(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 which is understandable to the OMAP Member;

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

(l) To receive covered services under the Oregon Health Plan which meet generally accepted standards of practice and are Medically Appropriate;

(m) To obtain covered Preventive Services;

(n) To have access to urgent and emergency services 24 hours a day, 7 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 which documents conditions, services received, and referrals made;

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

(r) To transfer of a copy of his/her 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 with the PHP and receive a response as defined in OAR 410-141-0260 - 410-141-0266;

(v) To request an administrative hearing with the Department of Human Resources;

(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) OMAP Members shall have the following responsibilities:

(a) To choose, or help with assignment to, a PHP or PCCM as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements, and a PCP or service site;

(b) To treat the PHP's, practitioner's, and clinic's 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 he/she expects to be late;

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

(e) To use his/her 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 care 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 which may include signing a release of information;

(j) To ask questions about conditions, treatments and other issues related to his/her 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 his/her health care is covered under the Oregon Health Plan before services are received and, if requested, to show the practitioner or other provider the OMAP Medical Care Identification form;

(o) To tell the DHR worker of a change of address or phone number;

(p) To tell the DHR worker if the Member becomes pregnant and to notify the DHR worker of the birth of the Member's child;

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

(r) To tell the DHR 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 PHP the amount of benefits it paid for an injury from any recovery received from that injury;

(v) To bring issues or complaints to the attention of the PHP; and

(w) To sign a release so that DHR and the PHP can get information which is pertinent and needed to respond to an Administrative Hearing request in a effective and efficient manner.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

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 agreements with OMAP and/or MHDDSD. PHPs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to OMAP and/or MHDDSD, as applicable:

(a) PHPs shall comply with solvency requirements specified in agreements with OMAP and/or MHDDSD, as applicable. Solvency requirements of PHPs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in agreements with OMAP and/or MHDDSD. If the PHP has agreements with both OMAP and MHDDSD, separate restricted reserve fund accounts shall be maintained for each agreement;

(B) Protection against catastrophic and unexpected expenses related to Capitated Services for FCHPs, CDOs and MHOs. The method of protection may include the purchase of stop loss coverage, reinsurance, self insurance or any other alternative determined acceptable by OMAP and/or MHDDSD, as applicable. Self-insurance must be determined appropriate by OMAP and/or MHDDSD;

(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 OMAP Members and accounting for Capitation Payments;

(iv) Tracking claims payment;

(v) Tracking all monies collected from third party resources on behalf of OMAP Members; and

(vi) Documention 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 OMAP and/or MHDDSD:

(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 Sheet(s);

(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 OMAP and/or MHDDSD.

(B) PHPspecific 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/hospital expenses that are covered by risk-sharing arrangements;

(vi) Restricted reserve documentation;

(vii) Third party resources collections (MHDDSD contractors); and

(viii) Corporate Relationships of Contractors (FCHPs and DCOs) 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, DCOs and CDOs 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 which 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 MHDDSD 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 MHDDSD. Regardless of the alternative selected, MHOs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with MHDDSD;

(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 MHDDSD, the MHO shall provide advance notice to MHDDSD 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 MHDDSD access to restricted reserve funds if insolvency occurs;

(e) MHOs shall have written policies and procedures to ensure that, if insolvency occurs, OMAP Members and related clinical records are transitioned to other MHOs or providers with minimal disruption.

Stat. Auth.: ORS Ch. 409

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

410-141-0400

Oregon Health Plan Prepaid Health Plan Case Management Services

(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 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;

(c) MHOs provide case management for capitated and non-capitated mental health services as defined in OAR 410-141-0000, Definitions.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

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

410-141-0405

Oregon Health Plan Fully Capitated Health Plan Exceptional Needs Care Coordination (ENCC)

Fully Capitated Health Plans (FCHP) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health

Plan:

(1) FCHPs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all Capitated Services;

(2) FCHPs shall make ENCC services available at the request of the Aged, Blind or Disabled OMAP Member, his or her Representative, a physician, or other medical personnel serving the OMAP Member, or the Aged, Blind or Disabled OMAP Member's agency case manager;

(3) FCHP's shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving their Aged, Blind and Disabled OMAP Members in all their service areas;

(4) FCHP 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 or Disabled. FCHPs 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 shall have written policies that outline how the level of staffing dedicated to ENCC is determined;

(6) FCHPs shall make ENCC services available to Aged, Blind and Disabled OMAP Members or their Representatives during normal office hours, Monday through Friday;

(7) FCHPs shall provide the Aged, Blind or Disabled OMAP Member or his or her Representative who requests ENCC services with an initial response by the next working day following the request, as appropriate;

(8) FCHPs shall periodically inform all plan Practitioners and their staffs of the availability of ENCC services and provide training for medical office staff on ENCC services and other support services available for serving Aged, Blind and Disabled OMAP Members;

(9) FCHPs shall have written procedures that describe how they will respond to ENCC requests;

(10) FCHPs shall make ENCC services available to coordinate the provision of Capitated Services to Aged, Blind and Disabled OMAP Members who exhibit inappropriate, disruptive or threatening behaviors in a Practitioner's office;

(11) Exceptional Needs Care Coordinators shall document ENCC services in OMAP Member medical records as appropriate and/or in a separate OMAP Member case file.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 25-1997, f. & cert. ef. 10-1-97

410-141-0407

Oregon Health Plan Ombudsman Services

(1) OMAP provides Ombudsman services for Aged, Blind and Disabled Oregon Health Plan clients as defined in OAR 410-141-0000, Definitions.

(2) OMAP shall inform all Aged, Blind and Disabled Oregon Health Plan clients of the availability of Ombudsman Services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 39-1994, f. 12-30-94, cert. ef. 1-1-95

410-141-0410

Oregon Health Plan Primary Care Case Manager Medical Case Management Services

(1) Primary Care Case Managers provide Primary Care Case Management Services under the Oregon Health Plan. Primary Care Case Managers provide Primary Care Case Management Services as defined in OAR 410-141-0000, Definitions, for the following PCCM Case Managed Services:

(a) Preventive services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics, Migrant and Community Health Clinics, federally qualified health centers, county health departments, Indian health service clinics, and tribal health clinics;

(b) Inpatient hospital services;

(c) Outpatient hospital services except laboratory, x-ray and maternity management services.

(2) Services which are not PCCM Case Managed Services include, but are not limited to, the following:

(a) Anesthesiology services;

(b) Dental care;

(c) Durable medical equipment;

(d) Family planning services;

(e) Immunizations, treatment for communicable diseases, and treatment for sexually transmitted diseases provided by a publicly funded clinic;

(f) Laboratory services;

(g) Maternity management services;

(h) Medical transportation services;

(i) Mental health and chemical dependency services;

(j) Pharmacy services;

(k) Physical therapy, occupational therapy, speech therapy, and audiology services;

(l) Preventive services for acquired immune deficiency syndrome and human immunodeficiency virus;

(m) Routine eye examinations and dispensing of vision materials;

(n) School-based services provided under an Individual Education Plan or an Individual Family Service Plan;

(o) Targeted case management services;

(p) X-ray services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0420

Billing and Payment Under the Oregon Health Plan

(1) All billings for Oregon Health Plan Clients to Prepaid Health Plans (PHPs) and to OMAP, shall be submitted within 4 months and 12 months, respectively, of the date of service, subject to other applicable OMAP billing rules.

(2) Providers must be enrolled with OMAP to be eligible for fee-for-service payment by OMAP. Mental health providers, except Federally Qualified Health Centers, must be approved by the Local Mental Health Authority (LMHA) and the Mental Health and Developmental Disability Services Division (MHDDSD) before Enrollment with OMAP. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260, Provider Enrollment.

(3) Providers, including mental health providers, do not have to be enrolled with OMAP to be eligible for payment for services by PHPs except that providers who have been excluded as Medicare/Medicaid providers by OMAP, HCFA or by lawful court orders are ineligible to receive payment for services by PHPs.

(4) Providers shall verify, before rendering services, that the client is Medicaid eligible on the date of service and that the service to be rendered is covered under the Oregon Health Plan Benefit Package of Covered Services. Providers shall also identify the party responsible for covering the intended service and seek Pre-authorizations from the appropriate payor before rendering services. Providers shall inform OMAP Members of any charges for Non-Covered services prior to the services being delivered.

(5) Capitated Services:

(a) PHPs receive a Capitation Payment to provide services to OMAP Members. These services are referred to as Capitated Services;

(b) PHPs are responsible for payment of all Capitated Services. Such services should be billed directly to the PHP, unless the PHP or OMAP specifies otherwise. PHPs may require providers to obtain pre-authorization to deliver certain Capitated Services.

(6) Payment by the PHP to providers for Capitated Services is a matter between the PHP and the provider, except as follows:

(a) Pre-Authorizations:

(A) PHPs shall have written procedures for processing pre-authorization requests received from any provider. The procedures shall specify time frames for:

(i) Date stamping pre-authorizations requests when received;

(ii) Determining within a specific number of days from receipt whether a pre-authorization request is valid or non-valid;

(iii) The specific number of days allowed for follow up on pended pre-authorization requests to obtain addition information;

(iv) The specific number of days following receipt of the additional information that a redetermination must be made;

(v) Providing services after office hours and on weekends that require pre-authorization;

(vi) Sending notice of the decision with appeal rights to the OMAP Member when the determination is made to deny the requested service.

(B) PHPs shall make a determination on at least 95% of Valid Authorization requests, within two working days of receipt of an authorization or reauthorization request related to urgent services; prescription drugs; alcohol and drug services; and/or care required while in skilled nursing facility. PHP shall notify providers of such determination within 2 working days of receipt of the request;

(C) For all other pre-authorization requests, PHPs shall notify providers of an approval, a denial or a need for further information within ten working days of receipt of the request. PHPs shall notify OMAP Members of a denial within five working days from the final determination;

(D) If the determination results in a denial of service, PHPs shall notify OMAP Members of the determination and their hearing rights within two working days of receiving a pre-authorization or reauthorization request.

(b) Claims Payment;

(A) PHPs shall have written procedures for processing claims submitted for payment from any source. The procedures shall specify time frames for:

(i) Date stamping claims when received;

(ii) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(iii) The specific number of days allowed for follow up of pended claims to obtain additional information;

(iv) The specific number of days following receipt of additional information that a determination must be made; and

(v) Sending notice of the decision with appeal rights to the OMAP Member when the determination is made to deny the claim.

(B) PHPs shall pay or deny at least 90% of Valid Claims within 45 calendar days of receipt and at least 99% of Valid Claims within 60 calendars days of receipt. PHPs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(C) PHPs shall not require providers to delay billing to the PHP;

(D) PHPs shall not require Medicare be billed as the primary insurer for services or items not covered by Medicare, nor require non-Medicare approved providers to bill Medicare;

(E) PHPs shall not deny payment of Valid Claims when the potential Third Party Resource is based only on a diagnosis, and no Third Party Resource has been documented in the OMAP Member's clinical record.

(c) FCHPs and MHOs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the OMAP Member receives within the plan, for authorized referral care, and for urgent or emergency services the OMAP Member receives from non-contracted providers. FCHPs and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care OMAP Members receive from non-plan providers;

(d) FCHPs shall pay transportation, meals and lodging costs for the OMAP Member and any required attendant for out-of-state services (as defined in General Rules) that the FCHP has arranged and authorized when those services are available within the state, unless otherwise approved by OMAP;

(e) PHPs shall be responsible for payment of Covered Services provided by a Non-Participating Provider that were not

pre-authorized if the following conditions exist:

(A) It can be verified that the Participating Provider ordered or directed the Covered Services to be delivered by a Non-Participating Provider; and

(B) The Covered Service was delivered in good faith without the pre-authorization; and

(C) It was a Covered Service that would have been pre-authorized with a Participating Provider if the PHP's referral protocols had been followed;

(D) The PHP shall be responsible for payment to Non-Participating Providers according to the PHPs reimbursement policies.

(7) Other Services:

(a) OMAP Members enrolled with PHPs may receive certain services on an OMAP fee-for-service basis. Such services are referred to as Non-Capitated Services;

(b) Certain services must be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though such services are then paid by OMAP on an OMAP fee-for-service basis. Before providing services, providers should contact the PHPs identified on the OMAP Member's Medical Care Identification or, for some mental health services, the CMHP. Alternatively, the provider may call the OMAP Provider Services Unit to obtain information about coverage for a particular service and/or pre-authorization requirements;

(c) Services authorized by the PHP or Community Mental Health Program are subject to the rules and limitations of the appropriate OMAP administrative rules and provider guides, including rates and billing instructions;

(d) Providers shall bill OMAP directly for Non-Capitated Services in accordance with billing instructions contained in the provider guides;

(e) OMAP shall pay at the Medicaid fee-for-service rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions and provider guides;

(f) OMAP will not pay a provider for provision of services for which a PHP has received a Capitation Payment unless otherwise provided for in OAR 410-141-0120;

(g) 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 OMAP, MHDDSD, nor a PHP except as provided for in OMAP rules and provider guides (e.g., Capitated Services that are not included in the nursing facility all-inclusive rate).

(8) Coverage of services through the Oregon Health Plan Benefit Package of Covered Services is limited by OAR 410-141-0500, Excluded Services and Limitations for OHP Clients.

(9) OHP Clients who are enrolled with a PCCM receive services on a fee-for-service basis:

(a) PCCMs are paid a monthly Capitation Payment to provide Primary Care Case Management Services, in accordance with OAR 410-141-0410, Primary Care Case Manager Medical Case Management;

(b) PCCMs provide Primary Care Case Management Services for Preventive Services, primary care services, specialty services, inpatient hospital services and outpatient hospital services. OMAP payment for these PCCM Case Managed Services is contingent upon PCCM authorization;

(c) All PCCM Case Managed Services and other services which are not case managed by the PCCM shall be billed directly to OMAP in accordance with billing instructions contained in the OMAP provider guides;

(d) OMAP shall pay at the OMAP fee-for-service rate in effect on the date the service is provided subject to the rules

and limitations described in the appropriate provider guides.

(10) OHP Clients who are not enrolled with a PHP or a PCCM receive services on an OMAP fee-for-service basis:

(a) Services may be received directly from any appropriate enrolled OMAP provider;

(b) All services shall be billed directly to OMAP in accordance with billing instructions contained in the OMAP provider guides;

(c) OMAP shall pay at the OMAP fee-for-service rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate provider guides.

Stat. Auth.: ORS Ch. 409

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 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

410-141-0480

Oregon Health Plan Benefit Package of Covered Services

(1) Oregon Health Plan (OHP) Clients are eligible to receive, subject to Section (12) of this rule, those treatments for the conditions appearing on the currently funded lines of the Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are Medically Appropriate.

(2) Diagnostic services that are necessary and reasonable to diagnose the presenting condition of the Oregon Health Plan Client are covered services, regardless of the placement of the condition on the Prioritized List of Health Services.

(3) Comfort care is a covered service for an Oregon Health Plan Client with a Terminal Illness.

(4) Preventive Services promoting health and/or reducing the risk of disease or illness are covered services for Oregon Health Plan Clients. Such 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).

(5) Ancillary Services are covered, subject to the service limitations of the Medical Assistance Program rules and provider guides, when the services are Medically Appropriate for the treatment of a covered condition-treatment pair, or the provision of ancillary services will enable the Oregon Health Plan Client to retain or attain the capability for independence or self-care. A list of Ancillary Services is included as C-1 of the Prioritized List of Health Services, OAR 410-141-0520.

(6) The provision of Chemical Dependency Services must be in compliance with the Office of Alcohol and Drug Abuse Programs Administrative Rules, OAR 415-020-0000 to 0090 and 415-051-0000 to 0130 and the Chemical Dependency Prepaid Health Plan Standards in the Fully Capitated Health Plan Agreement.

(7) In addition to the coverage available under Section (1) of this rule, an Oregon Health Plan Client shall be eligible to receive, subject to Section (12) of this rule, treatment, when Medically Appropriate, for a condition that does not appear (on lines 1-578) on the currently funded lines of the Prioritized List of Health Services when:

(a) The Oregon Health Plan Client has a condition or disability which causes substantial impairment and objectively exacerbates and/or is exacerbated by the unfunded Comorbid Condition for which treatment is being sought, making the expected outcome of treating the combined conditions equivalent to the expected outcome of treating a funded

condition-treatment pair. Expected outcome is a medical determination. In addition the following apply:

(A) Documentation must be provided that other funded treatments have failed or are less effective than the proposed unfunded treatment; and

(B) Any unfunded or funded comorbid conditions or disabilities must be represented by an ICD-9-CM diagnosis; or

(C) If any of the unfunded or funded comorbid conditions or disabilities are mental disorders, the condition must be represented by a DSM-IV diagnosis to the highest level of axis specificity; and

(D) General terms such as preventive service, personal hygiene, family planning or maternity are not considered related conditions, or comorbid conditions or disabilities; and

(E) In order for the treatment to be covered:

(i) There must be a medical determination and finding by OMAP that the proposed treatment of the Comorbid Condition has proven to be a medically effective treatment based on (1) medical research, (2) community standards, and (3) current peer review; or

(ii) In those situations of rare combinations of disabilities or conditions such that the proposed treatment has not been tried, or is not reported in the medical literature, and there is no reasonably available past experience by which to demonstrate proven effectiveness, then coverage of the proposed non-funded treatment will follow a medical determination based upon the preponderance of medical evidence applicable to the specific patient.

(b) Clients may receive treatment for an unfunded condition when the client has a medically related funded condition with which the same treatment is paired. In addition, the following apply:

(A) Both the funded and unfunded conditions must be represented by an ICD-9-CM diagnosis; or

(B) If either the funded or the unfunded condition is a mental disorder, the conditions must be represented by a DSM-IV diagnosis to the highest level of axis specificity; and

(C) General terms such as preventive service, personal hygiene, family planning or maternity are not considered "funded conditions" which may be used for the purposes of this rule.

(8) OMAP shall maintain a telephone information line for the purpose of providing assistance to practitioners in determining coverage under the Oregon Health Plan 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, OMAP shall make a retrospective determination under this subsection, provided OMAP is notified of the emergency situation during the next business day. If OMAP denies a requested service, OMAP shall provide written notification and a notice of the right to an Administrative Hearing to both the OHP Client and the treating physician within five working days of making the decision.

(9) PHPs shall provide written notification of PHP determinations related to Sections (1) - (7)(a) and (b) of this rule when such determinations result in a denial of requested services or denial of payment for services which have been obtained:

(a) When a PHP must provide written notification, such notice shall be provided to the OMAP Member and the treating provider within ten (10) working days of the decision. If the determination results in a denial of requested or obtained service, Prepaid Health Plans shall also provide written notice of the right to Administrative Hearing to the OMAP Member;

(b) If, as the result of a complaint or request for administrative hearing, OMAP determines a service is covered and the Oregon Health Plan Client is enrolled in a PHP that is required to provide the service as a Capitated Service, OMAP shall, within five working days of making a decision, provide written notification to the PHP.

(10) Oregon Health Plan Clients or practitioners, on behalf of Oregon Health Plan Clients, may request an Administrative Hearing to appeal OMAP decisions made related to Section (7) of this rule:

(a) Requests for Administrative Hearings may be made orally to the OMAP Medical Director or his or her designee when an Oregon Health Plan Client's condition warrants an expedited decision, OMAP shall respond in a timely manner determined by the nature of the circumstance and in no event greater than ten (10) working days after receiving notice of the oral request for expedited decision;

(b) Requests for Administrative Hearing, appealing OMAP decisions, other than those subject to Section (10)(a), must be written. Written appeals may be made through the client Administrative Hearings process or the provider appeals process and shall be responded to within the timelines of those processes in accordance with OAR 410-120-1560 through OAR 410-120-1840.

(11) If a condition/treatment pair is not on the Health Services Commission's list of prioritized services and OMAP determines the condition/treatment pair has not been identified by the Commission for inclusion on the list, OMAP shall make a coverage decision in consultation with the Health Services Commission.

(12) Coverage of services available through the Oregon Health Plan Benefit Package of Covered Services is limited by OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients.

Stat. Auth.: ORS Ch. 409

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

410-141-0500

Excluded Services and Limitations for Oregon Health Plan Clients - Effective for Services Provided On or After July 1, 1997

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200, Excluded Services and Limitations. Services that are excluded under the Oregon Medical Assistance program shall be excluded under the Oregon Health Plan unless the services are specifically identified in OAR 410-141-0520, Prioritized List of Health Services;

(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 Oregon Health Plan Administrative Rules;

(c) Any treatment, service, or item for a condition that is not listed in lines 1-578 of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(d) 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 in lines 579 - 745, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(e) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or noncovered Condition/Treatment Pair;

(f) Services requested by Oregon Health Plan (OHP) Clients in an emergency care setting that are diagnosed as nonemergent in nature and the OHP Client is informed that the services are not OHP covered services prior to provision

of the service;

(g) Services provided to an Oregon Health Plan Client outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(h) Services or items provided to an Oregon Health Plan 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;

(i) Services received while the OMAP Member is outside the Contractor's service area that were either:

(A) Not authorized by the OMAP Member's Primary Care Provider; or

(B) Not urgent or emergency services; or

(C) Normal delivery unless Contractor determines, subject to the Member's appeal rights, that the OMAP Member was outside Contractor's service area because of circumstances beyond the OMAP 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 Medically Appropriate to provide reasonable diagnosis and treatment or to enable the Oregon Health Plan 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 Oregon Health Plan Prioritized List of Health Services;

(c) Services that are limited under the Oregon Medical Assistance program as identified in OAR 410-120-1200, Excluded Services and Limitations. Services that are limited under the Oregon Medical Assistance program shall be limited under the Oregon Health Plan unless the services are specifically identified in OAR 410-141-0520, Prioritized List of Health Services or elsewhere in this chapter of the Oregon Administrative Rules.

(3) In the case of non-covered condition/treatment pairs, providers shall ensure that Oregon Health Plan 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 Ch. 409

Stats. Implemented: ORS 414.720

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

410-141-0520

Prioritized List of Health Services

(1) The Prioritized List of Health Services is the Health Services Commission listing of physical health services

presented to the Oregon Legislative Assembly.

(2) By this reference the Prioritized List of Health Services includes the "expanded definitions" of Ancillary Services and Preventive Services published at the end of the list.

(3) Certain Mental Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP) or authorized Fully Capitated Health Plan (FCHP). These codes are identified on their own Mental Health (MH) section of the appropriate lines on the Prioritized List of Health Services.

(4) Chemical dependency services are covered for all OHP clients when provided by an FCHP, PCO or by a provider who has a letter of approval from the Office of Alcohol and Drug Abuse Programs (ODAP) and approval to bill Medicaid for CD services. These codes are identified on the Chemical Dependency (CD) section of line 182. Graph 1, Table 1, Table 2, Table 3, Table 4, Table 5, Table 6, Table 7, Table 8. [Graph and Tables not included. See ED. NOTE.]

[ED. NOTE: The Graph and Tables referenced in this rule are not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.720 & 414.735

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; HR 27-1994(Temp), f. & cert. ef. 6-28-94; HR 29-1994(Temp), f. & cert. ef. 9-15-94; HR 35-1994, f. & cert. ef. 12-29-94; HR 44-1994(Temp), f. 12-30-94, cert. ef. 1-1-95; HR 12-1995, f. & 6-1-95; HR 18-1995, f. 9-28-95, cert. ef. 10-1-95; HR 2-1996, f. & cert. ef. 2-1-96; HR 20-1996, f. & cert. ef. 10-1-96; HR 30-1996(Temp), f. & cert. ef. 12-31-96; HR 13-1997, f. 5-30-97, cert. ef. 6-1-97; HR 26-1997, f. & cert. ef. 10-1-97

410-141-0660

Oregon Health Plan Primary Care Case Manager Provision of Health Care Services

Primary Care Case Managers shall ensure provision of medically appropriate covered services, including preventive services, in those categories of service included in agreements with OMAP:

(1) Each Primary Care Case Manager shall provide primary care, including preventive services, and diagnostic and treatment services.

(2) Primary Care Case Managers shall ensure that PCCM members have the same access to the Primary Care Case Manager referral practitioners that is available to non-OMAP patients.

(3) Primary Care Case Managers shall provide primary care to the PCCM member and arrange, coordinate, and monitor other PCCM Case Managed Services for the PCCM member on an ongoing basis.

(4) Primary Care Case Managers shall ensure that professional and related health services provided by the Primary Care Case Manager or arranged through referral by the Primary Care Case Manager to another provider are noted in the PCCM member's medical record.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0680

Oregon Health Plan Primary Care Case Manager Emergency and Urgent Care Medical Services

Primary Care Case Managers shall ensure the provision of triage services for all PCCM members on a 24-hour, seven-day-a-week basis:

(1) Primary Care Case Managers shall ensure that appropriate emergency services are available to PCCM members on a 24-hour, seven-day-a-week basis.

(2) Primary Care Case Managers shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from PCCM members.

(3) Primary Care Case Managers shall have procedures for notifying a referral emergency room concerning an arriving PCCM member's presenting problem, and whether or not the practitioner will meet the PCCM member there.

(4) During normal hours of operation, Primary Care Case Managers shall ensure that a health professional is available to triage urgent care and emergencies for PCCM members as follows:

(a) PCCM members who walk in for service shall be assessed to determine appropriate action;

(b) PCCM members who telephone shall be assessed to determine appropriate action;

(c) Phone calls from other providers requesting approval to treat PCCM members shall be assessed to determine appropriate action.

(5) Primary Care Case Managers shall have procedures for educating PCCM members on how to access urgent care and emergency care. Primary Care Case Managers shall have methods for tracking inappropriate use of outpatient hospital emergency care and shall take action to improve appropriate use of urgent and emergency care settings.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0700

Oregon Health Plan Primary Care Case Manager Continuity of Care

(1) Primary Care Case Managers shall ensure the provision of PCCM Case Managed Services for all PCCM Members and note in the PCCM Member's medical record referrals made by the Primary Care Case Manager to other providers for covered services:

(a) Primary Care Case Managers shall maintain a network of consultation and referral providers for all PCCM Case Managed Services covered by the Primary Care Case Manager's agreement with OMAP. Primary Care Case Managers shall establish and follow procedures for referrals;

(b) Primary Care Case Managers shall have policies and procedures for the use of urgent care centers and emergency rooms. Primary Care Case Managers shall ensure that services provided in these alternative settings are documented and incorporated into the PCCM Member's medical record;

(c) Primary Care Case Managers shall have procedures for referrals which ensure adequate notice to referral providers and adequate documentation of the referral in the PCCM Member's medical record;

(d) Primary Care Case Managers shall personally take responsibility for, or designate a staff member who is responsible

for, arrangement, coordination and monitoring of the Primary Care Case Manager's referral system;

(e) Primary Care Case Managers shall have procedures which ensure that relevant medical information is obtained from referral providers. These procedures shall include:

(A) Review of information by the Primary Care Case Manager;

(B) Entry of information into the PCCM Member's medical record;

(C) Arrangements for periodic reports from ongoing referral appointments; and

(D) Monitoring of all referrals, where appropriate, to ensure that information is obtained from the referral providers.

(f) Primary Care Case Managers shall have procedures to orient and train their staff/practitioners in the appropriate use of the Primary Care Case Manager's referral system. Procedures and education shall ensure use of appropriate settings of care;

(g) Primary Care Case Managers shall have procedures for processing all referrals made by telephone, whether during or after hours of operation, as a regular referral (e.g., referral form completed, information entered into PCCM Member's medical record, information requested from referral source);

(h) Primary Care Case Managers shall have procedures which ensure that an appropriate health professional will respond to calls from other providers requesting approval to provide care to PCCM Members who have not been referred to them by the Primary Care Case Manager;

(i) Primary Care Case Managers shall enter medical information from approved emergency visits into the PCCM Member's medical record;

(j) If a PCCM Member is hospitalized, Primary Care Case Managers shall ensure that:

(A) A notation is made in the PCCM Member's medical record of the reason, date, and expected duration of hospitalization;

(B) A notation is made in the PCCM Member's medical record upon discharge of the actual duration of hospitalization and follow-up plans, including appointments for practitioner visits; and

(C) Pertinent reports from the hospitalization are entered in the PCCM Member's medical record. Such reports shall include the reports of consulting practitioners and shall document discharge planning.

(k) Primary Care Case Managers shall have written policies and procedures that ensure maintenance of a recordkeeping system adequate to document all aspects of the referral process and to facilitate the flow of information to the PCCM Member's medical record.

(2) For PCCM Members living in residential facilities or homes providing ongoing care, Primary Care Case Managers shall either provide the PCCM Member's primary care or make provisions for the care to be delivered by the facility's "house doctor" for PCCM Members who cannot be seen in the Primary Care Case Manager's office.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95

410-141-0720

Oregon Health Plan Primary Care Case Manager Medical Recordkeeping

Primary Care Case Managers shall ensure maintenance of a medical recordkeeping system adequate to fully disclose and document the medical condition of the PCCM Member and the extent of covered services and/or PCCM Case Managed Services received by PCCM Members from the Primary Care Case Manager or the Primary Care Case Manager's referral provider.

(1) Primary Care Case Managers shall ensure maintenance of a medical record for each PCCM Member that documents all types of care delivered whether during or after office hours.

(2) The medical record shall include data which forms the basis of the diagnostic impression or the PCCM Member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The medical record shall also include:

(a) PCCM Member's name, date of birth, sex, address, phone number;

(b) Next of kin, sponsor, or responsible party; and

(c) Medical history, including baseline data, and preventive care risk assessment.

(3) The medical record shall include, for each PCCM Member encounter, as much of the following data as applicable:

(a) Date of service;

(b) Name and title of person performing the service;

(c) Pertinent findings on examination and diagnosis;

(d) Medications administered and prescribed;

(e) Referrals and results of referrals;

(f) Description of treatment;

(g) Recommendations for additional treatments or consultations;

(h) Medical goods or supplies dispensed or prescribed;

(i) Tests ordered or performed and results;

(j) Health education and medical social services provided; and

(k) Hospitalization order and discharge summaries for each hospitalization.

(4) Primary Care Case Managers shall have written procedures that ensure maintenance of a medical recordkeeping system that conforms with professional medical practice, permits internal and external medical audit, permits claim review, and facilitates an adequate system for follow-up treatment. All PCCM Member medical records shall be maintained for at least four years after the date of medical services for which claims are made or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever time period is longer.

(5) Primary Care Case Managers shall have written procedures that ensure the maintenance of the confidentiality of medical record information and may release such information only to the extent permitted by the Primary Care Case Manager's agreement with OMAP, by federal regulation **42 CFR 431 Subpart F** and by Oregon Revised Statutes. Primary Care Case Managers shall ensure that confidentiality of PCCM Members' medical records and other medical information is maintained as required by state law, including ORS 433.045(3) with respect to HIV test information.

(6) Primary Care Case Managers shall cooperate with OMAP representatives for the purposes of audits, inspection and examination of PCCM Member medical records.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Human Resources.]

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95

410-141-0740

Oregon Health Plan Primary Care Case Manager Quality Assurance System

(1) Primary Care Case Managers shall provide services that are in accordance with accepted medical practices and with accepted professional standards:

(a) Primary Care Case Managers shall establish procedures and protocols for assessing quality of PCCM member care:

(A) Primary Care Case Managers shall establish procedures for response to PCCM member complaints as outlined in OAR 410-141-0780, Primary Care Case Manager Complaint Proce-dures;

(B) Primary Care Case Managers shall establish or adopt criteria for adequate medical care for PCCM members and shall review care received by the PCCM member against these criteria. These criteria shall include those conditions and treatments identified by the OMAP sponsored statewide quality assurance committee as in need of study, review, or improvement;

(C) Primary Care Case Managers may use the services of a local medical society, other professional societies, quality assurance organizations, or professional review organizations approved by the Secretary of the U.S. Department of Health and Human Services, to assist in reviewing criteria and protocols for the adequate medical care of PCCM members.

(b) Primary Care Case Managers are expected to maintain and improve professional competencies, when needed, in order to provide quality care to PCCM members.

(2) The Office of Medical Assistance Programs conducts continuous and periodic reviews of enrollment and disenrollment, service utilization, quality of care, PCCM member satisfaction, PCCM member medical outcomes for specific tracer conditions, accessibility, complaints, PCCM member rights and other indicators of quality of care:

(a) The Office of Medical Assistance Programs contracts with an external medical review organization to monitor the treatment of specific conditions against national standards for treatment of those conditions. These tracer conditions may include, but are not limited to, asthma, anemia, diabetes, hypertension, pelvic inflammatory disease, teen pregnancy, toxemia, hypertension and diabetes in pregnancy;

(b) The Office of Medical Assistance Programs evaluates the management of adult and child preventive services through external medical review and through its research and evaluation program. These services are evaluated using national and state criteria, including criteria for mental health and chemical dependency screenings.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0760

Oregon Health Plan Primary Care Case Manager Accessibility

Primary Care Case Managers shall have written procedures which ensure that primary care, including Preventive Services, is accessible to PCCM Members. The Primary Care Case Manager shall not discriminate between PCCM Members and non-PCCM member patients as it relates to benefits to which they are both entitled.

(1) Primary Care Case Managers shall have procedures for scheduling of PCCM Member appointments which are appropriate to the reasons for the visit (e.g., PCCM Members with nonemergency needs; PCCM Members with persistent symptoms; PCCM Member routine visits; new PCCM Member initial assessment).

(2) Primary Care Case Managers are encouraged to establish a relationship with new PCCM Members.

(3) Under normal circumstances, Primary Care Case Managers shall ensure that PCCM Members are not kept waiting longer than non-PCCM Member patients.

(4) Primary Care Case Managers shall have procedures for following up of failed appointments, including rescheduling of appointments, as deemed medically necessary, and documentation in the PCCM Member medical record of broken appointments and recall efforts.

(5) Primary Care Case Managers shall have procedures to ensure the provision of triage of walk-in PCCM Members with urgent nonemergency medical need.

(6) When not an emergency, walk-in PCCM Members should either be scheduled for an appointment as Medically Appropriate or be seen within two hours.

(7) Primary Care Case Managers shall have procedures that ensure the maintenance of telephone coverage (not a recording) at all times either onsite or through call sharing or an answering service, unless OMAP waives this requirement in writing because of the Primary Care Case Manager's submission of an alternative plan that will provide equal or improved telephone access.

(8) Primary Care Case Managers shall ensure that the persons responding to telephone calls enter relevant information into the PCCM Member's medical record.

(9) Primary Care Case Managers shall ensure a response to each telephone call within a reasonable length of time. The length of time shall be appropriate to the PCCM Member's stated condition.

(10) Primary Care Case Managers shall have procedures that ensure that all persons answering the telephone have sufficient communication skills to reassure PCCM Members and encourage them to wait for a return call in appropriate situations.

(11) Primary Care Case Managers are expected to have a plan to access qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking PCCM Members. The plan shall address the provision of interpreter services by phone and in person. Such interpreters must be capable of communicating in English and the primary language of the PCCM Members and be able to translate medical information effectively. A substantial population is 35 non-English speaking households, enrolled with the Primary Care Case Manager, which have the same language. A non-English speaking household is a household that does not have an adult PCCM Member who is capable of communicating in English.

(12) Primary Care Case Managers shall provide education on the use of services, including Urgent Care Services and Emergency Services. OMAP may provide Primary Care Case Managers with appropriate written information on the use of services in the primary language of each substantial population of non-English speaking PCCM Members enrolled

with the Primary Care Case Manager.

(13) Primary Care Case Managers shall ensure that when a Medical Practitioner does not respond to a telephone call, there are written protocols specifying when a practitioner must be consulted and if Medically Appropriate, all such calls shall be forwarded to the on-call Medical Practitioner.

(14) Primary Care Case Managers shall have adequate practitioner back-up as an operative element of the Primary Care Case Manager's after-hours care. Should the Primary Care Case Manager be unable to act as PCCM for the PCCM Member, the Primary Care Case Manager shall designate a substitute Primary Care Case Manager.

(15) Primary Care Case Managers shall ensure compliance with requirements of the Americans with Disabilities Act of 1990.

(16) Primary Care Case Managers shall ensure that services, facilities and personnel are prepared to meet the special needs of visually and hearing impaired PCCM Members.

(17) Primary Care Case Managers shall arrange for services to be provided by referral providers when the Primary Care Case Manager does not have the capability to serve specific disabled populations.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95

410-141-0780

Oregon Health Plan Primary Care Case Manager Complaint Procedures

(1) Primary Care Case Managers shall have procedures for accepting, processing and responding to all complaints from PCCM members or their Representatives:

(a) Primary Care Case Managers shall have procedures for resolving all complaints. Primary Care Case Managers shall afford PCCM members the full use of the procedures, and shall cooperate if the PCCM member decides to pursue a remedy through the OMAP hearing process. Complaints are defined in OAR 410-141-0000, Definitions. See also OAR 410-141-0105, Primary Care Case Manager Member Complaints;

(b) Primary Care Case Managers shall designate a Primary Care Case Manager staff member or staff members who shall be responsible for receiving, processing, directing, and responding to complaints;

(c) Primary Care Case Managers shall ensure that all information concerning a PCCM member's complaint is kept confidential except that OMAP has a right to this information without a signed release from the PCCM member. If a PCCM member makes a complaint or files a hearing request, the Primary Care Case Manager may ask the PCCM member to consent to the release of information to those persons and to the extent necessary to resolve the complaint or hearing request. The Primary Care Case Manager shall inform the PCCM member that failure to consent may make it impossible to resolve the complaint or hearing request;

(d) Primary Care Case Managers shall have procedures for informing PCCM members orally and in writing about complaint procedures, which shall include the following:

(A) Written material describing the complaint process; and

(B) Assurance in all written and posted material of PCCM member confidentiality in the complaint process;

(C) Upon request, Office of Medical Assistance Programs shall pride Primary Care Case Managers with standard materials for tracking and documenting PCCM member complaints.

(e) Primary Care Case Managers shall have procedures for the receipt, disposition and documentation of all complaints from PCCM members. Primary Care Case Managers shall make available copies of the complaint forms (OMAP 3001). PCCM members may register a complaint in the following manner. Complaints: A PCCM member may relate any incident or concern to the Primary Care Case Manager or other staff person by stating this is a complaint:

(A) If the PCCM member indicates dissatisfaction, the Primary Care Case Manager or staff person shall advise the PCCM member that he or she may make a complaint;

(B) A staff person shall direct the PCCM member to the Primary Care Case Manager staff person designated for receiving complaints;

(C) A PCCM member may choose to utilize the Primary Care Case Manager's internal complaint procedure in addition to or in lieu of an OMAP hearing. If a PCCM member makes a complaint to the Primary Care Case Manager staff person designated for receiving complaints, the staff person shall notify the PCCM member that the PCCM member has the right to enter a written complaint with the Primary Care Case Manager or may attempt to resolve the complaint orally;

(D) Complaints concerning denial of service or service coverage shall be handled as described in subsection (1)(h) of this section in addition to procedures for oral or written complaints;

(E) All complaints made to the Primary Care Case Manager staff person designated to receive complaints shall be entered into a log. The log shall identify the PCCM member, the date of the complaint, the nature of the complaint, the resolution and the date of resolution;

(F) If the Primary Care Case Manager denies a service or service coverage, the Primary Care Case Manager shall notify the PCCM member of the right to a hearing.

(f) Oral Complaints:

(A) If the PCCM member chooses to pursue the complaint orally through the Primary Care Case Manager's internal complaint procedure, the Primary Care Case Manager shall within five working days form the date the oral complaint was received by the Primary Care Case Manager either:

(i) Make a decision on the complaint; or

(ii) Notify the PCCM member in writing that a delay in the Primary Care Case Manager's decision of up to 30 calendar days from the date the oral complaint was received by the Primary Care Case Manager is necessary to resolve the complaint. The Primary Care Case Manager shall specify the reasons the additional time is necessary.

(B) The Primary Care Case Manager's decision shall be communicated to the PCCM member orally or in writing no later than 30 calendar days from the date of receipt of the complaint. A written decision shall have both the Notice of Hearing Rights (OMAP 3030) and the complaint form (OMAP 3001) attached. An oral communication shall include informing the PCCM member of rights to hearing;

(C) If the PCCM member indicates dissatis-faction with the decision, the Primary Care Case Manager shall notify the PCCM member that the PCCM member may pursue the complaint further with an OMAP hearing.

(g) Written complaints: If the PCCM member files a written complaint with the Primary Care Case Manager, which does not concern denial of service or service coverage, the following procedures apply:

(A) The complaint shall be reviewed, investigated, considered or heard by the Primary Care Case Manager;

(B) A written decision shall be made on a PCCM member's written complaint. The decision shall be sent to the PCCM member no later than 30 calendar days from the date of receipt of the written complaint, unless further time is needed for the receipt of information requested from or submitted by the PCCM member. If the PCCM member fails to provide the requested information within 30 calendar days of the request by the Primary Care Case Manager, or another mutually agreed upon timeframe, the complaint may be resolved against the PCCM member. The decision on the complaint shall review each element of the PCCM member's complaint and address each of those concerns specifically;

(C) The Primary Care Case Manager's decision shall have the Notice of Hearing Rights (OMAP 3030) attached.

(h) Complaints concerning denial of service or service coverage: If a complaint made to the Primary Care Case Manager staff person designated to receive complaints concerns a denial of service or a service coverage decision, the following procedures apply in addition to the regular complaint procedures. The Primary Care Case Manager staff person shall notify the PCCM member in writing of the decision which denied the service or coverage within five working days. The decision letter shall include at least the following elements:

(A) The service requested;

(B) A statement of service denial;

(C) The basis for the denial;

(D) A statement that the PCCM member has a right to request an OMAP hearing, and that in order to request such a hearing the PCCM member must submit a Fair Hearing Request Form (AFS 443) to the PCCM member's DHR office within 45 calendar days of the date of the Primary Care Case Manager's decision on an oral or written complaint concerning denial of service or service coverage;

(E) A statement that an OMAP hearing request may be made in addition to or instead of using the Primary Care Case Manager's complaint procedure;

(F) A copy of the Notice of Hearing Rights (OMAP 3030) and Fair Hearing Request (AFS 443) shall be attached.

(i) PCCM member use of Primary Care Case Manager complaint procedure with request for hearing:

(A) If the PCCM member chooses to use the Primary Care Case Manager's complaint procedure as well as the OMAP hearing process, the Primary Care Case Manager shall ensure that either the complaint procedure is completed prior to the date on which the OMAP hearing is scheduled or obtain the written consent of the PCCM member to postpone the OMAP hearing. If the PCCM member consents to a postponement of the OMAP hearing, the Primary Care Case Manager shall immediately send such written consent to OMAP and to the local DHR office;

(B) The Primary Care Case Manager staff person shall encourage the PCCM member to use the Primary Care Case Manager's complaint procedure first, but shall not discourage the PCCM member from requesting an OMAP hearing;

(C) If the PCCM member files a request for an OMAP hearing, OMAP shall immediately notify the Primary Care Case Manager. The OMAP hearing process cannot be delayed without the PCCM member's consent;

(D) The Primary Care Case Manager staff person shall begin the process of establishing the facts concerning the complaint upon receipt of the complaint regardless of whether the PCCM member seeks an OMAP hearing or elects the complaint process, or both;

(E) If an OMAP hearing is requested by a PCCM member, the Primary Care Case Manager shall cooperate in the hearing process and shall make available, as determined necessary by the hearings officer, all persons with relevant information and all pertinent files and medical records.

(j) Should a PCCM member feel that his or her medical problem cannot wait for the normal Primary Care Case Manager review process, including the Primary Care Case Manager's final resolution, at the PCCM member's request, the

Primary Care Case Manager shall submit documentation to OMAP's medical director within, as nearly as possible, two working days for decision as to the necessity of an expedited OMAP hearing. OMAP's medical director shall decide within, as nearly as possible, two working days if that PCCM member is entitled to an expedited OMAP hearing.

(2) The Primary Care Case Manager's documentation shall include the log of complaints, a file of written complaints and records or their review or investigation and resolution. Files of complaints shall be maintained for a minimum of two calendar years from date of resolution.

(3) Primary Care Case Managers shall review and analyze all complaints.

(4) Primary Care Case Managers shall comply with and fully implement OMAP's hearing decision. Neither implementation of an OMAP hearing decision nor a PCCM member's request for a hearing may be a basis for a request by the Primary Care Case Manager for disenrollment of a PCCM member.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95

410-141-0800

Oregon Health Plan Primary Care Case Manager Informational Requirements

(1) OMAP shall provide basic models of informational materials which Primary Care Case Managers may adapt for PCCM members' use.

(2) Primary Care Case Managers shall ensure that all of their staff who have contact with potential PCCM members are fully informed of the Primary Care Case Manager and OMAP policies, including enrollment, disenrollment and complaint policies.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0820

Oregon Health Plan Primary Care Case Manager Member Education

Primary Care Case Managers shall have an ongoing process of PCCM member education and information sharing which includes orientation to the Primary Care Case Manager, health education and appropriate use of emergency facilities and urgent care:

(1) OMAP shall provide basic information about the use of Primary Care Case Manager services in a **PCCM Member Handbook**;

(2) Primary Care Case Managers shall provide new PCCM members with written information sufficient for the PCCM member to use the Primary Care Case Manager's services appropriately. Written information shall contain, at a minimum, the following elements:

(a) Location and office hours of the Primary Care Case Manager;

(b) Telephone number to call for more information;

(c) Use of the appointment system;

(d) Use of the referral system;

(e) How to access Urgent Care Services and advice;

(f) Use of Emergency Services; and

(g) Information on the complaint process.

(3) Primary Care Case Managers shall have procedures and criteria for health education designed to prepare PCCM members for their participation in and reaction to specific medical procedures, and to instruct PCCM members in self-management of medical problems and in disease and accident prevention. Health education may be provided by the Primary Care Case Manager, by any health practitioner or by any other individual or program approved by the Primary Care Case Manager. The Primary Care Case Manager shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from nondominant cultures;

(4) Primary Care Case Managers shall develop an educational plan for PCCM members for health promotion, disease and accident prevention, and patient self-care. OMAP may assist in developing materials which address specifically identified health education problems to the population in need.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0840

Oregon Health Plan Primary Care Case Manager Member Rights And Responsibilities

(1) Primary Care Case Managers shall ensure that PCCM Members are treated with the same dignity and respect as other patients who receive services from the Primary Care Case Managers.

(2) PCCM Members have both rights and responsibilities as follows:

(a) PCCM Members have the right to appropriate access to the Primary Care Case Manager. PCCM Members have the responsibility to keep appointments made with the Primary Care Case Manager;

(b) PCCM Members have the right to Preventive Services. PCCM Members have the responsibility to seek periodic health exams for children and adults based on Medically Appropriate guidelines for age, sex and risk factors;

(c) PCCM Members have the right to services necessary and reasonable to diagnose the presenting condition of the PCCM Member. PCCM Members have the responsibility to seek out diagnostic services from the Primary Care Case Manager except in an emergency.

(d) PCCM Members have the right to appropriate Urgent Care Services; and Emergency Services. PCCM Members have the responsibility to use the Primary Care Case Manager whenever possible. PCCM Members have the responsibility to use Urgent Care Services before Emergency Services whenever possible:

(A) PCCM Members have the right to written information on how to access emergency care and urgent care. PCCM Members have the responsibility to use emergency care appropriately. PCCM Members have the right to make a

Complaint if they believe that a request for payment for Emergency Services has been erroneously denied by the Primary Care Case Manager. PCCM Members may request a hearing before an OMAP representative if their Complaint is not acted on, to their satisfaction, by the Primary Care Case Manager;

(B) In addition to access to emergency care, PCCM Members have the right to the following triage services:

(i) A service which allows PCCM Members to access Primary Care Case Managed Services and contact the Primary Care Case Manager on a 24-hour, 7-day-a-week basis, when the PCCM Member requires urgent or emergency care;

(ii) To have the referral emergency room notified about the PCCM Member's presenting problem, and whether or not the Primary Care Case Manager will meet the PCCM Member there;

(iii) To have a health professional available to triage urgent care and emergencies for PCCM Members during regular working hours. This service includes individuals who walk in for service or who telephone for assessment.

(e) PCCM Members have the right to access specialty practitioners with the Primary Care Case Manager's referral when their condition warrants a referral. PCCM Members have the responsibility to access specialty services through referral by the Primary Care Case Manager;

(f) PCCM Members have the right to maintenance of a medical record which documents the medical condition of the PCCM Member and the services received by the PCCM Member. The PCCM Member has the right of access to his or her own medical record and to request transfer of a copy of his or her own record to another provider when appropriate. PCCM Members have the responsibility to give accurate information for inclusion into the record and to request transfer of a copy of the record to a new provider when changing providers;

(g) PCCM Members have the right to Medically Appropriate covered services which meet generally accepted standards of practice. PCCM Members have the right to information about medical services which permits them to make an informed decision about proposed medical services. PCCM Members have the right to refuse any recommended services. PCCM Members have the responsibility to use the information to make informed decisions about services. PCCM Members have the responsibility to follow prescribed treatment plans, once the PCCM Member has agreed to the plan;

(h) PCCM Members have the right to execute a statement of their wishes for treatment, including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care. This right is established and must be adhered to in accordance with ORS 127 as amended by the Oregon Legislative Assembly 1993 and the **OBRA 1990** - Patient Self-Determination Act.

(3) PCCM Members have the right to Medically Appropriate services covered under the Oregon Health Plan. PCCM Members have the responsibility to inform medical providers of their coverage as PCCM Members prior to receiving services

(4) PCCM Members enrolled with Primary Care Case Managers or their Representatives have the right to make Complaints to Primary Care Case Managers and to request hearings through the OAMP hearings process. PCCM Members have the responsibility to attempt resolution of Complaints with the Primary Care Case Manager and to release pertinent information necessary to effectively and efficiently resolve complaints and hearings.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95

410-141-0860

Oregon Health Plan Primary Care Case Manager Provider Qualification and Enrollment

(1) Primary Care Case Managers shall be trained and certified or licensed, as applicable under Oregon statutes and administrative rules, in one of the following disciplines:

(a) Doctors of medicine;

(b) Doctors of osteopathy;

(c) Naturopathic physicians;

(d) Nurse practitioners;

(e) Physician assistants.

(2) The following entities may enroll as Primary Care Case Managers:

(a) Hospital primary care clinics;

(b) Rural health clinics;

(c) Migrant and community health clinics;

(d) Federally qualified health clinics;

(e) Indian health service clinics;

(f) Tribal health clinics.

(3) Naturopaths must have a written agreement with a physician that is sufficient to support the provision of primary care, including prescription drugs, as well as the necessary referrals for hospital care.

(4) All applicants for enrollment as Primary Care Case Managers must:

(a) Be enrolled as Oregon Medicaid providers;

(b) Make arrangement to ensure provision of the full range of PCCM Case Managed Services, including prescription drugs and hospital admissions;

(c) Complete and sign the Primary Care Case Manager Application (OMAP 3119 (12/93)).

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 142

HOSPICE SERVICES

410-142-0000

Purpose

The OMAP administrative rules for Hospice Programs are to be used in conjunction with the Oregon Health Plan Administrative Rules and the General Rules for Oregon Medical Assistance Programs. Hospice benefits are available only to OMAP clients eligible for the Oregon Health Plan benefit package ("Basic Health Care Benefit Package").

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0020

Definitions

(1) "Accredited": The Hospice Program has received accreditation by the Oregon Hospice Association (OHA).

(2) "Ancillary Staff": Staff who provide 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 individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the indivdual's medical care.

(5) "Bereavement Services": Supportive services provided to the individual's family after the individual's death.

(6) "Coordinated": When used in conjunction with the phrase "hospice program", means the integration of the

interdisciplinary services provided by patient-family care staff, other providers and volunteers directed toward meeting the hospice needs of the patient.

(7) "Coordinator": A registered nurse designated to coordinate and implement the care plan for each hospice patient.

(8) "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.

(9) "Curative": Medical intervention used to ameliorate the disease.

(10) "Dying": The progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.

(11) "Family": The relatives and/or other significantly important persons who provide psychological, emotional, and spiritual support of the patient. The "family" need not be blood relatives to be an integral part of the hospice care plan.

(12) "Hospice": A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry,.

(13) "Hospice Continuity of Care": Services that are organized, coordinated and provided in a way that is responsive at all times to patient/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.

(14) "Hospice Home Care": Formally organized services designed to provide and coordinate hospice interdisciplinary team services to individual/family in the place of residence. The hospice will deliver at least 80 percent of the care in the place of residence.

(15) "Hospice Philosophy": Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

(16) "Hospice Program": A coordinated program of home and inpatient care, available 24 hours a day, that utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. ORS 443.850

(17) "Hospice Program Registry": A registry of all certified and accredited hospice programs maintained by the Oregon Hospice Association.

(18) "Hospice Services": Items and services provided to a patient/family unit by a hospice program or by other individuals or community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include acute, respite, home care, and bereavement services provided to meet the physical, psychosocial, spiritual and other special needs of the patient/family unit during the final stages of illness, dying and the bereavement period. ORS 443.850

(19) "Illness": The condition of being sick, diseased or with injury.

(20) "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 patient care program.

(21) "Medicare Certification": Health Care Financing Administration certifies the Hospice meets the conditions and standards of participation in the Medicare Program and is eligible for Medicare reimbursement.

(22) "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 patient/family are 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 patient/family.

(23) "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.

(24) "Period of Crisis": A period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

(25) "Primary Caregiver": The person designated by the patient or representative. This person may be family, an individual who has personal significance to the patient 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 patient as needed. If the patient has no designated primary caregiver the hospice may, according to individual program policy, make an effort to designate a primary caregiver.

(26) "Prognosis": The amount of time set for the prediction of a probable outcome of a disease.

(27) "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 individual who is mentally or physically incapacitated.

(28) "Terminal Illness": In hospice, a terminal illness is an illness or injury which is forecast to result in the death of the patient, for which treatment directed toward cure is no longer believed appropriate or effective.

(29) "Terminally Ill" means that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(30) "Volunteer": An individual who agrees to provide services to a hospice program without monetary compensation.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95

410-142-0040

Eligibility for the Hospice Benefit

(1) OMAP clients with the Basic Health Care Benefit Package who have been certified as terminally ill in accordance with OAR 410-142-0060 are eligible for hospice benefits.

(2) Clients eligible for Part A of Medicare will be served by a Medicare certified hospice, if available in the area, according to Medicare regulations; Medicare will be billed for reimbursement. Medicare payment is to be considered as payment in full.

(3) Clients not eligible for Part A of Medicare, or with no Medicare certified hospice available, may be served by a hospice meeting the definition of Hospice as shown in OAR 410-142-0020.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95

410-142-0060

Certification of Terminal Illness

(1) The hospice must obtain written certification of terminal illness for each of the periods listed in OAR 410-142-0120, even if a single election continues in effect for two, three or four periods.

(2) The hospice must obtain written certification that an individual is terminally ill no later than two calendar days after the period begins. For the initial 90-day period, if the hospice cannot obtain the written certifications within the two calendar days, it must obtain oral certification within two calendar days and written certification no later than eight calendar days after the period begins.

(3) The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

(4) Signatures of the attending physician and medical director of the hospice or physician member of the hospice's interdisciplinary group are required to certify the terminal illness.

(5) Recertification for subsequent periods is by signature of one of the following:

(a) The medical director of the hospice; or

(b) Physician member of the hospice's interdisciplinary group.

(6) Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and file written certifications in the medical record.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0080

Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form specifying the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or representative as defined in OAR 410-142-0020.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

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 acknowledgement 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) Acknowledgement that certain otherwise covered services are waived by the election. Election of a hospice benefit means that OMAP 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 represen-tative.

(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.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

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) A subsequent 30-day period;

(d) A last period that is unending if:

(A) Individual remains in the care of a hospice; and

(B) Individual does not revoke the election of hospice.

(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 OMAP 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 Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

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 Ch. 409

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 a statement to be placed in the medical record with the hospice 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 Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95

410-142-0180

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 Ch. 409

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:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A social worker;

(d) A pastoral or other counselor.

(2) Role of the 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 subsection (2)(b) 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 Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

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 OAR 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 Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

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 patients 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 palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician:

(a) Reimbursement for physician supervisory and interdiscplinary group services for those physicians employed by the hospice agency is included in the rate paid to the agency;

(b) Reimbursement of attending physician services for those physicians *not* employed by the hospice agency is according to the OMAP fee schedule. These physicians must bill OMAP for their services;

(c) Reimbursement of the hospice for consulting physician services furnished by hospice employees or by other physicians under arrangements by the hospice is as follows: The consulting physicians will bill the hospice. The hospice will bill OMAP for these physicians services and be reimbursed according to the OMAP fee schedule.

(4) Counseling Services. Counseling services must be available to both the individual 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 individual 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 paliation and management of the terminal illness are not covered under the hospice program.

(7) Home Health Aide and Homemaker Services.

(8) Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

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 an individual 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 an individual 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 aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis. 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;

(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 individual only when necessary to relieve the family members or other persons caring for the individual 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 individual only when necessary to relieve the family members or other persons caring for the individual 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. 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 an individual who has elected hospice care receives general inpatient care in an inpatient facility for procedures necessary for pain control or acute or chronic symptom management which cannot be managed or provided in other settings.

(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 Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0280

Recipient Benefits

Hospice recipients are entitled to receive services not included in the hospice benefit subject to the same rules as if they had not chosen the hospice benefit. 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) Optometric services.

(4) 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 Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0300

Billing Information

(1) Hospice care is defined as a group of services and is therefore paid on a per diem basis dependent upon the level of care being provided. If the client is enrolled in a prepaid health plan, the hospice must contact the plan and bill according to their instructions.

(2) If the client has the "Basic Health Care" benefit package but is not enrolled in a prepaid health plan, bill with the appropriate Revenue Center Codes using the instructions on how to complete the UB-92.

(3) If the client is enrolled in Medicare Part A, do not bill OMAP unless no Medicare certified Hospice is available.

(4) If the client is enrolled in Medicare Part B, enter NC or MC in Form Locator 84.

(5) If the client is enrolled in Medicare Part A and you are not a Medicare-certified hospice, and there is no Medicare-certfied hospice available in the area, enter NC or MC in Form Locator 84.

(6) Submit your claim on a hard copy UB-92 or electronically to OMAP.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95

410-142-0320

Instructions on How to Complete the UB-92

(1) Required items:

(a) Provider Identification: Enter provider name, mailing address and zip code if billing paper claim;

(b) Type of Bill: Enter the appropriate three-digit numeric code to identify the type of claim:

(A) Enter an "8" as the first digit;

(B) Enter a "1" as the second digit if the Hospice is non-hospital based, and a "2" if it is a hospital-based Hospice;

(C) The third digit identifies Frequency/ Definition:

(i) 1 -- Admit through discharge claim: Encompasses an entire course of hospice treatment and no further bills will be submitted for this client (i.e. client revokes or expires within the first billing period);

(ii) 2 -- First Claim: Use this code for the first of an expected series of payment bills for course of treatment;

(iii) 3 -- Interim-Continuing Claim: Use when a bill has been submitted and further bills are expected to be submitted;

(iv) 4 -- Last Billing: Use for a bill which is the last of series for a hospice course of treatment. The through date of this bill (Form Locator 6) is the discharge date or the date of death.

(c) Statement Covers Period: Enter the beginning and ending dates of service covered by this claim as MMDDYY;

(d) Patient's Name: Enter the client's last name, first name and middle initial as it appears on the Medical Care Identification;

(e) Condition Codes: Enter A1 if EPSDT (Medicheck);

(f) Revenue Codes: Enter the Revenue Code which most accurately describes the service provided:

(A) 651 -- Routine Home Care;

(B) 652 -- Continuous Home Care (billed in *hours*, not days);

(C) 655 -- Inpatient Respite Care;

(D) 656 -- General Inpatient Care;

(E) 659 -- Other Hospice - use for in-home respite care.

(g) Service Units: Enter total units of service (days or hours) for each type of service.

(h) Total Charges: Enter the total charges pertaining to the related code. At the bottom of Form Locator 42, enter Revenue Code 001. At the bottom of Form Locator 47, enter the total charge;

(i) Payer Identification (optional): Enter the names of up to three payer organizations in order:

(A) Primary payer;

(B) Secondary payer;

(C) Tertiary payer;

If Medicaid is primary enter "Medicaid" on line A. If Medicaid is secondary or tertiary payer, enter the primary payer on line A and Medicaid on line B or C as appropriate.

(j) Provider Number: Enter your six-digit OMAP provider number on the line (A, B or C) which corresponds to the line

you used to identify OMAP in Form Locator 50. Your OMAP provider number is required. OMAP does not require that you report your provider number for other payers listed in Form Locator 50;

(k) Prior Payments: Enter the amount of payments received from a third party resource on the same letter line listed in Form Locator 50;

(L) Cert-SSN-HIC-ID No.: Enter the patient's Medicaid Identification number on the same letter line (A, B or C) that corresponds to the line on which Medicaid payer information is shown in Form Locator 50;

(m) Principal Diagnosis Code: Enter the ICD-9-CM code describing the principal diagnosis (i.e., the condition for which the plan of treatment was established and the patient taken into service). The ICD-9-CM must be carried out to its highest degree of specificity - see General Rules for specific details. Do not enter decimal points or unnecessary characters.

(n) Attending Physician I.D.: Enter the attending physician's six-digit OMAP provider number or UPIN.

(o) Remarks: Use this space for Third Party Resource (TPR) explanation codes.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 16-1995, f. & cert. ef. 8-1-95

410-142-0360

Individual Adjustment Request

(1) Overpayments, underpayments and payments received after OMAP has paid a claim can be resolved through the adjustment process

(2) Much of the information required on the Adjustment Request form is printed on the Remittance Advice (RA). You may submit documentation to support your request. Submit Adjustment Requests to OMAP.

(3) How to complete an Adjustment Request:

(a) Check the appropriate box if this request is an underpayment (OMAP paid too little) or an overpayment (OMAP paid too much);

(b) Enter the 13-digit Internal Control Number (ICN). This number is found on the RA in Field 7;

(c) Enter the client's Medicaid identification number. This number is found on the RA in Field 6, or on the client's Medical Care Identification;

(d) Enter the client's name;

(e) Enter your six-digit provider number;

(f) Enter your provider name;

(g) Enter the date printed at the top of the RA;

(h) Description. This column contains possible areas you might want to correct. Check only the box you want to change:

(A) Quantity/Unit -- Use to correct the number of services you are billing;

(B) Revenue Center Code -- Use to correct revenue center codes (Form Locator 42 on the UB-92 or Field 10 on the RA);

(C) Insurance Payment/Patient Liability -- Use to correct payments received from other sources (Form Locator 54 on the UB-92 or Field 16 on the RA);

(D) Billed Amount -- Use to correct the amount you billed OMAP (Form Locator 47 on the UB-92, or Field 13 on the RA);

(E) Other -- Use to correct ICD-9-CM codes appearing on the RA. Also used if none of the above address your problems.

(i) Line# -- Use the line number from the original claim (UB-92) you are adjusting;

(j) Service Date -- Enter the date you performed the service;

(k) Wrong Information -- Enter the incorrect information submitted on your original claim in this column;

(l) Right Information -- Enter the corrected information submitted in this column;

(m) Remarks -- Give additional information or explain your request, if necessary;

(n) Provider's Signature -- The signature of the provider or other authorized person must be in this space;

(o) Date -- Enter the date this form was completed.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 16-1995, f. & cert. ef. 8-1-95

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DIVISION 143

HIV/AIDS PREVENTION SERVICES PROGRAM

410-143-0000

Purpose - Effective for Services Provided on or After February 1, 1994

(1) This program aims to control the spread of HIV through prevention efforts. The program:

(a) Expands HIV services to include management of nonmedical services, which address social, behavioral, and nutritional factors as well as HIV-risk reduction techniques;

(b) Is an additional set of services over and above current medical management of HIV Seropositive clients.

(2) There are two components to the program:

(a) Component one (counseling and testing) is available to any client seeking counseling and testing services;

(b) Component two (seropositive wellness program) is available to all HIV seropositive clients.

(3) These rules are to be used in conjunction with the OMAP General Rules and the Administrative Rules governing the Oregon Health Plan Medicaid Demonstration Project.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 1-1995, f. 1-13-95, cert. ef. 1-17-95

410-143-0020

Definitions -- Effective for Services Provided on or After February 1, 1994

(1) Public Health Seropositive Wellness Program (SW) - This program, consisting of six SWP treatment sessions, is a

carefully stated series of medical, behavioral and social interventions designed to engage client in self-management of his/her HIV disease and prevention of secondary spread of HIV. Each SWP session contains an intervention component as well as a medical and/or community support/case management component as appropriate.

(2) SWP Intervention Component - A series of cognitive and behavior modification counseling sessions designed to teach client skills to reduce/eliminate high risk behaviors and maximize health. Interventions include techniques in stress reduction and relaxation.

(3) SWP Medical Component - General medical history at first sessions and, as indicated, at subsequent sessions: immunizations and appropriate lab tests.

(4) SWP Community Support Priorities/Case Management Component - As indicated, assistance to clients in accessing services appropriate to his/her level of illness through ongoing assessment, advice and referral, including but not limited to, financial resources, housing, practical support, medical services and emotional support services.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 409.010

Hist.: HR 1-1995, f. 1-13-95, cert. ef. 1-17-95

410-143-0040

Provider Qualifications -- Effective for Services Provided on or After February 1, 1994

HIV/AIDS Prevention services providers must be:

(1) Currently licensed as a physician, nurse practitioner, or a registered nurse with a minimum of two years experience, or other professional or paraprofessional working under the supervision of one of the above practitioners; and

(2) Trained and certified as a provider of the HIV/AIDS Prevention Services Program by the Oregon Health Division and following the protocols established by the Oregon Health Division for this program.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.085

Hist.: HR 1-1995, f. 1-13-95, cert. ef. 1-17-95

410-143-0060

Procedure Codes -- Effective for Services Provided on or After February 1, 1994

(1) Public Health HIV Counseling and Testing - Code PUB01. This code includes:

(a) Pre-test counseling:

(A) Counseling covering basic facts about HIV, modes of transmission, risk factors, testing methodology, procedures, alternatives and risks of the test. Distribute condoms;

(B) Risk assessment of factors that place client at risk for contracting HIV;

(C) Risk reduction counseling as appropriate;

(D) Phlebotomy and specimen processing.

(b) Post-test counseling:

(A) Counseling, provide test results, and reiterating basic facts about HIV;

(B) Risk reduction counseling; condom demonstration, dispense condoms to client;

(C) As appropriate:

(i) Special behavioral intervention to assist client in reducing/eliminating high risk behaviors through:

(I) Abstinence;

(II) Reduction in number of sexual partners;

(III) "Safe" injection of drugs using decontaminated syringes/needles; and

(IV) Proper and consistent use of condoms, including condom demonstration and dispense condoms to client.

(ii) Deal with traumatized client who is first learning s/he has a terminal disease;

(iii) Obtain information needed for partner notification;

(iv) Begin discussion of risk reduction behavior changes needed to avoid infecting others;

(v) Cover the prognosis, discuss T-cell testing, medical and dental referrals for long-term follow-up;

(vi) Community support priorities/case management, as indicated;

(vii) Enroll client in Seropositive Wellness Program and schedule next session.

(d) This code is paid four times per year per client.

(2) Public Health HIV-1 Screening and Confirmation Testing - Code PUB02. This code is paid two times per year per client.

(3) Public Health Seropositive Wellness Program (SWP) Treatment Session - Code PUB03:

(a) The subsequent SWP treatment sessions, following Oregon Health Division protocols, are a carefully stated series of medical, behavioral and social interventions designed to engage client in self-management of his/her HIV disease and prevention of secondary spread of HIV:

(A) SWP Treatment Session #1:

(i) Medical/diagnostic: Take client's general medical history. Also, do specimen collection, as appropriate, for: T-cell testing, including slide preparation and expedited handling; CBC as diagnostic adjunct; Hepatitis B serology; and HIV retest if indicated;

(ii) Intervention: Teach the client basic relaxation techniques as an adjunctive treatment for depression, in addition to reducing anxiety which has a deteriorating effect on the immune system. This technique has been demonstrated to enhance immune system functioning, cardiovascular functioning, and digestion/metaboism. Distribute condoms.

(iii) Community support priorities/case management, as indicated.

(B) SWP Treatment Session #2:

(i) Medical: T-cell result, PPD administration with controls. Administer Hepatitis B vaccine dose #1, if indicated. Specimen collection for RPR serology;

(ii) Intervention: Focus on biofeedback in order to enhance the patient's locus of control regarding his/her perception of illness, stimulate the use of imagery (a demonstrated technique of immune system enhancement), and to facilitate localized enhancement of stress reduction. Clients also use this technique to suppress medication side-effects. Distribute condoms;

(iii) Community support priorities/case management, as indicated.

(C) SWP Treatment Session #3:

(i) Medical: RPR results. PPD results and referral for x-ray follow-up, if indicated. Administer vaccines (Pneumovax, Influenza) as indicated;

(ii) Intervention: Begin to teach client techniques relating to HIV-risk reduction, in addition to behavior modification of health threatening activities. This session focusses on the analysis of antecedents which stimulate risky behavior performance. The client is also taught to use self-monitoring techniques related to risk behaviors. This session also incorporates a de-conditioning technique for reducing client's fears regarding illness and possible death. Distribute condoms;

(iii) Community support priorities/case management, as indicated.

(D) SWP Treatment Session #4:

(i) Medical: Administer Hepatitis B dose #2 and other vaccinations as indicated. Nutrition counseling, general review of immune system;

(ii) Intervention: Begin to develop a cognitive approach in which the client is instructed to restructure his/her thought processes regarding risky behavior related to sexuality, substance abuse, smoking, etc. Distribute condoms;

(iii) Community support priorities/case management, as indicated.

(E) SWP Treatment Session #5:

(i) Medical: Specimen collection for toxoplasmosis serology;

(iii) Intervention: The client is assisted in a cognitive rehearsal of risk reduction thought processes, and instructed in generalizing this process to overt environmental and behavioral situations. Nutritional counseling is enhanced in this session through the application of behavior modification techniques to HIV counterproductive dietary habits. Distribute condoms;

(iii) Community support priorities/case management, as indicated.

(F) SWP Treatment Session #6:

(i) Medical Administer vaccines (MMR, dT, HIB) as indicated;

(ii) Intervention: Summary session. Review client's understanding and implementation of psychological techniques relating to HIV. Ancillary services (e.g., A&D intervention), community level psychosocial support needs as well as medical and dental services, are summarized and reviewed. Distribute condoms;

(iii) Community support priorities/case management, as indicated.

(b) This code is paid six times per year per client.

(4) Public Health Treatment Follow-up Sessions (3, 6 and 12 months post-enrollment) Code PUB04:

(a) Medical: Administer Hepatitis B vaccine as indicated. Specimen collection for T4 count, CBC, as indicated;

(b) Intervention: Review medical and psychological issues relating to HIV and the client's health, and risk reduction behaviors. Provide specific behavioral interventions based on relapsing behaviors identified with the client. Distribute condoms;

(c) Community support priorities/case management, as indicated;

(d) This code is paid three times per year per client.

Stat. Auth.: ORS Ch. 409

Stats. Implemented: ORS 414.085

Hist.: HR 1-1995, f. 1-13-95, cert. ef. 1-17-95

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DEPARTMENT OF HUMAN RESOURCES, OFFICE OF MEDICAL ASSISTANCE PROGRAMS

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 Resources.

(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 ORS 441.015 to 441.097 and includes community health programs established under ORS 430.610 to 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 OAR 410-145-0040(3)(b) and orders under OAR 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 442.700 & 442.755

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 to 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, Department of Human resources, Human Resources Building, Salem, Oregon 97310. The application must be accompanied by an application fee of $30,000. Checks should be made payable to the Oregon Department of Human Resources.

(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 442.705, 442.710, 441.715 & 442.755

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 442.720 & 442.755

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 442.725 & 442.755

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 442.730 & 442.755

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 442.735 & 442.755

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 OAR 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 to 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 to 442.760 shall be to withdraw the immunities granted under ORS 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

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 to 192.505.

Stat. Auth.: ORS 442.750 & 442.755

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 OAR 137-003-0080 through OAR 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 ORS 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 442.710, 442.730, 442.740 & 442.755

Hist.: HR 16-1994, f. & cert. ef. 3-31-94

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