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DIVISION 1

PROCEDURAL AND ELECTRONIC DATA INTERCHANGE RULES

410-001-0000
Model Rules of Procedure

Department of Human Services (Department), Division of Medical Assistance Programs, chapter 410, will adhere to Department rules in chapter 407 regarding Model Rules of Procedure.

Stat. Auth.: ORS 183.335, 183.341 & 409.050
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 409.050 & 409.120
Hist.: HR 3(Temp), f. & ef. 12-29-76; HR 5, f. & ef. 3-10-77; HR 2-1978, f. & ef. 3-3-78; HR 5-1980, f. & ef. 9-17-80; HR 6-1982, f. & ef. 7-1-82; HR 1-1986, f. & ef. 4-2-86; HR 1-1988, f. & cert. ef. 1-4-88; HR 7-1991, f. & cert. ef. 1-25-91; OMAP 9-2006, f. 5-3-06, cert. ef. 6-1-06

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

Department of Human Services (Department), Division of Medical Assistance Programs, chapter 410, will comply with Department rules in chapter 407 for Notices of Rulemaking and adoption of Temporary rules.

Stat. Auth.: ORS 183.335, 183.341 & 409.050
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 409.050 & 409.120
Hist.: HR 3(Temp), f. & ef. 12-29-76; HR 5, f. & ef. 3-10-77; HR 2-1978, f. & ef. 3-3-78; HR 5-1980, f. & ef. 9-17-80; OMAP 9-2006, f. 5-3-06, cert. ef. 6-1-06

410-001-0020
Delegation of Rulemaking Authority

Department of Human Services (Department), Division of Medical Assistance Programs, chapter 410, will comply with Department rules in chapter 407 for Delegation of Rulemaking Authority.

Stat. Auth.: ORS 183.335, 183.341 & 409.050
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 409.050 & 409.120
Hist.: HR 6(Temp), f. & ef. 7-1-77; HR 7, f. & ef. 9-1-77; OMAP 9-2006, f. 5-3-06, cert. ef. 6-1-06

410-001-0100
Definitions

For purposes of these rules, the following terms shall have the meanings set forth below. Capitalized terms used in these Electronic Data Interchange (EDI) Rules have the same meaning as those terms are defined in this section.

(1) Access. The ability or the means necessary to read, write, modify or communicate Data or information or otherwise use any Information System resource.

(2) Agents. Third parties or organizations that contract with a Trading Partner to perform designated services in order to facilitate a Transaction or the conduct of other business functions on behalf of the Trading Partner.

(a) Examples of Agents include billing agents, including but not limited to the following: claims clearinghouses, vendors, billing services, service bureaus, and accounts receivable management firms.

(b) Agents may also include clinics, group practices and facilities that submit billings on behalf of Providers but the payment is made to the Provider, including the following: an employer of a Provider, if the Provider is required as a condition of employment to turn over his fees to the employer; the facility in which the service is provided, if the Provider has a contract under which the facility submits the claim; or a foundation, plan, or similar organization operating an organized health care delivery system, if the Provider has a contract under which the organization submits the claim.

(c) Agents may also include EDI Submitters as that term is defined in these DHS EDI rules.

(3) Allied Agencies. Local and regional Allied Agencies include the following: local Mental Health Authority; Community Mental Health Programs; Oregon Youth Authority; Department of Corrections; local Health departments; schools; education service districts; developmental disability service programs; area agencies on aging; federally recognized American Indian tribes; and such other governmental agencies or regional authorities that have a Contract (including an interagency agreement, or an intergovernmental agreement, or a grant agreement, or an agreement with an American Indian tribe pursuant to ORS 190.110) with DHS to provide for the delivery of services to Covered Individuals and that requests to be a Trading Partner with DHS in the conduct of EDI in relation to the Contract.

(4) ANSI. American National Standards Institute.

(5) Centers for Medicare and Medicaid Services ("CMS"). CMS is the federal agency charged with the administration of the Medicare and Medicaid programs within the U.S. Department of Health and Human Services and also charged with implementation of the HIPAA Transaction Rule.

(6) Clinic. A group practice, facility or organization that is an employer of a Provider, if the Provider is required as a condition of employment to turn over his fees to the employer; the facility in which the service is provided, if the Provider has a contract under which the facility submits the claim; or a foundation, plan, or similar organization operating an organized health care delivery system, if the Provider has a contract under which the organization submits the claim; and such group practice, facility or organization is enrolled with DHS, and payments are made to the group practice, facility or organization. If such entity solely submits billings on behalf of Providers and payments are made to each Provider, then the entity is an Agent.

(7) Companion Guide. DHS's business-specific instructions describing the Transaction-specific information necessary to submit a Data Transmission and have it be successfully processed.

(8) Confidential Information. Information relating to Covered Individuals (as defined herein) which is exchanged by and between DHS, the Provider, Prepaid Health Plan, Clinic or Allied Agency and/or Agents for various business purposes, but which is protected from disclosure to unauthorized persons or entities by applicable state and federal statutes such as ORS 344.600, 410.150, 411.320, 418.130, or the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and its implementing regulations, which statutes and regulations shall hereinafter be collectively referred to as "Privacy Statutes and Regulations."

(9) Contract. A specific written agreement between DHS and a Provider, Prepaid Health Plan, Clinic or Allied Agency that provides, or manages the provision of, services, goods or supplies to Covered Individuals and in the provision of which DHS and the Provider, Prepaid Health Plan, Clinic or Allied Agency may exchange Data (as defined herein). A Contract specifically includes, without limitation, a DMAP Provider Enrollment Agreement, a Fully Capitated Heath Plan Managed Care Contract, a Dental Care Organization Managed Care Contract, a Mental Health Organization Managed Care Contract, a Chemical Dependency Organization Managed Care Contract, a County Financial Assistance Agreement, or any other applicable written agreement, interagency agreement, intergovernmental agreement, or grant agreement between DHS and Provider, Prepaid Health Plan, Clinic or Allied Agency.

(10) Covered Individuals. Individual persons who are eligible for payment of certain services or supplies provided to them or their eligible dependents by or through a Provider, Prepaid Health Plan, Clinic or Allied Agency (as defined herein) under the terms, conditions, limitations and exclusions of a Contract applicable to a governmental program and for which DHS processes or administers Data Transmissions.

(11) Data. A formalized representation of specific facts or concepts suitable for communication, interpretation, or processing by people or by automatic means.

(12) Data Transmission. The transfer or exchange of Data between DHS and an EDI Submitter by means of an Information System (as defined herein) which is compatible for that purpose, and including without limitation, EDI, ERA, or EMC (all as defined herein) transmissions, pursuant to the terms and conditions set forth in a Trading Partner Agreement and these rules.

(13) Department of Human Services ("DHS"). The Oregon Department of Human Services or any of its divisions, programs or offices, including DHS Information Systems.

(14) Electronic Data Interchange ("EDI"). The exchange of business documents from application to application in a federally mandated format or (if no federal Standard has been promulgated) such other format as DHS shall designate.

(15) EDI Submitter. A person or entity authorized to establish the Electronic Media connection with DHS to conduct an EDI Transaction. An EDI Submitter may be the Trading Partner, or may be an Agent of the Trading Partner.

(16) Electronic Media.

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

(17) Electronic Media Claims ("EMC"). An Electronic Media means of submitting claims or encounters for or in relation to payment of services or supplies provided by a Provider, Prepaid Health Plan, Clinic or Allied Agency (as defined herein) to a Covered Individual.

(18) Electronic Remittance Advice ("ERA"). A document or electronic file containing information pertaining to the disposition of a specific claim for payment of services or supplies rendered to Covered Individuals (as defined herein) which are filed with DHS on behalf of the Covered Individual by Providers, Clinics or Allied Agencies (as defined herein). The documents include, without limitation, information such as the Provider name and address, Individual name, date of service, amount billed, amount paid, whether the claim was approved or denied, and if denied, the specific reason for the denial. For Prepaid Health Plans the Remittance Advice file contains information on the adjudication status of claims submitted.

(19) Envelope. A control structure in a mutually agreed format for the electronic interchange of one or more encoded Data Transmissions either sent or received by the EDI Submitter or DHS.

(20) HIPAA Transaction Rule. The Standards for Electronic Transactions at 45 CFR Part 160 and 162 (2003) adopted by the U.S. Department of Health and Human Services to implement the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq. ("HIPAA").

(21) Information System. An interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications and trained personnel necessary for a successful Data Transmission.

(22) Lost or Indecipherable Transmission. A Data Transmission which is never received by or cannot be processed to completion by the receiving Party in the format or composition received because it is garbled or incomplete, regardless of how or why the message was rendered garbled or incomplete.

(23) Prepaid Health Plan. A managed health care, dental care, chemical dependency or mental health care organization that contracts with DHS on a case managed, prepaid, capitated basis under the Oregon Health Plan.

(24) Provider. An individual, facility, institution, corporate entity, or other organization which supplies or provides for the supply of services, goods or supplies to Covered Individuals pursuant to a Contract with DHS. The term "Provider" as used in these DHS EDI rules does not include Billing Providers as that term is used in the DMAP General Rules. DMAP Billing Providers are defined in these DHS EDI Rules as Agents (defined herein), except for DMAP Billing Providers that are Clinics (as defined herein).

(25) Registered Transaction. Each type of Transaction (e.g., claims submission, eligibility inquiry, etc.) applicable to a Trading Partner must be registered with DHS before it can be tested or approved for transmission. Registration is initiated with an EDI Registration Form.

(26) Security Access Codes. Those alpha-numeric codes assigned to the EDI Submitter by DHS for the purpose of allowing access to DHS's Information System for the purpose of successfully executing Data Transmissions or otherwise carrying out the express terms of a Trading Partner Agreement and these rules.

(27) Source Documents. Documents or electronic files containing underlying Data which is or may be required as part of a Data Transmission with respect to a claim for payment of charges for medical services rendered or supplies provided to a Covered Individual, or with respect to any other Transaction. Examples of Data contained within a specific Source Document may include, without limitation, the following: Individual's name and identification number, claim number, diagnosis code for the services rendered, dates of service, service procedure description, applicable charges for the services rendered, the Provider's, Prepaid Health Plan's, Clinic's or Allied Agency's name and/or identification number and signature.

(28) Standard. A rule, condition or requirement describing the following information for products, systems or practices:

(a) Classification of components;

(b) Specification of materials, performance, or operations; or

(c) Delineation of procedures.

(29) Standards for Electronic Transactions. A Transaction that complies with the applicable Standard adopted by the U.S. Department of Health and Human Services (DHHS) to implement the Standards for Electronic Transactions.

(30) Transaction. The exchange of Data between DHS and its Trading Partner using Electronic Media to carry out financial or administrative activities.

(31) Trade Data Log. The complete written summary of Data and Data Transmissions exchanged between DHS and an EDI Submitter over the period of time a Trading Partner Agreement is in effect and, including, without limitation, sender and receiver information, the date and time of transmission and the general nature of the transmission.

(32) Trading Partner. A Provider, Prepaid Health Plan, Clinic or Allied Agency (as defined herein) that has entered into a Trading Partner Agreement with DHS in order to satisfy all or part of its obligations under a Contract by means of EDI, ERA and/or EMC or any other mutually agreed means of electronic exchange or transfer of Data as provided for herein.

(33) Trading Partner Agreement ("TPA"). A specific written agreement between DHS and a Provider, Prepaid Health Plan, Clinic or Allied Agency that governs the terms and conditions for EDI Transactions in the performance of obligations under a Contract. A Provider, Prepaid Health Plan, Clinic or Allied Agency that has executed a TPA will be referred to herein as a Trading Partner in relation to those functions.

Stat. Auth.: ORS 409.050 & 409.110

Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264

Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0110
Purpose

(1) The purpose of these rules is to establish a registration process and requirements applicable to individuals or entities that desire to be treated as Trading Partners or EDI Submitters with the Department of Human Services. These rules govern the conduct of all EDI Transactions with DHS.

(2) These rules also set forth DHS EDI Transaction requirements for purposes of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d–1320d-8, Public Law 104-191, sec. 262 and sec 264, and the implementing Standards for Electronic Transactions Rule. The Standards for Electronic Transactions Rule permits the use of a Trading Partner Agreement ("TPA") to establish the parameters under which Covered Entities conduct Electronic Data Interchange ("EDI") Transactions. Where a federal HIPAA Standard has been adopted for an EDI Transaction, this rule should be construed to implement and not to alter the requirements of the Standards for Electronic Transactions Rule.

Stat. Auth.: ORS 409.050 & 409.110

Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0120
Registration Process

(1) EDI Registration is an administrative process governed by these EDI Transaction rules. The EDI Registration process is initiated by the submission of a Trading Partner Registration Agreement (TPA) by a Provider, Prepaid Health Plan, Clinic or Allied Agency, including all requirements and documentation required by these EDI rules.

(2) Trading Partners Must Be DHS Providers, Prepaid Health Plans, Clinics or Allied Agencies with a current DHS Contract. DHS will accept a TPA only from those individuals or entities who are Providers, Prepaid Health Plans, Clinics or Allied Agencies that have a current Contract with DHS.

(a) DHS may receive and hold the TPA for individuals or entities that have submitted a Provider Enrollment Agreement or other pending Contract, subject to the satisfactory execution of a Contract.

(b) Termination, revocation, suspension or expiration of the Contract shall be deemed to result in the concurrent termination, revocation, suspension or expiration of the TPA without any additional notice; except that the TPA shall remain in effect to the extent necessary for Trading Partner or DHS to complete obligations involving EDI under the Contract for dates of service when the Contract was in effect. Contracts that are periodically renewed or extended do not require renewal or extension of the TPA unless there is a lapse of time between Contracts.

(c) Failure to identify a current DHS Contract as requested during the registration process will result in a rejection of the TPA. DHS will verify that the Contract numbers identified by a Provider, Prepaid Health Plans, Clinic or Allied Agency are current Contracts.

(d) If Contract number or Contract status changes, a Trading Partner shall provide DHS with updated information within five (5) business days of the change in Contract status. If DHS determines that a valid Contract no longer exists, DHS shall discontinue EDI Transactions applicable for any time period in which the Contract no longer exists; except that the TPA shall remain in effect to the extent necessary for the Trading Partner or DHS to complete obligations involving EDI under the Contract for dates of service when the Contract was in effect.

(3) Trading Partner Agreement. In order to register as a Trading Partner with DHS, a Provider, Prepaid Health Plan, Clinic or Allied Agency must submit a signed TPA to DHS. Signing the TPA constitutes agreement by the Provider, Prepaid Health Plan, Clinic or Allied Agency to comply with all DHS EDI Rules, OAR 410-001-0100 through 410-001-0200, and other DHS, state and federal laws and regulations applicable to the application for and conduct of EDI Transactions with DHS, and further constitutes Provider's, Prepaid Health Plan's, Clinic's or Allied Agency's agreement to ensure compliance by its Agents with such laws, rules, policies and procedures.

(4) Application for Authorization. In addition to the requirements of subsection (3) of this Rule, a Trading Partner must submit an Application for Authorization to DHS. The Application provides specific identification of and legal authorization from the Trading Partner for the EDI Submitter to conduct EDI Transactions on behalf of the Trading Partner.

(5) Trading Partner Agents. A Trading Partner may use Agents in order to facilitate the electronic transmission of Data. If Trading Partner will be using an Agent as the EDI Submitter, the Application for Authorization required under subsection (4) of this Rule shall identify and authorize the EDI Submitter and shall include the EDI Certification signed by the EDI Submitter before DHS may accept an electronic submission from, or send an electronic transmission to, such EDI Submitter. Submitting an Application for Authorization is not a guarantee that the EDI Submitter has been accepted by DHS to conduct EDI transactions.

(6) EDI Registration. In addition to the requirements of subsection (3) of this Rule, a Trading Partner shall also submit its EDI Registration Form. This form requires the Trading Partner or its authorized EDI Submitter to register the EDI Submitter and the name and type of EDI Transaction(s) they are prepared to conduct. Signature of the Trading Partner or authorized EDI Submitter is required on the EDI Registration Form. The Registration Form will also permit the Trading Partner to identify the individuals or EDI Submitter(s) who are authorized to submit or receive EDI Registered Transactions.

(7) Review and Acceptance Process. DHS shall review the documentation provided to determine compliance with sections (1)–(6) of this Rule. Submission of such information is not a guarantee that a TPA or an authorization of an EDI Submitter has been accepted by DHS. The information provided may be subject to verification by DHS. When DHS determines that the information complies with these EDI rules, DHS will notify the Trading Partner and EDI Submitter by email about any testing or other requirements applicable to place the Registered Transaction(s) into a production environment.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0130
Trading Partner as EDI Submitter

(1) Trading Partner may be EDI Submitter. Any registered Trading Partner that also qualifies as an EDI Submitter may submit his or her own EDI transactions directly to DHS. The Trading Partner will be referred to as the EDI Submitter when functioning in that capacity, and shall be required to comply with all terms and conditions of the these rules applicable to an EDI Submitter, except as expressly provided in subsection (3) of this Rule.

(2) Authorization and Registration Designating Trading Partner as EDI Submitter. Prior to acting as an EDI Submitter, the Trading Partner shall designate in the Application for Authorization that Trading Partner is the EDI Submitter who is authorized to send and/or receive Data Transmissions in the performance of EDI transactions. Trading Partner must complete the "Trading Partner Application for Authorization to Submit EDI Transactions" and the "EDI Submitter Information" required in the Application. Trading Partner shall also submit the EDI Registration Form identifying Trading Partner as the EDI Submitter in applicable required fields. The Trading Partner shall notify DHS of any material changes in the information no less than ten (10) days prior to the effective date of such changes.

(3) EDI Submitter Certification Conditions Not Required. Where Trading Partner is acting as its own EDI Submitter, Trading Partner is not required to submit the EDI Submitter Certification Conditions in the Application for Authorization applicable to Agents.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0140
Trading Partner Agents as EDI Submitters

(1) Responsibility for Agents. If the Trading Partner uses the services of an Agent, including but not limited to an EDI Submitter, in any capacity in order to receive, transmit, store or otherwise process Data or Data Transmissions or perform related activities, the Trading Partner shall be fully responsible to DHS for any acts, failures or omissions of the Agent in providing said services as though they were the Trading Partner's own acts, failures or omissions.

(2) Notices Regarding EDI Submitter. Prior to the commencement of an EDI Submitter's services, the Trading Partner shall designate in the Application for Authorization, its specific EDI Submitter(s) that are authorized to send and/or receive Data Transmissions in the performance of EDI Transactions of the Trading Partner. Trading Partner must complete the "Trading Partner Authorization of EDI Submitter" and the "EDI Submitter Information" required in the Application. Trading Partner shall also submit the EDI Registration Form identifying and providing information about the EDI Submitter in applicable required fields. The Trading Partner or authorized EDI Submitter shall notify DHS of any material changes in the EDI Submitter authorization or information no less than five (5) days prior to the effective date of such changes.

(3) Authority of EDI Submitter. A Trading Partner shall authorize the actions that an EDI Submitter may take on behalf of Trading Partner. The Application for Authorization permits the Trading Partner to authorize which decisions may be made only by Trading Partner and which decisions are authorized to be made by the EDI Submitter. The EDI Submitter information authorized in the Application for Authorization will be recorded by DHS in an EDI Submitter profile. DHS may reject EDI Transactions from an EDI Submitter acting without authorization from the Trading Partner.

(4) EDI Submitter Certification Conditions. Each authorized EDI Submitter acting as an Agent of a Trading Partner shall execute and shall comply with the EDI Submitter Certification Conditions that are incorporated into the Application for Authorization. Failure to include the

signed EDI Submitter Certification Conditions with the Application shall result in a denial of EDI Submitter authorization by DHS. Failure of an EDI Submitter to comply with the EDI Submitter Certification Conditions may result in termination of EDI Submitter registration for EDI Transactions with DHS.

(5) Responsibilities Regarding EDI Submitters. In addition to the requirements of section (1) of this Rule, the Trading Partner is responsible for ensuring that the EDI Submitter will make no unauthorized changes in the Data content of any and all Data Transmissions or the contents of an Envelope, and further that such EDI Submitter will take all appropriate measures to maintain the timeliness, accuracy, truthfulness, confidentiality, security and completeness of each Data Transmission. Furthermore, the Trading Partner further is responsible for ensuring that its EDI Submitter(s) are specifically advised of, and will comply in all respects with, the terms of these rules and any TPA.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0150
Testing

(1) When a Trading Partner or authorized EDI Submitter registers an EDI Transaction with DHS, DHS may require testing before authorizing the Transaction. Testing may include both third party compliance testing and business-to-business testing. An EDI Submitter must be able to demonstrate its capacity to send and/or receive each Transaction type for which it has registered. DHS will reject any EDI Transaction if the EDI Submitter either refuses or fails to comply with DHS testing requirements.

(2) Except as otherwise provided for by DHS, DHS may require its EDI Submitters to complete compliance testing, at the EDI Submitter's expense, for each Transaction type with a DHS selected third party testing firm. Use of the third party testing service allows DHS to efficiently manage the testing process by ensuring that each EDI Submitter has reached a standard level of readiness to send and receive compliant EDI Transactions before entering in to business-to-business testing.

(3) After successfully demonstrating the ability to sustain compliant third party testing and obtaining required documentation of successful completion of third party testing requirements for a specific Transaction type to DHS satisfaction, DHS shall initiate business-to-business testing for that Transaction type.

(4) When business-to-business testing is completed to DHS satisfaction, DHS will notify the EDI Submitter that it will register and accept the Transaction(s) in the production environment. This notification authorizes the EDI Submitter to submit the registered EDI Transaction(s) to DHS for processing and response, as applicable. If there are any changes in the Trading Partner or EDI Submitter authorization, profile data or EDI Registration information on file with DHS, updated information shall be submitted to DHS as required in OAR 410-001-0190 of these Rules.

(5) Testing will be conducted using secure Electronic Media communications methods.

(6) The EDI Submitter may be required to re-test with DHS if DHS format changes or if the EDI Submitter format changes.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0160
Conduct of Transactions

(1) EDI Submitter Obligations. In addition to the obligations of the Trading Partner and/or Agent(s) set forth elsewhere in these rules, the EDI Submitter is responsible for the conduct of the EDI Transactions registered on behalf of the Trading Partner, including the following:

(a) Accuracy of EDI Transmission. The EDI Submitter shall take reasonable care to ensure that Data and Data Transmissions are timely, complete, accurate and secure, and shall take reasonable precautions to prevent unauthorized access to the Information System, the Data Transmission itself or the contents of an Envelope which is transmitted either to or from DHS pursuant to these rules. DHS will not correct or modify an incorrect Transaction prior to processing; such Transactions may be rejected and the EDI Submitter will be notified of the rejection.

(b) Re-transmission of Indecipherable Transmissions. Where there is evidence that a Data Transmission is a Lost or Indecipherable Transmission, the sending party shall make best efforts to trace and re-transmit the original Data Transmission in a manner which allows it to be processed by the receiving party as soon as practicable.

(c) Cost of Equipment. EDI Submitter and DHS shall bear their own Information System costs. EDI Submitter shall, at its own expense, obtain and maintain its own Information System. Furthermore, EDI Submitter shall pay its own costs for any and all charges related to Data Transmission under these DHS EDI rules and specifically including without limitation, charges for Information System equipment, software and services, charges for maintaining an electronic mailbox, connect time, terminals, connections, telephones, modems, and any applicable minimum use charges, and for translating, formatting, or sending and receiving communications over the electronic network to the electronic mailbox, if any, of DHS. DHS is not responsible for providing technical assistance in the processing of an EDI Transaction.

(d) Back-up Files. EDI Submitter shall maintain adequate Data archives and back-up files or other means sufficient to re-create a Data Transmission in the event that such re-creation becomes necessary for any purpose, within a timeframe as required by other state and federal law, or by contractual agreement. Such Data archives or back-up files shall be subject to the terms of these DHS EDI rules to the same extent as the original Data Transmission.

(e) Format of Transmissions. Except as otherwise provided herein, the EDI Submitter shall send and receive all Data Transmissions in the federally mandated format, or (if no federal Standard has been promulgated) such other format as DHS shall designate.

(f) Testing. EDI Submitter shall, prior to the initial Data Transmission and throughout the term of a TPA, test and cooperate with DHS in the testing of Information Systems as DHS considers reasonably necessary to ensure the accuracy, timeliness, completeness and confidentiality of each Data Transmission.

(2) Security and Confidentiality. In addition to the other obligations in these rules, EDI Submitter shall also be specifically obligated to do all of the following:

(a) To refrain from copying, reverse engineering, disclosing, publishing, distributing or altering any Data, Data Transmissions or the contents of an Envelope, except as necessary to comply with the terms of these rules or the TPA, or use the same for any purpose other than that for which the EDI Submitter was specifically given Access and authorization by DHS or the Trading Partner;

(b) To refrain from obtaining Access by any means to any Data, Data Transmission, Envelope or DHS's Information System for any purpose other than that which the EDI Submitter has received express authorization to receive Access. Furthermore, in the event that the EDI Submitter receives Data or Data Transmissions from DHS, which are clearly not intended for the receipt of the EDI Submitter, the EDI Submitter shall immediately notify DHS and make arrangements to return the Data or Data Transmission or re-transmit the Data or Data Transmission to DHS. After such re-transmission, the EDI Submitter shall immediately delete the Data contained in such Data Transmission from its Information System;

(c) To install necessary security precautions to ensure the security of the Information System or records relating to the Information System of either DHS or the EDI Submitter when the Information System is not in active use by the EDI Submitter;

(d) To protect and maintain at all times the confidentiality of Security Access Codes issued by DHS to the EDI Submitter; and

(e) To provide special protection for security and other purposes, where appropriate, by means of authentication, encryption, the use of passwords or by other mutually agreed means. Unless otherwise provided in these DHS EDI rules, the recipient of a Data Transmission so protected shall use at least the same level of protection for any subsequent transmission of the original Data Transmission.

(3) DHS Obligations. In addition to the other obligations of DHS, which are set forth herein, DHS shall also do the following:

(a) Availability of Data. DHS shall, subject to the terms of these DHS EDI Rules, make available to the EDI Submitter by Electronic Media those types of Data and Data Transmissions which the EDI Submitter is authorized to receive.

(b) Notices Regarding Formats. DHS shall inform the EDI Submitter of acceptable formats in which Data Transmissions may be made and shall provide such notices to the EDI Submitter within reasonable time periods consistent with HIPAA Transaction Standards, if applicable, or at least thirty (30) days prior electronic notice of other changes in such formats.

(c) Security Access Codes. DHS shall arrange to provide the EDI Submitter with Security Access Codes which will allow the EDI Submitter access to DHS's Information System. It is expressly required by these rules that such Security Access Codes are strictly confidential and specifically subject, without limitation, to any and all of the restrictions contained in OAR 410-001-0170. Furthermore, DHS reserves the right to change the designated Security Access Codes at any time and in such manner as DHS in its sole discretion deems necessary. Furthermore, the release of Security Access Codes shall be limited to authorized electronic data personnel of EDI Submitter and DHS with a need to know.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0170
Confidentiality and Security

General Requirements. The Trading Partner and any EDI Submitter or other Agent(s) shall maintain adequate security procedures to prevent unauthorized Access to Data, Data Transmissions, Security Access Codes or the DHS Information System, and shall immediately notify DHS of any and all unauthorized attempts by any person or entity to obtain Access to or otherwise tamper with the Data, Data Transmissions, Security Access Code or the DHS Information System.

(1) Individually Identifiable Health Information. The Trading Partner and EDI Submitter or other Agent(s) and DHS are responsible for ensuring the confidentiality of Individually Identifiable Health Information, consistent with the requirements of the Privacy Statutes and Regulations, and shall take reasonable action to prevent any unauthorized disclosure of Confidential Information by the Trading Partner and any EDI Submitter or other Agent(s).The Trading Partner and EDI Submitter or other Agent(s) shall in their performance under these DHS EDI Rules, comply with any and all applicable Privacy Statutes and Regulations relating to Confidential Information (as defined in these rules).

(2) Notice of Unauthorized Disclosures. The Trading Partner and EDI Submitter will promptly notify DHS of any and all unlawful or unauthorized disclosures of Confidential Information that comes to its attention or to the attention of its Agent(s), and will cooperate with DHS in the event that corrective action is required by DHS. DHS will promptly notify the Trading Partner and EDI submitter of any and all unlawful or unauthorized disclosures of Confidential Information that comes to its attention of the attention of its Agent(s), and will cooperate with the Trading Partner in the event corrective action is required pursuant to contract or Privacy regulations.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0180
Record Retention and Audit

(1) Records Retention. The Trading Partner and EDI Submitter shall maintain, for a period of no less than seven (7) years from the date of its receipt complete, accurate and unaltered copies of any and all Source Documents associated with all Data Transmissions.

(2) Trade Data Log. The EDI Submitter shall establish and maintain a Trade Data Log which shall record any and all Data Transmissions taking place between the EDI Submitter and DHS during the term of a TPA. The Trading Partner and EDI Submitter will take necessary and reasonable steps to ensure that such Trade Data Log constitutes a current, truthful, accurate, complete and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Trade Data Log may be maintained on Electronic Media or other suitable means provided that, if it is necessary to do so, the information contained in the Trade Data Log may be timely retrieved and presented in readable form.

(3) Right to Audit. The Trading Partner shall allow, and shall require any EDI Submitter or other Agent to allow, access to DHS, the Oregon Secretary of State, the Oregon Department of Justice Medicaid Fraud Unit, or its designees, and the U.S. Department of Health and Human Services, or its designees, to audit those relevant business records, Source Documents, Data, Data Transmissions, Trade Data Log or Information System of the Trading Partner and/or its Agents as necessary to ensure compliance with these DHS EDI Rules. Trading Partner shall allow, and shall require any EDI Submitter or other Agent to allow, Access by DHS or its designees to ensure that adequate security precautions have been made and are implemented by the Trading Partner and its EDI Submitter or other Agent(s) in order to prevent unauthorized disclosure of any Data, Data Transmissions or other information.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0190
Material Changes

(1) Changes in Any Material Information. Trading Partner shall submit an updated TPA, Application for Authorization or EDI Registration form to DHS within ten (10) business days of any material changes in the information. A material change includes but is not limited to changes in address or email address, Contract number or Contract status (termination, expiration, extension), identification of authorized individuals of the Trading Partner or EDI Submitter, the addition or deletion of authorized Transactions, or any other change that may affect the accuracy of or authority for an EDI Transaction. DHS is authorized to act on Data Transmissions submitted by the Trading Partner and its EDI Submitter(s) based on information on file in the Application for Authorization and EDI Registration forms until an updated form has been received and approved by DHS. Trading Partner's signature or the signature of an authorized EDI Submitter is required to ensure that an updated TPA, Authorization or EDI Registration form is valid and authorized.

(2) Failure to submit a timely updated form may impact the ability of a Data Transaction to be processed without errors. Failure to submit a signed updated form may result in a rejection of a Data Transmission.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

410-001-0200
DHS System Administration

(1) No person or entity shall be registered to conduct an EDI Transaction with DHS except as authorized under these DHS EDI rules. Eligibility and continued participation as a Trading Partner or EDI Submitter in the conduct of Registered Transactions is conditioned on the execution and delivery of the documents required in these DHS EDI Rules, the continued accuracy of that information consistent with OAR 410-001-0190, and compliance with the requirements of these DHS EDI rules. The information disclosed by Trading Partner or any EDI Submitter may be subject to verification. Data, including Confidential Information, governed by these DHS EDI Rules may be used for purposes related to treatment, payment and health care operations and for the administration of programs or services by DHS.

(2) In addition to the requirements of subsection (1) of this Rule, in order to qualify as a Trading Partner:

(a) A person or entity must be a DHS Provider, Prepaid Health Plan, Clinic or Allied Agency pursuant to a current valid Contract; and

(b) The Provider, Prepaid Health Plan, Clinic or Allied Agency must have submitted an executed TPA and all related documentation, including the Application for Authorization that identifies and authorizes the EDI Submitter.

(3) In addition to the requirements of subsection (1) of this Rule, in order to qualify as an EDI Submitter:

(a) A Trading Partner must have identified the person or entity as an authorized EDI Submitter in the Application for Authorization.

(b) If the Trading Partner identifies itself as the EDI Submitter, the Application for Authorization must include the information required in the "Trading Partner Authorization of EDI Submitter" and the "EDI Submitter Information."

(c) If the Trading Partner uses an Agent as the EDI Submitter, the Application for Authorization must include the information described in subsection (b) of this section and the signed EDI Submitter Certification.

(4) The EDI Registration process described in these DHS EDI rules provides DHS with essential profile information that may be used by DHS to confirm that the Trading Partner or EDI Submitter is not otherwise excluded or disqualified from submitting EDI Transactions to DHS.

(5) Nothing in these rules or a TPA prevents DHS from requesting additional information from a Trading Partner or EDI Submitter to determine their qualifications or eligibility for registration as a Trading Partner or EDI Submitter.

(6) DHS shall deny a request for registration as a Trading Partner Agreement or for authorization of an EDI Submitter or an EDI Registration if it finds any of the following:

(a) The Trading Partner or EDI Submitter has substantially failed to comply with the applicable administrative rules or laws; or

(b) The Trading Partner or EDI Submitter has been convicted of (or entered a plea of nolo contendere) a felony or misdemeanor related to a crime or violation of federal or state public assistance laws or Privacy Statutes or Regulations (as defined in these rules);

(c) The Trading Partner or EDI Submitter is excluded from participation in the Medicare program, as determined by the Secretary of Health and Human Services; or

(d) The Trading Partner or EDI Submitter fails to meet the qualifications as a Trading Partner or EDI Submitter.

(7) Failure to comply with the terms of these DHS EDI rules, a Trading Partner Agreement, or EDI Submitter Certification or failure of the Application or Certification to be accurate in any respect may also result in sanctions and/or payment recovery pursuant to the applicable DHS program Contract or DHS rule.

Stat. Auth.: ORS 409.050 & 409.110
Stats. Implemented: Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d - 1320d-8, Public Law 104-191, Sec. 262 & Sec. 264
Hist.: OMAP 25-2003(Temp), f. & cert. ef. 3-21-03 thru 9-8-03; OMAP 55-2003, f. & cert. ef. 8-22-03

DIVISION 4

REGULATION OF COUNTY CAPACITY OF RESIDENTIAL CARE FACILITIES

410-004-0001 [Renumbered to **309-035-0500**]

DIVISION 5

RESIDENTIAL CARE, TREATMENT, AND TRAINING FACILITIES

Providing Services to Residential Care Clients

410-005-0080 [Renumbered to **309-035-0550**]

410-005-0085 [Renumbered to **309-035-0560**]

410-005-0090 [Renumbered to **309-035-0570**]

410-005-0095 [Renumbered to **309-035-0580**]

410-005-0100 [Renumbered to **309-035-0590**]

410-005-0105 [Renumbered to **309-035-0600**]

DIVISION 6

CONFIDENTIALITY AND MEDIATION COMMUNICATIONS

410-006-0011 [Renumbered to **407-014-0200**]

410-006-0021 [Renumbered to **407-014-0205**]

DIVISION 7

CRIMINAL HISTORY CHECK RULES

410-007-0200 [Renumbered to **407-007-0200**]

410-007-0210 [Renumbered to **407-007-0210**]

410-007-0220 [Renumbered to **407-007-0220**]

410-007-0230 [Renumbered to **407-007-0230**]

410-007-0240 [Renumbered to **407-007-0240**]

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410-007-0260 [Renumbered to **407-007-0260**]

410-007-0270 [Renumbered to **407-007-0270**]

410-007-0280 [Renumbered to **407-007-0280**]

410-007-0290 [Renumbered to **407-007-0290**]

410-007-0300 [Renumbered to **407-007-0300**]

410-007-0310 [Renumbered to **407-007-0310**]

410-007-0320 [Renumbered to **407-007-0320**]

410-007-0330 [Renumbered to **407-007-0330**]

410-007-0340 [Renumbered to **407-007-0340**]

410-007-0350 [Renumbered to **407-007-0350**]

410-007-0360 [Renumbered to **407-007-0360**]

410-007-0370 [Renumbered to **407-007-0370**]

410-007-0380 [Renumbered to **407-007-0380**]

DIVISION 8

STANDARDS FOR MARIJUANA EVALUATION SPECIALISTS

410-008-0000 [Renumbered to **415-054-0300**]

410-008-0005 [Renumbered to **415-054-0310**]

410-008-0010 [Renumbered to **415-054-0320**]

410-008-0015 [Renumbered to **415-054-0330**]

410-008-0020 [Renumbered to **415-054-0340**]

410-008-0025 [Renumbered to **415-054-0350**]

410-008-0030 [Renumbered to **415-054-0360**]

410-008-0035 [Renumbered to **415-054-0370**]

DIVISION 9

ABUSE REPORTING AND PROTECTIVE SERVICES IN COMMUNITY PROGRAMS AND COMMUNITY FACILITIES

410-009-0050 [Renumbered to **407-045-0250**]

410-009-0060 [Renumbered to **407-045-0260**]

410-009-0070 [Renumbered to **407-045-0270**]

410-009-0080 [Renumbered to **407-045-0280**]

410-009-0090 [Renumbered to **407-045-0290**]

410-009-0100 [Renumbered to **407-045-0300**]

410-009-0110 [Renumbered to **407-045-0310**]

410-009-0120 [Renumbered to **407-045-0320**]

410-009-0130 [Renumbered to **407-045-0330**]

410-009-0140 [Renumbered to **407-045-0340**]

410-009-0150 [Renumbered to **407-045-0350**]

410-009-0160 [Renumbered to **407-045-0360**]

DIVISION 11

ABUSE OF INDIVIDUALS LIVING IN STATE HOSPITALS AND RESIDENTIAL TRAINING CENTERS

410-011-0000 [Renumbered to **407-045-0400**]

410-011-0010 [Renumbered to **407-045-0410**]

410-011-0020 [Renumbered to **407-045-0420**]

410-011-0030 [Renumbered to **407-045-0430**]

410-011-0040 [Renumbered to **407-045-0440**]

410-011-0050 [Renumbered to **407-045-0450**]

410-011-0060 [Renumbered to **407-045-0460**]

410-011-0070 [Renumbered to **407-045-0470**]

410-011-0080 [Renumbered to **407-045-0480**]

410-011-0090 [Renumbered to **407-045-0490**]

410-011-0100 [Renumbered to **407-045-0500**]

410-011-0110 [Renumbered to **407-045-0510**]

410-011-0120 [Renumbered to **407-045-0520**]

DIVISION 14

PRIVACY OF PROTECTED INFORMATION

410-014-0000
Privacy Definitions

(1) Administrative Hearing: An Administrative proceeding, whether conducted by the director, administrator, designated employee of an Oregon state agency, or an administrative hearing officer in a contested case hearing pursuant to Oregon law.

(2) Authorization: Permission by an Individual, or his/her Personal Representative(s) for the release or use of information. An "authorization" is a written document that gives DHS permission to obtain and use information from third parties for specified purposes or to disclose information to a third party specified by the Individual.

(3) Business Associate: An Individual or entity who performs on behalf of the Department any function or activity involving the Use or Disclosure of Protected Health Information (PHI) and is not a member of the Department's workforce.

(a) The definition of "function or activity" includes: claims processing or administration, data analysis, utilization review, quality assurance, billing, legal, actuarial, accounting, consulting, data processing, management, administrative, accreditation, financial services and similar services for which the Department might contract are included, if access to PHI is involved.

(b) Business associates do not include Licensees or Providers unless the Licensee or Provider also performs some "function or activity" on behalf of DHS.

(4) Client: An Individual who requests or receives services from the Department of Human Services. Examples of Clients include but are not limited to: Applicants for or recipients of public assistance; minors and adults receiving protective services from DHS; Oregon Health Plan Members or Enrollees; persons who apply for or are admitted to a state training center or a state hospital or who are committed to the custody of the Department; children in the custody of the Department receiving services on a voluntary basis; and children committed to the custody of DHS.

(5) Client Information: Personal information relating to a DHS Client which DHS may maintain in one or more locations and in various forms, reports, or documents, including information that is stored or transmitted by electronic media.

(6) Collect/Collection: The assembling of personal information through interviews, forms, reports, or other information sources.

(7) Contract: The specific written agreement between DHS and a contractor setting forth the rights and obligations of the parties, including but not limited to contracts, licenses, agreements, interagency agreements, and intergovernmental agreements.

(8) Correctional Institution: Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. "Other persons held in lawful custody" includes juvenile offenders, adjudicated delinquents; aliens detained awaiting deportation, witnesses, or others awaiting charges or trial.

(9) Corrective Action: For purposes of DHS programs, an action that a DHS Business Associate must take to remedy a breach or violation of the Business Associate's obligations under the Business Associate agreement or other contractual requirement, including but not limited to reasonable steps that must be taken to cure the breach or end the violation, as applicable.

(10) Covered Entity: Health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a transaction that is subject to federal HIPAA requirements, as those terms are defined and used in the HIPAA regulations, 45 CFR Parts 160 and 164.

(11) Cure Letter: A letter sent by DHS to a Business Associate describing actions that the Business Associate will take to correct errors or defects that have occurred under a contract between the parties or other legal requirement.

(12) Department: The Department of Human Services (DHS).

(13) DHS: The Department of Human Services, also referred to as "The Department."

(14) DHS Workforce: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for DHS, is under the direct control of DHS, whether or not they are paid by DHS.

(15) Disclosure/ Disclose: The release, transfer, relay, provision of access to, or conveying of Client information to any individual or entity outside DHS.

(16) Employee: A public employee or officer for whom DHS is the appointing official.

(17) Health Care: Care, services or supplies related to the health of an individual. Health Care includes but is not limited to: preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling services, assessment, or procedure with respect to the physical or mental condition, or functional status of an individual, or that affects the structure or function of the body; and the sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

(18) Health Care Operations: Any of the following activities of DHS to the extent that the activities are related to Health Care, Medicaid or any other Health care related programs, services, or activities administered by DHS:

(a) Conducting quality assessment and improvement activities, including income evaluation and development of clinical guidelines.

(b) Population-based activities related to improving health or reducing Health Care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about Treatment alternatives; and related functions that do not include Treatment.

(c) Reviewing the competence of qualifications of Health Care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students and trainees in areas of Health Care learn under supervision to practice or improve their skills, accreditation, certification, licensing, or credentialing activities.

(d) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract for Medicaid or Health Care related services.

(e) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs, and disclosure to the Medicaid Fraud Unit pursuant to 43 CFR 455.21.

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating DHS, including administration, development or improvement of methods of payments or Health Care coverage.

(g) Business management and general administrative activities of DHS, including but not limited to the following:

(A) Management activities relating to implementation of and compliance with the requirements of HIPAA;

(B) Customer service, including the provision of data analysis;

(C) Resolution of internal grievances, including administrative hearings and the resolution of disputes from patients or enrollees regarding the quality of care and eligibility for services.

(D) Creating de-identified data or a limited data set.

(19) Health Oversight Agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or grantees that is authorized by law to oversee the health care system or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant. When performing such functions, DHS acts as a Health Oversight Agency for the purposes of these DHS Privacy Rules.

(20) HIPAA: Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq., and the federal regulations adopted to implement the Act.

(21) Individual: The person who is the subject of information collected, used or disclosed by DHS.

(22) Individually Identifying Information: Any single item or compilation of information or data that indicates or reveals the identity of an Individual, either specifically (such as the individual's name or social security number), or that does not specifically identify the Individual but from which the Individual's identity can reasonably be ascertained.

(23) Information: Personal information relating to an individual, a participant, or a client of DHS.

(24) Inmate: A person incarcerated in or otherwise confined in a correctional institution. An individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in custody.

(25) Institutional Review Board (IRB): A specially constituted review body established or designated by an entity in accordance with 45 CFR Part 46 to protect the welfare of human subjects recruited to participate in biomedical or behavioral research.

(26) Law enforcement official: An officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

(a) Investigate or conduct an official inquiry into a potential violation of law; or

(b) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

(27) Licensee: A person or entity that applies for or receives a license, certificate, registration or similar authority from DHS to perform or conduct a service or activity or function.

(28) Minimum Necessary: The least amount of information, when using or disclosing confidential client information, that is needed to accomplish the intended purpose of the use, disclosure or request.

(29) Non-routine Disclosure: A disclosure of records that is not for a purpose for which it was collected.

(30) Participant: Individuals participating in DHS population-based services, programs, and activities that serve the general population, but who do not receive program benefits or direct services received by a "Client." Examples of "Participants" include but are not limited to: A person whose birth certificate is recorded with DHS Vital Statistics; the subjects of public health studies, immunization or cancer registries, newborn screening, and other public health services; and Individuals who contact DHS hotlines or the ombudsman for general public information services.

(31)(a) Payment: Any activities undertaken by DHS related to an individual to whom Health Care or Payment for Health Care is provided in order to:

(A) Obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Medicaid Program or other publicly funded Health Care services;

(B) Obtain or provide reimbursement for the provision of health care.

(b) Payment activities include:

(A) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication of health benefit or Health Care claims;

(B) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(C) Billing, claims management, collection activities, obtaining payment under a Contract for reinsurance, and related Health Care data processing;

(D) Review of Health Care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(E) Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and

(F) Disclosure to consumer reporting agencies of any of the following information relating to collection of premiums or reimbursement: name and address; date of birth; Payment history; account number; and name and address of the health care provider or health plan.

(32) Personal Representative: A person who has authority, under applicable state law, to act on behalf of an Individual who is an adult or an emancipated minor in making decisions related to the program, service or activity that DHS provides to the Individual. If under applicable state law a parent, guardian, DHS or other person acting in loco parentis has authority to act on behalf of an Individual who is an unemancipated minor in making decisions related to the program, service or activity, DHS will treat that person or DHS as the Personal Representative of the Individual. DHS policy, procedure or rule may include requirements related to documentation of the authority of the Personal Representative.

(33) Privacy Rights: The specific actions that an Individual can take or request to be taken with regard to the Uses and Disclosures of their Information.

(34) Protected Health Information (PHI): Any Individually Identifiable Health Information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Any data transmitted or maintained in any other form or medium by covered entities, including paper records, fax documents and all oral communications, or any other form, i.e. screen prints of eligibility information, printed e-mails that have identified individual's health information, claim or billing information, hard copy birth or death certificate. Protected Health Information excludes: school records that are subject to the Family Educational Rights and Privacy Act; and employment records held in the DHS' role as an employer.

(35) Protected Information: Any participant or client information that DHS may have in its records or files that must be safeguarded pursuant to DHS policy. This includes but is not limited to "individually identifying information."

(36) Provider: A person or entity that may seek reimbursement from DHS as a provider of services to DHS Clients pursuant to a Contract. For purposes of the DHS Privacy Rules, reimbursement may be requested on the basis of claims or encounters or other means of requesting Payment.

(37) Psychotherapy Notes: Notes recorded in any medium by a Health Care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session, or a group, joint, or family counseling session, when such notes are separated from the rest of the individual's record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date.

(38) Public Health Agency: An agency, including DHS, or a person or entity acting under a grant of authority from or contract with DHS or such public agency, that performs or conducts one or more of the following essential functions that characterize public health programs, services or activities:

(a) Monitor health status to identify community health problems;

(b) Diagnose and investigate health problems and health hazards in the community;

(A) Inform, educate, and empower people about health issues;

(B) Mobilize community partnerships to identify and solve health problems;

(C) Develop policies and plans that support individual and community health efforts;

(D) Enforce laws and regulations that protect health and ensure safety;

(E) Link people to needed personal health services and assure the provision of health care when otherwise unavailable;

(F) Assure a competent public health and personal health care workforce;

(G) Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and

(H) Research for new insights and innovative solutions to health problems. DHS provides and conducts a wide range of public health programs, services and activities.

(39) Public Health Authority: For purposes of these DHS Privacy Rules, Public Health authority is intended to have the same meaning as the HIPAA Privacy rules, as follows: "An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate." When performing functions as a Public Health Agency, DHS acts as a Public Health Authority for purposes of these DHS Privacy rules.

(40) Research: A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

(41) Required by Law: A duty or responsibility that federal or state law specifies that a person or entity must perform or exercise. Required by law includes but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of Information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or rules that require the production of Information, including statutes or rules that require such Information if payment is sought under a government program providing public benefits.

(42) Routine and Recurring Disclosure: The disclosure of records for a purpose that is compatible with the purpose for which the information was collected.

(43) Treatment, Payment, and Operation (TPO): Please refer to the separate definitions for Treatment, Payment, and Health care operations.

(44) Treatment: The provision, coordination, or management of Heath Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with the third party; consulting between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another.

(45) Use: The sharing of employment, application, utilization, examination, or analysis of information with DHS.

Stat. Auth.: ORS 409.010
Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

410-014-0010
Purpose of DHS Privacy Rules

(1) These DHS Privacy Rules set forth the general policies and procedures that govern the Collection, Use and Disclosure of Protected Information by DHS.

(a) Except as provided in subsection (c) of this section, State and federal statutes, rules, policies and procedures that govern the administration of DHS programs, services and activities continue to govern the Use and Disclosure of Protected Information in those DHS programs, services and activities.

(b) These DHS Privacy Rules also set forth DHS policies and procedures that govern the Use and Disclosure of Protected Health Information (PHI) for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320-d through 1320d-8, Pub L 104-191, sec. 262 and 264, and the implementing HIPAA Privacy Rules, 45 CFR 160 and 164.

(c) In the event that it is not possible to comply with the requirements of both subsections (a) and (b) of this section, DHS will act in accordance with whichever federal or state law imposes a stricter requirement regarding the privacy or safeguarding of Information and which provides the greater protection or access to the Individual who is the subject of the information, unless one of the following applies:

(A) Public health. Nothing in these rules shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, birth, or death, public health surveillance, or public health investigation or intervention.

(B) Child abuse. Nothing in these rules shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of child abuse.

(C) State regulatory reporting. Nothing in these rules shall limit the ability of the State of Oregon or DHS to require a health plan to report, or to provide access to Information for management audits, financial audits, program monitoring, facility licensure or certification, or individual licensure or certification.

(2) DHS may collect, maintain, use, transmit, share and Disclose Information about any Individual to the extent authorized by law to administer DHS programs, services and activities.

(3) DHS will safeguard Information, provide information about DHS' privacy practices, and observe privacy rights in accordance with these DHS Privacy Rules, OARs 410-014-0000 through 410-014-0070.

(4) When DHS obtains information about Licensee or providers, DHS may use and disclose such information consistent with federal and state laws and regulations. Information regarding the qualifications of Licensees and Providers are public records.

(a) DHS will safeguard confidential information about Licensees and providers consistent with federal and state rules and regulations and DHS policies and procedures.

(b) When DHS obtains information about individuals that relates to determining payment responsibility when a Provider submits a request for payment to DHS, DHS will safeguard such information consistent with federal and state laws and regulations and DHS policies and procedures.

(c) DHS is authorized to review the performance of Licensees and Providers in the conduct of their health oversight activities and will safeguard information obtained about individuals obtained during those activities in accordance with federal and state laws and regulations and DHS policies and procedures.

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Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

410-014-0020
Uses and Disclosures of Client or Participant Information

(1) Uses and Disclosures with Individual Authorization. Except as otherwise permitted or required by law and consistent with these DHS Privacy Rules, DHS must obtain a completed and signed Authorization for release of Information from the Individual, or the Individual's Personal Representative, before obtaining or using Protected Information about an Individual from a third party or disclosing Protected Information about the Individual to a third party.

(a) Uses and Disclosures must be consistent with what the Individual has approved on the signed Authorization form approved by DHS.

(b) DHS must document and retain each signed Authorization form for a minimum of six years.

(c) An Individual can revoke an Authorization at any time. The revocation must be in writing and signed by the Individual, except that substance abuse treatment patients may orally revoke an Authorization to Disclose Information obtained from substance abuse treatment programs. No revocation shall apply to Information already released while the Authorization was valid and in effect.

(2) Uses and Disclosures without Authorization. Unless prohibited or limited by federal or state laws or rules applicable to the DHS program, service, or activity, DHS may Use or Disclose Protected Information without written Authorization in the following circumstances:

(a) Individual access. DHS may Disclose Information to Individuals who have requested Disclosure to themselves of their Information, consistent with OAR 410-014-0020(6).

(b) Required by law. DHS may Use or Disclose information without an Individual's Authorization if the law requires such Disclosure, and the Use or Disclosure complies with, and is limited to, the relevant requirements of such law.

(c) Treatment, Payment, or Health Care Operations. DHS may Use or Disclose Information without Authorization:

(A) For its own Treatment, Payment, or Health Care Operations;

(B) To another Covered Entity or a Health Care Provider for the Payment activities of the entity that receives the Information;

(C) To another Covered Entity for the Health Care activities of that entity, if:

(i) Both that entity and DHS have or have had a relationship with the Individual who is the subject of the Information;

(ii) The Information pertains to such relationship; and

(iii) The Disclosure is for the purpose of:

(I) Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines; population-based activities relating to improving health or reducing Health Care costs; protocol development; case management and care coordination; contacting Health Care Providers and patients with Information about Treatment alternatives; and related functions that do not include Treatment; or

(II) Reviewing the competence or qualifications of Health Care professionals; evaluating practitioner and Provider performance; conducting training programs in which students, trainees or practitioners practice or improve their skills as Health Care Providers; training of non-health care professionals; and accrediting, certifying, licensing, or credentialing activities; or

(III) Detecting Health Care fraud and abuse or for compliance purposes.

(d) Psychotherapy Notes. DHS may Use or Disclose Psychotherapy Notes:

(A) In training programs where students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;

(B) When a Health Oversight Agency Uses or Discloses in connection with oversight of the originator of the Psychotherapy Notes; or

(C) To the extent authorized under state law to defend DHS in a legal action or other proceeding brought by the Individual.

(e) Public health activities. DHS may Disclose an Individual's Protected Information to appropriate entities or persons for governmental public health activities and purposes, including but not limited to:

(A) A governmental Public Health Authority that is authorized by law to collect or receive such Information for the purpose of preventing or controlling disease, injury, or disability. This includes, but is not limited to, reporting disease, injury, and vital events such as birth or death; and the conducting of public health surveillance, investigations, and interventions;

(B) An official of a foreign government agency that is acting in collaboration with a lawful governmental Public Health Authority;

(C) A governmental Public Health Authority, or other appropriate government authority that is authorized by law to receive reports of child abuse or neglect;

(D) A person subject to the jurisdiction of the federal Food and Drug Administration (FDA), regarding an FDA-regulated product or activity for which that person is responsible, for activities related to the quality, safety, or effectiveness of such FDA-regulated product or activity; and

(E) A person who may have been exposed to a communicable disease, or may be at risk of contracting or spreading a disease or condition, if DHS or another Public Health Authority is authorized by law to notify such person as necessary in conducting a public health intervention or investigation.

(F) As a Public Health Authority, DHS is authorized to Use and Disclose an Individual's Protected Information in all cases in which DHS is permitted to Disclose such Information for the public health activities listed above.

(G) Exception: Where state or federal law prohibits or restricts Use or Disclosure of Information obtained or maintained for public health purposes, DHS will deny such Use or Disclosure accordingly.

(f) Child abuse reporting and investigation. If DHS has reasonable cause to believe that a child is a victim of abuse or neglect, DHS may Disclose Protected Information to appropriate governmental authorities authorized by law to receive reports of child abuse or neglect (including reporting to DHS protective services staff if appropriate). If DHS receives Information as the child protective services agency, DHS is authorized to Use and Disclose the Information consistent with its lawful authority.

(g) Adult abuse reporting and investigation. If DHS has reasonable cause to believe that an adult is a victim of abuse or neglect, DHS may Disclose Protected Information, as required by law, to a government authority, including but not limited to a social service or protective services agencies (which may include DHS) authorized by law to receive such reports. If DHS receives Information as the social services or protective services agency, DHS is authorized to Use and Disclose the Information consistent with its lawful authority.

(h) Health oversight activities. DHS may Disclose Information without Authorization for health oversight activities authorized by law, including audits; civil, criminal, or administrative investigations, prosecutions, or actions; licensing or disciplinary actions; Medicaid fraud; or other activities necessary for oversight.

(i) Judicial and administrative proceedings. To the extent otherwise authorized or unless prohibited by applicable federal and state law, DHS may Disclose Information without Authorization for judicial or administrative proceedings as required by law, in response to an order of a court, a subpoena, a discovery request, or other lawful process.

(A) In any case in which federal or state law prohibits or restricts the Use or Disclosure of Information in an administrative or judicial proceeding, DHS shall assert the confidentiality of such confidential Information, consistent with rules and policies adopted by DHS applicable to the DHS program, service, or activity, to the presiding officer at the proceeding.

(B) If a court orders DHS to conduct a mental examination (such as in accordance with state law at ORS 161.315, 161.365, 161.370, 419B.352), or orders DHS to provide any other report or evaluation to the court such examination, report or evaluation shall be deemed to be "required by law" for purposes of HIPAA.

(C) If DHS has obtained Information in performing its duties as a Health Oversight Agency, Public Health Authority, protective service entity, or public benefit program, DHS may lawfully Use that Information in a hearing consistent with the other confidentiality requirements applicable to that program, service or activity.

(j) Law enforcement purposes. For limited law enforcement purposes and to the extent authorized by applicable federal or state law, DHS may report certain injuries or wounds; provide Information to identify or locate a suspect, victim, or witness; alert law enforcement of a death as a result of criminal conduct; and provide Information which constitutes evidence of criminal conduct on DHS premises.

(k) Deceased persons. These DHS Privacy Rules apply to Uses and Disclosures or Protected Information about deceased Individuals.

(A) DHS may Disclose Individual Information to a coroner or medical examiner for the purpose of identifying a deceased Individual, determining a cause of death, or other duties authorized by law. If DHS personnel are performing the duty or function of a coroner or medical examiner, DHS may Use an Individual's Information for such purposes.

(B) DHS may Disclose Individual Information to funeral directors, consistent with applicable law, as needed to carry out their duties regarding the decedent. DHS may also Disclose such Information prior to, and in anticipation of, the death.

(l) Organ or tissue donation. DHS may Disclose Individual Information to organ procurement organizations or other entities engaged in procuring, banking, or transplantation of cadaver organs, eyes, or tissue, for the purpose of facilitating transplantation.

(m) Research. DHS may Disclose Individual Information without Authorization for research purposes, as specified in OAR 410-014-0060, "Uses and Disclosures of Protected Information for research purposes and waivers."

(n) To avert a serious threat to health or safety. DHS may Disclose Individual Information if:

(A) DHS believes in good faith that the Information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) The report is to a person or persons reasonably able to prevent or lessen the threat, including to the target of the threat.

(o) Specialized governmental functions. DHS may Disclose Protected Information for other specialized government functions, including to authorized federal officials for the conduct of lawful intelligence, counterintelligence, and other national security activities that federal law authorizes.

(p) Correctional Institutions and law enforcement custody situations. DHS may Disclose Information to a Correctional Institution or a Law Enforcement Official having lawful custody of an Inmate or other person, for the limited purpose of providing Health Care or ensuring the health or safety of the Individual or of other Inmates.

(q) Emergency Treatment. In case of an emergency, DHS may Disclose Individual Information to the extent needed to provide emergency Treatment.

(r) Government entities providing public benefits. To the extent authorized by law, DHS may Disclose eligibility and other Information to governmental entities administering a government program providing public benefits.

(3) Authorization not required if opportunity to object given. When permitted by law, DHS may Use or Disclose an Individual's Information without Authorization if the Individual has been informed in advance and has been given the opportunity to either agree or to refuse or restrict the Use or Disclosure.

(a) These Disclosures are limited to Disclosure of Information to a family member, other relative, or close personal friend of the Individual, or any other person named by the Individual, subject to the following limitations:

(A) DHS may reveal only the Protected Information that directly relates to such person's involvement with the Individual's care or Payment for such care.

(B) DHS may Use or Disclose Protected Information for notifying (including identifying or locating) a family member, Personal Representative, or other person responsible for care of the Individual, regarding the Individual's location, general condition, or death.

(C) If the Individual is present for, or available prior to, such a Use or Disclosure, DHS may Disclose the Protected Information if DHS:

(i) Obtains the Individual's agreement;

(ii) Provides the Individual an opportunity to object to the Disclosure, and the Individual does not express an objection; or

(iii) Reasonably infers from the circumstances that the Individual does not object to the Disclosure.

(D) If the Individual is not present, or the opportunity to object to the Use or Disclosure cannot practicably be provided due to the Individual's incapacity or an emergency situation, DHS may determine, using professional judgment, that the Use or Disclosure is in the Individual's best interests.

(b) Exception: Oral permission to Use or Disclose Information for purposes described in subsection (a) of this section is not sufficient when the Individual is referred to or receiving substance abuse Treatment, mental health or vocational rehabilitation services. Written Authorization is required under those circumstances, unless Disclosure is otherwise permitted under 42 CFR Part 2 or ORS 179.505.

(c) Personal Representative: DHS must treat a Personal Representative as the Individual for purposes of these DHS Privacy Rules, except that:

(A) A Personal Representative must be authorized under state law to act on behalf of the Individual with respect to Use or Disclosure of Information. DHS may require a Personal Representative to provide a copy of the document or order authorizing the person to act on behalf of the individual.

(B) DHS may elect not to treat a person as a Personal Representative of an Individual if:

(i) DHS has a reasonable belief that the Individual has been or may be subjected to domestic violence, abuse or neglect by such person; or treating such person as the Personal Representative could endanger the Individual; and

(ii) DHS, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's Personal Representative.

(4) Redisclosure. Unless otherwise prohibited by state and federal laws, Information held by DHS and authorized by the Individual for Disclosure may be subject to redisclosure and no longer Protected by these DHS Privacy Rules.

(a) Pursuant to federal regulations at 42 CFR part 2 and 34 CFR 361.38, DHS may not make further Disclosure of vocational rehabilitation and alcohol and drug rehabilitation Information without the specific written Authorization of the Individual to whom it pertains.

(b) Pursuant to ORS 433.045 and OAR 333-012-0270, DHS may not make further Disclosure of Individual Information pertaining to HIV/AIDS.

(c) Pursuant to ORS 659.700 through 659.720 and OAR 333-024-0500 through 333-024-0560, DHS may not make further Disclosure of an Individual's genetics Information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general Authorization for the release of medical Information is not sufficient for this purpose.

(d) DHS is subject to the restrictions in ORS 179.505 regarding redisclosure of Information regarding Clients of publicly funded mental health or developmental disability Providers.

(5) Requests for Disclosures of Information on a Routine or Recurring basis. For Routine and Recurring Disclosures, DHS will:

(a) Determine who is requesting the Information, the purpose for the request, and if the request is compatible with the purpose for which the Information was collected;

(b) Confirm that the applicable DHS policies and program rules permit the requested Use and that the nature or type of Use recurs within the program; and

(c) Identify the kind and amount of Information that is necessary to respond to the request and provide the Information that is reasonably necessary to accomplish the intended purpose or the Use or Disclosure.

(6) Non-Routine Requests for Disclosure of Information. For Non-routine Disclosures, DHS will:

(a) Determine who is requesting the Information and the purpose for the request. If the request is not compatible with the purpose for which the Information was collected, DHS will apply non-routine Disclosure procedures;

(b) Determine which Information about the Individual is within the scope of the request, and what DHS policies and program rules apply to the purpose for which the Information was collected and to the requested Disclosure;

(c) Deny the request if the requested Information is exempt from Disclosure under the Oregon Public Records Law or these DHS Privacy Rules; and

(d) If Information is subject to Disclosure, limit the Information Disclosed to the Minimum Necessary amount of Information necessary to accomplish the purpose for which the Disclosure is sought.

(7) Verification of person or entity requesting Information. DHS may not Disclose Information about an Individual without first verifying the identity of the person or entity requesting the Information, unless the DHS Workforce member fulfilling the request already knows the person or has already so verified identity.

(8) Denial of requests for Information. Unless an Individual has signed an Authorization, or unless DHS can Disclose the requested Information about the Individual without a signed Authorization pursuant to these DHS Privacy Rules, DHS shall deny any request for Information about an Individual.

(9) Whistleblowers. DHS is not considered to have violated the HIPAA Privacy Rules if a DHS Workforce member or Business Associate Discloses an Individual's Protected Information provided that:

(a) The DHS Workforce member or Business Associate believes, in good faith, that DHS has engaged in conduct that is unlawful or that otherwise violates professional standards or DHS policy, or that the care, services, or conditions provided by DHS could endanger DHS staff, persons in DHS care, or the public; and

(b) The Disclosure is to a government oversight agency or Public Health Authority, or an attorney of a DHS Workforce member or Business Associate retained for the purpose of determining the legal options of the Workforce member or Business Associate with regard to the conduct alleged under section (9) above; and

(c) Nothing in this rule is intended to interfere with ORS 659A.200 to 659A.224 describing the circumstances applicable to Disclosures by DHS Workforce or Business Associates.

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Stats. Implemented:
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410-014-0030
Client Privacy Rights

(1) General rights of Clients. DHS Clients have the right to, and DHS may not deny, the following:

(a) Access to their own Information, consistent with certain limitations pursuant to subsection (6) of this rule;

(b) Receive an accounting of Disclosures DHS has made of their Protected Health Information (PHI) for up to six years prior to the date of requesting such accounting pursuant to subsection (8) of this rule. However, DHS is not required to provide Information regarding Disclosures made prior to April 14, 2003, if DHS does not have such Information available, and certain limitations apply as specified in this rule.

(c) Submit complaints if they believe or suspect that DHS has improperly Used or Disclosed Information about them, or if they have concerns about the privacy policies of DHS pursuant to subsection (9) of this rule.

(2) Rights to request specific actions. Clients may ask DHS to take specific actions regarding the Use or Disclosure of their Information, and DHS may either approve or deny the request. Specifically, Clients have the right to request:

(a) That DHS restrict Uses and Disclosures of their Individual Information while carrying out Treatment, Payment activities, or Health Care Operations pursuant to subsection (4) of this rule;

(b) To receive Information from DHS by alternative means, such as mail, e-mail, fax, or telephone, or at alternative locations pursuant to subsection (5); and

(c) That DHS amend their Information that is held by DHS pursuant to subsection (7) of this rule.

(3) DHS Notice of Privacy Practices. Clients have the right to receive adequate notice from DHS of DHS privacy practices.

(a) DHS will provide each Client with a notice of DHS privacy practices that describes the duty of DHS to maintain the privacy of Protected Information and includes a description that clearly informs the Client of the types of Uses and Disclosures DHS is permitted or required to make;

(b) Whenever their is a material change in DHS privacy practices, DHS will revise the notice of privacy practices and make the revised notice available to all Clients. Any such changes to DHS privacy practices will apply to Information DHS already has as well as to any Information DHS receives in the future;

(c) DHS will post a copy of the DHS notice of privacy practices for public viewing at each DHS worksite and on the DHS website; and

(d) DHS will give a paper copy of the DHS notice of privacy practices to any person upon request.

(4) Right to request restrictions on Uses or Disclosures. Clients have the right to request restrictions on the Use or Disclosure of their Information.

(a) DHS may deny the Client's request or limit its agreement to restrict within the following provisions:

(A) DHS will not agree to restrict Uses or Disclosures of Information if the restriction would adversely affect the quality of the Client's care or services.

(B) DHS cannot agree to a restriction that would limit or prevent DHS from making or obtaining payment for services.

(b) DHS may not deny a Client's request for restriction of records of alcohol and drug Treatment or records relating to vocational rehabilitation services.

(c) DHS will document the Client's request, and the reasons for granting or denying the request, in the Client's hard-copy or electronic DHS case record file.

(d) If the Client needs emergency Treatment and the restricted Protected Information is needed to provide such Treatment, DHS may Use, or Disclose the restricted Protected Information to a Provider, for the limited purpose of providing Treatment. However, once the emergency situation subsides DHS will ask the Provider not to redisclose the Information.

(e) DHS may terminate its agreement to a restriction if:

(A) The Client agrees to or requests the termination in writing; or

(B) The Client orally requests or agrees to the termination, and DHS documents the oral request or agreement in the Client's DHS case record file; or

(C) With or without the Client's agreement, DHS informs the Client that DHS is terminating its agreement to the restriction. Information created or received while the restriction was in place shall remain subject to the restriction.

(5) Rights of Clients to request to receive information from DHS by alternative means or at alternative locations. DHS must accommodate reasonable requests by Clients to receive communications from DHS by alternative means, such as by mail, e-mail, fax, or telephone, and at an alternative location.

(a) The Client must specify the preferred alternative means or location.

(b) The Client may submit the request for alternative means or locations either orally or in writing.

(A) If the Client makes a request orally, DHS will document the request and ask for the Client's signature.

(B) If the Client makes a request by telephone or electronically, DHS will document the request and verify the identity of the requestor.

(c) DHS may terminate its agreement to an alternative location or method of communication if:

(A) The Client agrees to or requests termination of the alternative location or method of communication in writing or orally. DHS will document the oral agreement or request in the Client's DHS case record file.

(B) DHS informs the Client that DHS is terminating its agreement to the alternative location or method of communication because the alternative location or method of communication is not effective. DHS may terminate its agreement to communicate at the alternative location or by the alternate method if:

(i) DHS is unable to contact the Client at the location or by the method requested; or

(ii) The Client fails to respond to payment requests if applicable.

(6) Rights of Clients to access their Information. Clients have the right to access, inspect, and obtain a copy of Information on their own cases in DHS files or records, consistent with federal and state law.

(a) All requests for access will be made with the Client completing the approved DHS form.

(b) Clients may request access to their own Information that is kept by DHS by using a personal identifier such as the Client's name or DHS case number.

(c) If DHS maintains Information about the Client in a record that includes Information about other people, the Client is authorized to see Information only about himself or herself, except:

(A) If a person identified in the file is a minor child of the Client, and the Client is authorized under Oregon law to have access to the minor's Information or to act on behalf of the minor for making decisions about the minor's care, the Client may also obtain Information about the minor.

(B) If a person requesting information is recognized under Oregon law as a guardian or custodian of the Client and is authorized under Oregon law to have access to the Client's Information or to act on behalf of the Client for making decisions about the Client's services or care, DHS will release Information to the requestor.

(C) Under these special circumstances: the system in ORS 192.517(1), to protect and advocate the rights of Individuals with developmental disabilities under Part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.) and the rights of Individuals with mental illness under the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10801 et seq.), shall have access to all records, as defined in ORS 192.515, as provided in ORS 192.517.

(d) DHS may deny Clients access to their own Protected Health Information if federal law prohibits the disclosure. Clients have the right to access, inspect, and obtain a copy of health Information on their own cases in DHS files or records except for:

(A) Psychotherapy notes;

(B) Information compiled for Use in civil, criminal, or administrative proceedings;

(C) Information that is subject to the federal Clinical Labs Improvement Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2);

(D) Information that DHS believes, in good faith, can cause harm to the Client, Participant, or to any other person;

(E) Documents protected by attorney work-product privilege; and

(F) Information where release is prohibited by state or federal laws.

(e) DHS may deny a Client access to Protect Health Information (PHI), provided that DHS gives the Client a right to have the denial reviewed, in the following circumstances:

(A) A licensed Health Care professional or other designated staff has determined, in the exercise of professional judgment, that the Information requested may endanger the life or physical safety of the Client or another person; or

(B) The Protected Health Information makes reference to another person, and a licensed Health Care professional or other designated staff has determined, in the exercise of professional judgment, that the information requested may cause substantial harm to the Client or to another person; or

(C) The request for access is made by the Client's Personal Representative, and a licensed Health Care professional or other designated staff has determined, in the exercise of professional judgment, that allowing the Personal Representative to access the Information may cause substantial harm to the Client or to another person.

(f) If DHS denies access under subsection (6)(e) of this rule, the Client has the right to have the decision reviewed by a licensed Health Care professional or other designated staff not directly involved in making the original denial decision.

(A) DHS must promptly refer a Client's request for review to the designated reviewer.

(B) The reviewer must determine, within a reasonable time, whether or not to approve or deny the Client's request for access, in accordance with these DHS Privacy Rules.

(C) Based on the reviewer's decision, DHS must:

(i) Promptly notify the client in writing of the reviewer's determination; and

(ii) Take action to carry out the reviewer's determination.

(g) DHS must act on a Client's request for access no later than 30 days after receiving the request, except in the case of written accounts under ORS 179.505, which must be Disclosed within five (5) days.

(A) In cases where the Information is not maintained or accessible to DHS on-site, and does not fall under ORS 179.505, DHS must act on the Client's request no later than 60 days after receiving the request.

(B) If DHS is unable to act within these 30-day or 60-day limits, DHS may extend this time period by up to an additional 30 days, subject to the following:

(i) DHS must notify the Client in writing of the reasons for the delay and the date by which DHS will act on the request.

(ii) DHS will use only one such 30-day extension to act on a request for access.

(h) If DHS grants the Client's request, in whole or in part, DHS must inform the Client of the access decision and provide the requested access.

(A) If DHS maintains the same Information in more than one format (such as electronically and in a hard-copy file) or at more than one location, DHS need only provide the requested Information once.

(B) DHS must provide the requested Information in a form or format requested by the Client, if readily producible in that form or format. If not readily producible, DHS will provide the Information in a readable hard-copy format or such other format as agreed to by DHS and the Client.

(C) DHS may provide the Client with a summary of the requested Information, in lieu of providing access, or may provide an explanation of the Information if access has been provided, if:

(i) The Client agrees in advance; and

(ii) The Client agrees in advance to pay any fees DHS may impose, per subparagraph (6)(h)(F) of this rule.

(E) DHS must arrange with the Client for providing the requested access in a time and place convenient for the Client and DHS. This may include mailing the Information to the Client if the Client so requests or agrees.

(F) Fees: If a Client (or legal guardian or custodian) requests a copy of the requested Information, or of a written summary or explanation, DHS may impose a reasonable cost-based fee, limited to covering the following:

(i) Copying the requested Information, including the costs of supplies and the labor of copying;

(ii) Postage, when the Client has requested or agreed to having the Information mailed; and

(iii) Preparing an explanation or summary of the requested Information, if agreed to in advance by the Client.

(i) If DHS denies access, in whole or in part, to the requested Information, DHS must:

(A) Give the Client access to any other requested Client Information, after excluding the Information to which access is denied; and

(B) Provide the Client with a timely written denial. The denial must:

(i) Be sent or provided within the time limits specified in subsection (6)(g) of this rule;

(ii) State the basis of the denial, in plain language;

(iii) If the reason for the denial is due to danger to the Client or to another person, explain the Client's review rights as specified in subsection (6)(e) of this rule, including an explanation of how the Client may exercise these rights; and

(iv) Provide a description of how the Client may file a complaint with DHS, and if the Information is Protected Health Information (PHI), with the United States Department of Health and Human Services (DHHS), Office for Civil Rights, pursuant to section (9) of this rule.

(j) If DHS does not maintain the requested Information, in whole or in part, and knows where such Information is maintained (such as by a medical Provider, insurer, other public agency, private business, or other non-DHS entity), DHS must inform the Client of where to direct the request for access.

(7) Right of Clients to request amendment of their Information. Clients have the right to request that DHS amend Information about themselves in DHS files.

(a) For all requests for amendment, DHS will have the Client complete the approved DHS form.

(b) DHS is not obligated to agree to an amendment and may deny the request or limit its agreement to amend.

(c) DHS must act on the Client's request no later than 60 days of receiving the request. If DHS is unable to act within 60 days, DHS may extend this time limit by up to an additional 30 days, subject to the following:

(A) DHS must notify the Client in writing, within 60 days if receiving the request, of the reasons for the delay and the date by which DHS will act on the request; and

(B) DHS will use only one such 30-day extension for any such request.

(d) If DHS grants the request, in whole or in part, DHS must:

(A) Make the appropriate amendment to the Information or records, and document the amendment in the Client's DHS file or record;

(B) Provide timely notice to the Client that the amendment has been accepted, pursuant to the time limits under subsection (7)(c) of this rule;

(C) Seek the Client's agreement to notify other relevant persons or entities with whom DHS has shared or needs to share the amended Information; and

(D) Make reasonable efforts to inform, and to provide the amendment within a reasonable time to:

(i) Persons named by the Client as having received Information and who thus need the amendment; and

(ii) Persons, including Business Associates of DHS, that DHS knows have the Information that is the subject of the amendment and who may have relied, or could foreseeably rely, on the Information to the Client's detriment.

(e) Prior to any decision to amend a health or medical record, the request and any related documentation must be reviewed by the program's medical director, a licensed health care professional designated by the program administrator, or a DHS staff person involved in the Client's case.

(f) Prior to any decision to amend any other Information that is not a health or medical record, a staff person designated by DHS shall review the request and any related documentation.

(g) DHS may deny the Client's request for amendment if:

(A) DHS finds the Information to be accurate and complete;

(B) The Information was not originated by DHS, unless the Client provides a reasonable basis to believe that the originator of such Information is no longer available to act on the requested amendment;

(C) The Information is not part of DHS records; or

(D) The information would not be available for inspection or access by the Client, pursuant to subsection (6)(c) of this rule.

(h) If DHS denies the requested amendment, in whole or in part, DHS must provide the Client with a timely written denial. The denial must:

(A) Be sent within the time limits specified in subsection (7)(c) of this rule;

(B) State the basis for the denial, in plain language; and

(C) Explain the Client's right to submit a written statement disagreeing with the denial and how to file such a statement. If the Client files such a statement:

(i) DHS will enter the written statement into the Client's DHS case file;

(ii) DHS may also enter a DHS written rebuttal of the Client's written statement into the Client's DHS case record. DHS will send a copy of any such written rebuttal to the Client;

(iii) DHS will include a copy of the statement, and of any written rebuttal by DHS, with any future Disclosures of the relevant Information;

(iv) DHS will explain that if the Client does not submit a written statement of disagreement, the Client may ask that if DHS makes any further Disclosures of the relevant information, DHS will also include a copy of the Client's original request for amendment and a copy of the DHS written denial; and

(v) DHS will provide information on how the Client may file a complaint with DHS and, if the Information is Protected Health Information (PHI), with the United States Department of Health and Human Services (DHHS), Office for Civil Rights, pursuant to section (9) of this rule.

(8) Rights of Clients to request an accounting of Disclosures of Protected Health Information (PHI). Clients have the right to receive an accounting of Disclosures of PHI that DHS has made for any period of time, not to exceed six years, preceding the date of requesting the accounting.

(a) This right does not apply to Disclosures made prior to April 14, 2003.

(b) The accounting will include only PHI not previously authorized by the Client for Use or Disclosure, and will not include Information collected, Used, or Disclosed for Treatment, Payment, or Health Care Operations for that Client.

(c) For all requests for an accounting of Disclosures, DHS will have the Client complete the authorized DHS form (DHS 2096, "Accounting of Disclosures Request Form").

(d) DHS is not required to track and account for Disclosures that are:

(A) Authorized by the Client;

(B) Made prior to April 14, 2003;

(C) Made to carry out Treatment, Payment, or Health Care Operations;

(D) Made to the Client;

(E) Made to persons involved in the Client's care;

(F) Made as part of a limited data set in accordance with OAR 410-014-0070, "De-identification of Client Information and Use of limited data sets under data use agreements";

(G) Made for national security or intelligence purposes; or

(H) Made to Correctional Institutions or Law Enforcement Officials having lawful custody of an Inmate.

(e) The accounting must include, for each Disclosure:

(A) The date of the Disclosure;

(B) The name and address, if known, of the person or entity who received the Disclosed Information;

(C) A brief description of the Information Disclosed; and

(D) A brief statement of the purpose of the Disclosure that reasonably informs the Client of the basis for the Disclosure, or, in lieu of such statement, a copy of the Client's written request for a Disclosure, if any.

(f) If, during the time period covered by the accounting, DHS has made multiple Disclosures to the same person or entity for the same purpose, DHS may provide the required Information for only the first such Disclosure (DHS need not list the same identical information for each subsequent Disclosure to the same person or entity) if DHS adds:

(A) The frequency or number of disclosures made to the same person or entity; and

(B) The date of the most recent Disclosure during the time period for which the accounting is requested.

(g) DHS must act on the Client's request for an accounting no later than 60 days of receiving the request. If DHS is unable to act within 60 days, DHS may extend this time limit by up to an additional 30 days, subject to the following:

(A) DHS must notify the Client in writing, within 60 days of receiving the request, of the reasons for the delay and the date by which DHS will act on the request; and

(B) DHS will use only one such 30-day extension for any such request.

(h) Fees: DHS must provide the first requested accounting in any 12-month period without charge. DHS may charge the Client a reasonable cost-based fee for each additional accounting requested by the Client within the 12-month period following the first request, provided that DHS:

(A) Informs the Client of the fee before proceeding with any such additional request; and

(B) Allows the Client an opportunity to withdraw or modify the request in order to avoid or reduce the fee.

(i) DHS must document the Information required to be included in an accounting of Disclosures, as specified in subsection (8)(e) of this rule, and retain a copy of the written accounting provided to the Client.

(j) DHS will temporarily suspend a Client's right to receive an accounting of Disclosures that DHS has made to a Health Oversight Agency or to a Law Enforcement Official, for a length of time specified by such agency or official, if the agency or official provides a written or oral statement to DHS that such an accounting would be reasonably likely to impede their activities. However, if such agency or official makes an oral request, DHS will:

(A) Document the oral request, including the identity of the agency or official making the request.

(B) Temporarily suspend the Client's request to an accounting of Disclosures, pursuant to the request; and

(C) Limit the temporary suspension to no longer than 30 days from the date of the oral request, unless the agency or official submits a written request specifying a longer time period.

(9) Filing a complaint. Clients may file complaint with DHS or, if the Information is Protected Health Information, with the Office for Civil Rights of the United States Department of Health and Human Services (DHHS).

(a) Upon request, DHS must give Clients the name and address of the specific person or office of where to submit complaints to DHS or DHHS.

(b) DHS will not intimidate, threaten, coerce, discriminate against, or take any other form of retaliatory action against any person filing a complaint or inquiring about how to file a complaint.

(c) DHS may not require Clients to waive their rights to file a complaint as a condition of providing Treatment, Payment, enrollment in a health plan, or eligibility for benefits.

(d) DHS will designate staff to review and determine action on complaints filed with DHS. These designated staff will also perform these functions when DHS is contacted about complaints filed with the Office for Civil Rights of DHHS.

(e) DHS will document, in the Client's DHS case record or file, all complaints, the findings from reviewing each complaint, and DHS actions resulting from the complaint. This documentation will include a description of corrective actions that DHS has taken, if any are necessary, or of why corrective actions are not needed, for each specific complaint.

Stat. Auth.: ORS 409.010
Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

410-014-0040
Minimum Necessary Standards

(1) DHS will limit the Use and Disclosure of Protected Information to that which is reasonably necessary to accomplish the intended purpose of the Use or Disclosure which will be referred to in these DHS Privacy Rules as the Minimum Necessary Standard.

(2) This Minimum Necessary Standard is not intended to impede the essential DHS activities of Treatment, Payment, Health Care Operations, or service delivery.

(3) The Minimum Necessary Standard applies:

(a) When using Protected Information within DHS;

(b) When Disclosing Protected Information to a third party in response to a request; and

(c) When requesting Protected Information from another Covered Entity.

(4) The Minimum Necessary Standard does not apply to:

(a) Disclosures to or requests by a Health Care Provider for Treatment;

(b) Disclosures made to the Individual, including Disclosures made in response to a request for access or an accounting;

(c) Disclosures made in accordance with a valid Authorization;

(d) Disclosures made to the United States Secretary of Health and Human Services for the purposes of compliance and enforcement of federal regulations under 45 CFR 160;

(e) Uses and Disclosures that are required by law; and

(f) Uses or Disclosures required for compliance with federal regulations under 45 CFR 164.

(5) When requesting Protected Information about an Individual from another entity, DHS will limit requests to those that are reasonably necessary to accomplish the purposes for which the request is made. DHS will not request a person's entire medical record unless DHS can specifically justify why the entire medical record is needed.

Stat. Auth.: ORS 409.010
Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

410-014-0050
Business Associate

(1) DHS may disclose an Individual's Protected Health Information (PHI) to a Business Associate, and may allow a Business Associate to create or receive an Individual's Protected Health Information on behalf of DHS, if DHS and the Business Associate first enter into a Contract or other written agreement that complies with applicable federal and state law.

(a) If a contractor or business partner is a Business Associate, the Contract remains subject to all federal and state laws and rules governing the contractual relationship.

(b) A Business Associate relationship with DHS also requires additional contractual provisions that must be incorporated into the

Contract. A Contract with a Business Associate must substantially comply with OAR 125-055-0100 through 125-055-0130.

(2) The written Contract or agreement between DHS and the Business Associate may permit the Business Associate to:

(a) Use Information it receives in its capacity as a Business Associate if necessary for its proper management and administration or to carry out its legal responsibilities.

(b) Disclose Information it receives in its capacity as a Business Associate if:

(A) The Disclosure is required by law; or

(B) The Business Associate receives assurances from the person to whom the Information is Disclosed that it will be held or Disclosed further only as required by law or for the purposes to which it was disclosed to such person; and

(C) The person notifies the Business Associate of any instances of any known instances in which the confidentiality of the Information has been breached.

(3) DHS may require a Business Associate to implement corrective actions plans or mitigation, if necessary, of known violations, up to and including contract termination if DHS knows of a pattern of activity or practice of a Business Associate that constitutes a material breach or violation of the Business Associate's obligation under the contract or other arrangement.

(a) If DHS receives a complaint or notification regarding Business Associate activities or practices DHS may send a letter to the Business Associate requesting that the Business Associate review the circumstances related to the alleged conduct. DHS will require that the Business Associate respond, in writing, within 10 business days.

(b) If the facts known to DHS demonstrate a pattern of activity or practice of the Business Associate that violated the Business Associate's Contract with DHS, DHS will send a "Cure Letter" to the Business Associate, outlining required remediation in order for the Business Associate to attain Contract compliance.

(c) If Contract compliance cannot be attained, DHS must terminate the Contract if feasible. If termination is not feasible, DHS will report the problem to the United States Department of Health and Human Services, Office for Civil Rights.

Stat. Auth.: ORS 409.010
Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

410-014-0060
Uses and Disclosures of Protected Information for Research Purposes

DHS may Use and Disclose an Individual's Information for Research purposes as specified in this rule.

(1) All research Disclosures are subject to applicable requirements of federal and state laws and rules. These requirements may include federal regulations in 45 CFR Part 46, promulgated by the United States Department of Health and Human Services for the protection of human subjects in Research.

(2) De-identified Information or a limited data set may be Used or Disclosed for purposes of Research, pursuant to OAR 410-014-0070, "De-identification of Client Information and use of limited data sets under data use agreements."

(3) DHS may Use or Disclose Information regarding an Individual for Research purposes with the specific written Authorization of the Individual. The Authorization must meet all requirements in OAR 410-014-0030 "Uses and Disclosures," and may indicate an expiration date with terms such as "end of Research study" or similar language. An Authorization for Use and Disclosure for a research study may be combined with other types of written permission for the same research study. If Research includes Treatment, the researcher may require an Authorization for Use and Disclosure for such Research as a provision of providing Research related Treatment.

(4) Notwithstanding Section (3) of this rule, DHS may Use and Disclose an Individual's Information for Research purposes without the Individual's written Authorization, regardless of the source of funding for the Research, provided that:

(a) DHS obtains documentation that a waiver of an Individual's Authorization for release of Information requirements has been approved by either:

(A) An Institutional Review Board (IRB); or

(B) A privacy board established pursuant to 45 CFR 164.512(i)(1) as amended effective October 15, 2002.

(b) Documentation required of an Institutional Review Board or privacy board when granting approval of a waiver of an Individual's Authorization for release of Information must include all criteria specified in 45 CFR 164.512(i)(2) as amended effective October 15, 2002.

(c) A researcher may request access to Individual Information maintained by DHS in preparation for Research or to facilitate the development of a Research protocol in anticipation of Research. DHS shall determine whether to permit such Use or Disclosure, without Individual Authorization or use of an Institutional Review Board, pursuant to 45 CFR 164.512(i)(1)(ii) as amended effective October 15, 2002.

(d) A researcher may request access to Individual Information maintained by DHS about Individuals who are deceased. DHS shall determine whether to permit such Use or Disclosure of Information about decedents, without Individual Authorization or use of an Institutional Review Board, pursuant to 45 CFR 164.512(i)(1)(iii) as amended effective October 15, 2002.

(5) To the extent permitted under state or federal law, DHS is authorized as a Public Health Authority to obtain and use Individual Information without Authorization for the purpose of preventing injury or controlling disease and for the conduct of public health surveillance, investigations and interventions. DHS may also collect, Use or Disclose Information, without Individual Authorization, to the extent that such collection, Use or Disclosure is required by law. When DHS uses Information to conduct Research or studies as a Public Health Authority, no additional Individual Authorization is required nor does this rule require an Institutional Review Board or privacy board waiver of Authorization based on the HIPAA Privacy rules.

(6) DHS may Use and Disclose Information without Individual Authorization for studies and data analysis conducted for DHS' own quality assurance purposes or to comply with reporting requirements applicable to federal or state funding requirements in accordance with the definition of "Health Care Operations" in 45 CFR 164.501 as amended effective October 15, 2002.

Stat. Auth.: ORS 409.010
Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

410-014-0070
De-identification of Client Information and Use of Limited Data Sets Under Data Use Agreements

(1) Unless otherwise restricted or prohibited by other applicable federal or state law or rule, DHS may Use and Disclose Information as appropriate for the work of DHS, without further restriction, if DHS or another entity has taken steps to de-identify the Information pursuant to 45 CFR 164.514(a) and (b) as amended effective October 15, 2002.

(2) DHS may assign a code or other means of record identification to allow DHS to re-identify Information that DHS has de-identified under this rule, provided that:

(a) The code or other means of record identification is not derived from or related to Information about the Individual and cannot otherwise be translated to identify the Individual; and,

(b) DHS does not Use or Disclose the code or other means of record identification for any other purpose, and does not Disclose the mechanism for re-identification.

(3) DHS may Use or Disclose a limited data set if DHS enters into a data use agreement with an entity requesting, or providing DHS with, a limited data set subject to the requirements of 45 CFR 164.514 (e) as amended effective October 15, 2002.

(a) DHS may Use and Disclose a limited data set only for the purposes of Research, public health, or Health Care operations. DHS is not restricted to using a limited data set for its own activities or operations unless DHS has obtained a limited data set that is subject to a data use agreement.

(b) If DHS knows of a pattern of activity or practice of a limited data set recipient that constitutes a material breach or violation of a data use agreement, DHS shall take reasonable steps to cure the breach or end the violation. If such steps are unsuccessful, DHS shall discontinue Disclosure of Information to the recipient and report the problem to the Secretary of the United States Department of Health and Human Services.

Stat. Auth.: ORS 409.010
Stats. Implemented:
Hist.: OMAP 26-2003, f. 3-31-03 cert. ef. 4-1-03

DIVISION 30

CLIENT CIVIL RIGHTS

410-030-0010 [Renumbered to **407-030-0010**]

410-030-0020 [Renumbered to **407-030-0020**]

410-030-0030 [Renumbered to **407-030-0030**]

410-030-0040 [Renumbered to **407-030-0040**]

DIVISION 50

MEDICAID MANAGED CARE TAX

410-050-0100
Definitions

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

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

(3) "Department" means the Oregon Department of Human Services or its successor organization.

(4) "Director" means the Director of the Oregon Department of Human Services or the Director's designee or agent.

(5) "Premium Payments" means all capitation payments received by Prepaid Health Plans (PHPs) on a per enrollee per month basis for the provision of health services specified by contract. Premiums do not include any form of payment by Oregon Health Plan enrollees to the Department.

(6) "Managed Care Premiums" means all Premium Payments paid to a PHP including the Capitation Payments as defined in OAR 410-141-0000(12). Managed Care Premiums do not include Medicare premiums.

(7) "Medicaid Managed Care Organization" (MMCO) means a managed health, dental, mental health or chemical dependency organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725. A MMCO is also referred to as a Prepaid Health Plan (PHP) as defined in OAR 410-141-0000(88). A PHP may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 37
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0110
General Administration

(1) The purpose of these rules is to implement the Medicaid managed care tax on the Prepaid Health Plans in the State of Oregon.

(2) The Department will administer, enforce and collect the Medicaid managed care tax. The Department may assign employees, auditors and such other agents as the Director may designate to assist in the administration, enforcement and collection of the taxes.

(3) The Department may make such rules and regulations, not inconsistent with legislative enactments, that it considers necessary to administer, enforce and collect the taxes.

(4) The Department may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to administer, enforce and collect the taxes.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 38 & 409.050
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0120
Disclosure of Information

(1) Except as otherwise specifically required by law, the Department must not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the taxes. "Particulars" includes but is not limited to, social security numbers, employer number or other organization identification number, and any business records required to be submitted to or inspected by the Department or its designee to allow it to determine the amounts of any assessments, delinquencies, or deficiencies payable or paid, or otherwise administer, enforce or collect a health care assessment to the extent that such information would be exempt from disclosure under ORS 192.501(5).

(2) The Department may:

(a) Upon request, furnish any PHP, or representative authorized to represent the PHP, with a copy of the PHP's report filed with the Department for any quarter, or with a copy of any other information filed by the PHP in connection with the report, or as the Department considers necessary;

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

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 37-51
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0130
The Medicaid Managed Care Tax: Calculation; Report; Due Date; Verification of Report

(1) The tax is assessed on the Managed Care Premiums paid to a PHP on or after January 1, 2004, based on calendar quarters. The first calendar quarter begins on January 1; the second calendar quarter begins on April 1; the third calendar quarter begins on July 1; and the fourth quarter begins on October 1. For purposes of this rule, Managed Care Premiums will be taxed as of the calendar quarter in which the Managed Care Premium payment is received by the PHP.

(2) Adjustments to the Managed Care Premium subject to tax shall be determined as follows:

(a) Managed Care Premiums attributable to periods prior to January 1, 2004 are not subject to the tax and shall be deducted from the taxable Managed Care Premiums when calculating the tax due. Managed Care Premiums attributable to the period between January 1, 2004 and April 31, 2004 are taxed at the rate of 0%. This deduction includes maternity payments, adjustments due to changes in the client's status, and other Managed Care Premium adjustments resulting in additional payments received by the PHP on or after May 1, 2004;

(b) If Managed Care Premiums received after May 1, 2004 are reduced by a recoupment by the Department for an overpayment paid prior to May 1, 2004, then the taxable Managed Care Premiums will be deemed to include the recouped amount;

(c) If both the overpayment and recoupment occur after May 1st, 2004, then the PHP will be subject to the tax on the Managed Care Premiums received in the calendar quarter in which the Managed Care Premium payment is received by the PHP;

(d) Sub-capitation payments made to a PHP by another PHP are not included in the total Managed Care Premiums subject to tax if the payor PHP certifies to the payee PHP in writing that the payor PHP is already responsible for the Managed Care Tax on the originating Managed Care Premiums.

(3) The rate of the assessment on and after May 1, 2004, will be determined in accordance with OAR 410-050-0140.

(4) The tax becomes operative on May 1, 2004. The first calendar quarter for which a tax is due is a partial quarter. First quarter taxes will be due on Managed Care Premiums received between May 1, 2004 and June 30, 2004.

(5) The PHP must pay the tax and file the report on a form approved by the Department on or before the 75th day following the end of the calendar quarter for which a tax is due. The PHP must provide all information required on the report.

(6) Any report, statement or other document required to be filed under any provision of these rules shall be certified by the Chief Financial Officer of the PHP or an individual with delegated authority to sign

for the PHP's Chief Financial Officer. The certification must attest, based on best knowledge, information and belief, to the accuracy, completeness and truthfulness of the document.

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

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 38, 39 & 45
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0140
Filing an Amended Report

(1) The claims for refunds or payments of additional tax must be submitted by the PHP on a form approved by the Department. The PHP must provide all information required on the report. The Department may audit the PHP, request additional information or request an informal conference prior to granting a refund or as part of its review of a payment of a Deficiency.

(2) Claim for Refund.

(a) If the amount of the tax imposed by these rules is less than the amount paid by the PHP and the PHP does not then owe a tax for any other calendar period, such overpayment may be refunded by the Department to the PHP. In no event will a refund applicable to a particular calendar quarter exceed the tax amount actually paid by the PHP;

(b) The PHP may file a claim for refund on a form approved by the Department within 180 days after the end of the calendar quarter to which the claim for refund applies;

(c) If there is an amount due from the PHP to the Department for any past due taxes or penalties, any refund otherwise allowable will first be applied to the unpaid taxes and penalties and the PHP so notified.

(3) Payment of Deficiency.

(a) If the amount of the tax imposed by these rules is more than the amount paid by the PHP, the PHP may file a corrected report on a form approved by the Department and pay the Deficiency at any time. The penalty under OAR 410-050-0180 will stop accruing after the Department receives of payment of the total Deficiency for the calendar quarter;

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

(4) If the Department discovers/identifies information in the administration of these Managed Care tax rules that it determines could give rise to the issuance of a Notice of Proposed Action, or the issuance of a refund, the Department will notify the PHP. The PHP will have 30 calendar days from the date of the Department's notice to respond. It is the PHP's responsibility to determine what response, if any, it will make. The PHP may request a refund pursuant to subsection (2) of this rule or file an amended report pursuant to subsection (3) of this rule. Nothing in this subsection (4) prevents or limits the Department from issuing a Notice of Proposed Action pursuant to OAR 410-050-0190.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 38, 40, 41& 48
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0150
Determining the Date Filed

For the purposes of OAR 410-050-0100 through 410-050-0250, any reports, requests, appeals, payments or other response by the PHP must be received by the Department either:

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

(2) If mailed, postmarked before midnight of the due date. When the due date falls on a Saturday, Sunday or legal holiday, the response is due on the next business day following such Saturday, Sunday or legal holiday.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 38
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0160
Departmental Authority to Audit Records

(1) The PHP must maintain financial records necessary and adequate to determine the amount of Managed Care Premiums for any calendar period for which a tax may be due.

(2) The Department or its designee may audit the PHP's records at any time for a period of five years following the date the tax is due to verify or determine the Managed Care Premiums for the PHP.

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

(4) The Department may notify the PHP of a potential Deficiency or issue a refund based upon its findings during the audit.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 42
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0170
Assessing Tax on Failure to File

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

(2) In the case of a failure by the PHP to file a report or to maintain necessary and adequate records, the Department will determine the tax liability of the PHP according to the best of its information and belief. "Best of its information and belief" means that the Department will use evidence available to the Department at the time of the determination on which a reasonable person would rely in determining the tax. The Department's determination of tax liability will be the basis for the assessment due in any Notice of Proposed Action.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 38
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0180
Financial Penalty for Failure to File a Report or Failure to Pay Tax When Due

(1) A PHP that fails to file a report or pay a tax when due under OAR 410-050-0130 is subject to a penalty of $500 per day of Delinquency. The penalty accrues from the date of Delinquency, notwithstanding the date of any notice under these rules.

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

(3) Penalties imposed under this section will be collected by the Department of Human Services and deposited in the Department of Human Services Account established under ORS 409.060.

(4) Penalties paid under this section are in addition to the Medicaid Managed Care tax.

(5) If the Department determines that a PHP is subject to a penalty under this section, it will issue a Notice of Proposed Action as described in OAR 410-050-0190.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 40
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0190
Notice of Proposed Action

(1) Prior to issuing a Notice of Proposed Action, the Department will notify the PHP of a potential deficiency or failure to report that could give rise to the imposition of a penalty and provide the PHP with not less than 30 calendar days from the date of the notice to respond to the notification. The Department may consider the response, if any, and any amended report under OAR 410-050-0150 in its Notice of Proposed Action.

(2) The Department will notify the PHP if it determines that the PHP is subject to the imposition of a penalty for a calendar quarter or if there is a Deficiency for a calendar quarter.

(3) Contents of the Notice of Proposed Action must include:

(a) The applicable calendar quarter;

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

(c) The corrected tax due for the quarter as determined by the Department;

(d) The amount of tax paid for the quarter by the PHP;

(e) The resulting Deficiency, which is the difference between the amount received by the Department for the calendar quarter and the corrected amount due as determined by the Department;

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of Delinquency;

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

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

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

(k) Instructions for responding to the notice, and a statement of the PHP's right to a hearing.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 50
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0200
Required Notice

(1) Any notice required to be sent under these rules to the PHP will be sent to the person and address identified as the point of contact for the PHP in its contract with the Department of Human Services under ORS 414.725.

(2) Any notice required to be sent to the Department under these rules shall be sent to the contact point identified on the communication from the Department to the PHP.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 50
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0210
Hearing Process

(1) Any PHP that receives a Notice of Proposed Action may request a contested case hearing under ORS 183.310 to 183.550.

(2) The PHP may request a hearing by submitting a written request within 20 days of the date of the Notice of Proposed Action.

(3) Prior to the hearing, the Department and PHP will meet for an informal conference.

(4) Except as provided in subsection (e) of this rule, if the case proceeds to a hearing, the administrative law judge will issue a proposed order with respect to the Notice of Proposed Action. The Department will issue a Final Order.

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 50
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0220
Final Order of Payment

The Department will issue a Final Order of Payment for deficiencies and/or penalties when:

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

(2) The PHP did not make a timely request for a hearing; or

(3) Upon the agreement of the PHP and the Department.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 37-51
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0230
Remedies Available after Final Order of Payment

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

(1) Collection activities including but not limited to deducting the amount of the final Deficiency and/or Penalty from any sum then or later owed to the PHP by the Department;

(2) Every payment obligation shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the Final Order of Payment and continuing until the payment obligation, including interest has been discharged.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 37-51
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0240
Director Determines the Tax Rate

(1) The tax rate is determined by the Director.

(2) The tax rate for the period beginning January 1, 2004 through April 30, 2004 is 0 percent. The tax rate for the period beginning May 1, 2004 is 5.8 percent.

(3) The rate may not exceed six (6) percent of Managed Care Premiums paid to a PHP.

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 38 & 39
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0250
Sunset Provisions

The Medicaid managed care tax applies to Managed Care Premiums received by Prepaid Health Plans on or after May 1, 2004 and before January 1, 2008.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736 § 50
Hist.: OMAP 30-2004(Temp), f. 4-28-04 cert. ef. 5-1-04 thru 10-27-04; OMAP 80-2004, f. & cert. ef. 10-28-04

410-050-0401
Definitions

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

(2) "Delinquency" means the facility failed to pay the tax as correctly computed when the tax was due.

(3) "Department" means the Oregon Department of Human Services or its successor organization.

(4) "Director" means the Director of the Oregon Department of Human Services or the Director's designee or agent.

(5) "Gross Revenue" means the revenue paid to a long term care facility for patient care, room, board and services, less contractual adjustments. It does not include revenue derived from sources other than operations, including but not limited to interest and guest meals.

(6) "Long Term Care Facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director, to provide treatment for two or more unrelated patients. "Long term care facility" includes licensed skilled nursing facilities and licensed intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455. Long Term Care Facility does not include any Intermediate Care Facility for the Mentally Retarded.

(7) "Patient Days" means the total number of patients occupying beds in a long term care facility, determined as of 12:01 a.m. of each day, for all days in the calendar period for which an assessment is being reported and paid. For purposes of this subsection, if a Long Term Care facility patient is admitted and discharged on the same day, the patient is deemed present on 12:01 a.m. of that day.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §15
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0411
General Administration

(1) The purpose of these rules to is implement the long term care facility tax imposed on long term care facilities in the State of Oregon.

(2) The Department will administer, enforce and collect the Long Term Care Facility tax.

(3) The Department may assign employees, auditors and such other agents as the Director may designate to assist in the administration, enforcement and collection of the taxes.

(4) The Department may make such rules and regulations, not inconsistent with legislative enactments, that it considers necessary to administer, enforce and collect the taxes.

(5) The Department may prescribe such forms and reporting requirements, and change the forms and reporting requirements, as necessary to administer, enforce and collect the taxes.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§15-38
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0421
Disclosure of Information

(1) Except as otherwise specifically provided by law, the Department must not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the taxes. "Particulars" includes but is not limited to, social security numbers, employer number or other facility identification number, and any business records required to be submitted to or inspected by the Department or its designee to allow it to determine the amounts of any assessments, delinquencies, deficiencies, penalties or interest payable or paid, or otherwise administer, enforce or collect a health care assessment to the extent that such information would be exempt from disclosure under ORS 192.501(5).

(2) The Department may:

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

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

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

Stat. Auth.: ORS 410 & 411
Stats. Implemented: ORS 410 & 411
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0431
Entities Subject to the Long Term Care Facility Tax

Each Long Term Care Facility in the State of Oregon is subject to the Long Term Care Facility Tax except the Oregon Veterans' Home, and Long Term Care Facilities that have received written notice from the Department that they are exempt under the terms of a waiver. For these facilities, the exemption from the Long Term Care Facility Tax only applies for the specific period of time described in the notice from the Department.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 sec.18, sec.33
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05; OMAP 31-2006(Temp), f.& cert. ef. 8-7-06 thru 2-2-07; Administrative correction, 2-16-07

410-050-0441
The Long Term Care Facility Report of Gross Revenues

(1) Each Long Term Care Facility subject to the Long Term Care Facility Tax must submit a statement of its Gross Revenue on a form approved by the Department.

(2) The report may be combined with the quarterly tax assessment report at the discretion of the Department.

(3) The Department may require the facility to provide additional reports in order to calculate the tax rate for the next fiscal year.

(4) The Department will require a report from the facilities of their adjusted net revenue on or before May 30, 2004 in order to determine the rate of tax for the fiscal year beginning July 1, 2004.

(5) For the purposes of this rule, adjusted net revenue includes the facilities' total routine and ancillary revenues, less contractual adjustments, bad debt, and charity care.

(a) Contractual adjustments are the difference between the amounts charged based on the facility's full established charges and the contractual amounts due from the payor;

(b) Charity care is the difference between the amounts charged based on the facility's full established charges and the contractual amount due from the patient based upon the patient's indigence or lack of insurance; and

(c) Bad debt is the total amount of accounts receivables that are analyzed and deemed uncollectible during the quarter. The amount of the deduction is reduced by any payments received on accounts receivables that were deemed uncollectible in a previous quarter.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §17
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0451
The Long Term Care Facility Tax: Calculation, Report, Due Date

(1) The tax is assessed upon each Patient Day at a Long Term Care Facility. The amount of the tax equals the assessment rate times the number of Patient Days at the long term care facility for the calendar quarter. The current rate of the assessment will be determined in accordance with these rules.

(2) The facility must pay the tax and file the report on a form approved by the Department on or before the 30th day of the month following the end of the calendar quarter for which the tax is being reported.

(3) Any report, statement or other document required to be filed under any provision of these rules shall be certified by the Chief Financial Officer of the facility or an individual with delegated authority to sign for the facility's Chief Financial Officer. The certification must attest, based on best knowledge, information and belief, to the accuracy, completeness and truthfulness of the document.

(4) For calendar quarters beginning July 1, 2003, October 1, 2003, and January 1, 2004, the first payment of tax and reports will be due June 30, 2004. These quarters include Patient Days throughout the nine-month period from July 1st, 2003 through April 30, 2004.

(5) Payments may be made electronically and the accompanying report may either be faxed to the Department at the fax number provided on the report form or mailed to the Department at the address provided on the report form.

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

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §16
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0461
Filing an Amended Report

(1) The claims for refunds or payments for additional tax must be submitted by the facility on a form approved by the Department. The facility must provide all information required on the report. The Department may audit the facility, request additional information or request an informal conference prior to granting a refund or as part of its review of a payment of a Deficiency.

(2) Claim for Refund:

(a) If the amount of the tax is less than the amount paid by the facility and the facility does not then owe a tax for any other calendar period, such overpayment may be refunded by the Department to the facility;

(b) The facility may file a claim for refund on a form approved by the Department within 180 days after the end of the calendar quarter to which the claim for refund applies; and

(c) If there is an amount due from the facility for any past due taxes or penalties, the refund otherwise allowable will be applied to the unpaid taxes and penalties and the facility so notified.

(3) Payment of Deficiency:

(a) If the amount of the tax is more than the amount paid by the facility, the facility may file a corrected report on a form approved by the Department and pay the Deficiency at any time. The penalty under OAR 410-050-0491 will stop accruing after the Department receives of payment of the total Deficiency for the calendar quarter; and

(b) If there is an error in the determination of the tax due, the facility may describe the circumstances of the late additional payment with the late filing of the amended report. The Department, in its sole discretion,

may determine that such a late additional payment does not constitute a failure to file a report or pay an assessment giving rise to the imposition of a penalty. In making this determination, the Department will consider the circumstances, including but not limited to: nature and extent of error; facility explanation of the error; evidence of prior errors; and evidence of prior penalties (including evidence of informal dispositions or settlement agreements). This provision only applies if the facility has filed a timely original return and paid the assessment identified in the return.

(4) If the Department discovers/identifies information in the administration of these tax rules that it determines could give rise to the issuance of a Notice of Proposed Action, or the issuance of a refund, DHS will notify the facility. The facility will have 30 calendar days from the date of the Department's notice to respond. It is the facility's responsibility to determine what response, if any, it will make. The facility may request a refund pursuant to subsection (2) of this rule or file an amended report pursuant to subsection (3) of this rule. Nothing in this subsection (4) prevents or limits DHS from issuing a Notice of Proposed Action pursuant to OAR 410-050-0510.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §22
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0471
Determining the Date Filed

For the purposes of these rules, any reports, requests, appeals, payments or other response by the facility must be either received by the Department before the close of business on the date due, or, if mailed, postmarked before midnight of the due date. When the due date falls on a Saturday, Sunday or a legal holiday, the return is due on the next business day following such Saturday, Sunday or legal holiday.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§15-36
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0481
Assessing Tax on Failure to File

In the case of a failure by the facility to file a report or to maintain necessary and adequate records, the Department will determine the tax liability of the facility according to the best of its information and belief. "Best of its information and belief" means that the Department will use evidence on which a reasonable person would rely in determining the tax, including, but not limited to, estimating the days of Patient Days based upon the number of licensed beds in the facility. The Department's determination of tax liability will be the basis for the assessment due in a Notice of Proposed Action.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§15-36
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0491
Financial Penalty for Failure to File a Report or Failure to Pay Tax When Due

(1) A Long Term Care Facility that fails to file a report or pay a tax when due under OAR 410-050-0451 is subject to a penalty of $500 per day of delinquency. The penalty accrues from the date of Deficiency, notwithstanding the date of any notice under these rules.

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

(3) Penalties imposed under this section will be collected by the Department of Human Services and deposited in the Department of Human Services Account established under ORS 409.060.

(4) Penalties paid under this section are in addition to the Long Term Care Facility tax.

(5) Any penalties arising from a failure to pay or file a timely report on Patient Days from July 1, 2003 through December 31, 2003, will be deposited into the long term care quality assurance suspense account.

(6) If the Department determines that a facility is subject to a penalty under this section, it will issue a Notice of Proposed Action as described in OAR 410-050-0510.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §19
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0501
Departmental Authority to Audit Records

(1) The facility must maintain clinical and financial records sufficient to determine the actual number of Patient Days for any calendar period for which a tax may be due.

(2) The Department or its designee may audit the facility's records at any time for a period of three years following the date the tax is due to verify or determine the number of Patient Days at the facility.

(3) The Department may issue a Notice of Proposed Action or issue a refund based upon its findings during the audit.

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

(5) The Department may issue a refund and otherwise take such actions as it deems appropriate based upon the findings of the audit.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §21
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0511
Notice of Proposed Action

(1) Prior to issuing a Notice of Proposed Action, the Department will notify the facility of a potential deficiency or failure to report that could give rise to the imposition of a penalty and provide the facility with not less than 30 calendar days from the date of the notice to respond to the notification. The Department may consider the response, if any, and any amended report under OAR 410-050-0461 in its Notice of Proposed Action.

(2) The Department will notify the facility if it determines that the facility is subject to the imposition of a penalty for a calendar quarter or if there is a Deficiency for a calendar quarter with a Notice of Proposed Action.

(3) Contents of the Notice of Proposed Action must include:

(a) The applicable calendar quarter;

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

(c) The corrected tax due for the quarter as determined by the Department;

(d) The amount of tax paid for the quarter by the facility;

(e) The resulting Deficiency, which is the difference between the amount received by the Department for the calendar quarter and the corrected amount due as determined by the Department;

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of Delinquency;

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

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

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

(k) Instructions for responding to the notice, and a statement of the facility's right to a hearing.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§15-36
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0521
Required Notice

(1) Any notice required to be sent to the facility will be sent to the current licensee and any former licensee who was occupying the property during time period to which the notice relates.

(2) Any notice required to be sent to the Department under these rules shall be sent to the contact point identified on the communication from the Department to the facility.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §15-36
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0531
Hearing Process

(1) Any facility that receives a Notice of Proposed Action may request a contested case hearing under ORS 183.310 to 183.550.

(2) The written request must be received by the Department within 20 days of the date of the notice.

(3) Prior to the hearing, the Department and the facility will meet for an informal conference.

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

(5) If the case proceeds to a hearing, the administrative law judge will issue a proposed order with respect to the Notice of Proposed Action.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §20
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0541
Final Order of Payment

The Department will issue a Final Order of Payment for deficiencies and/or penalties when:

(1) Any part of the deficiency or penalty is upheld after a hearing;

(2) The facility did not make a timely request for a hearing; or

(3) Upon the stipulation of the facility and the Department.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§15-36
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0551
Remedies Available after Final Order of Payment

(1) Any amounts due and owing under the Final Order of Payment and any interest thereon may be recovered by the State of Oregon as a debt to the State, using any available legal and equitable remedies. These remedies include, but are not limited to:

(a) Collection activities including but not limited to deducting the amount of the final Deficiency and/or Penalty from any sum then or later owed to the facility or its owners or operators by the Department, CMS or their designees to the extent allowed by law;

(b) Nursing facility license denial, suspension or revocation under OAR 411-089-0040;

(c) Restrictions of admissions to the facility under OAR 411-089-0050; and

(d) Terminating the provider contract with the owners or operators of the facility under OAR 411-070-0015.

(2) Every payment obligation shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the Final Order of Payment and continuing until the payment obligation, including interest has been discharged.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§15-36
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0561
Calculation of the Long Term Care Facility Tax for Periods Beginning on and after July 1, 2004

(1) The amount of the tax is based on the assessment rate determined by the Director multiplied by the number of Patient Days at the Long Term Care Facility for a calendar quarter.

(2) The Director must establish an annual assessment rate for Long Term Care Facilities that applies for each 12-month period beginning July 1. The Director must establish the assessment rate on or before June 15th preceding the 12-month period for which the rate applies.

(3) At the time the annual assessment rate is established, the Director may adjust the assessment rate to account for overages and underages in the aggregate amount actually collected during previous assessment periods.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §§17, 27(c)
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0571
Initial Tax for Calendar Quarters Beginning July 1, 2003 and October 1, 2003

The amount of tax on LTC Facilities for calendar quarters beginning July 1, 2003 and October 1, 2003 must be determined using an assessment rate of $8.25 per Patient Day.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §28
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0581
Tax for Calendar Quarters Beginning January 1, 2004 and April 1st, 2004

(1) The amount of tax on LTC Facilities for calendar quarters beginning January 1, 2004 and ending before July 1st, 2004, must be determined using an assessment rate of $8.25 per Patient Day.

(2) This rate may be adjusted by the Department to take into account overages or underages raised under the Initial Assessment Rate under OAR 410-050-0570, including, but not limited to, overages and underages caused by an approval or denial by the Centers for Medicare and Medicaid Services. An adjustment under this subsection may be made at any time.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §27
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

410-050-0591
Limitations On The Imposition of the Long Term Care Facility Tax

The long term care facility tax may be imposed only in a calendar quarter for which the long term care facility reimbursement rate that is part of the Oregon Medicaid reimbursement system was calculated according to the methodology described in Oregon Laws, ORS 736§ 24.

Stat. Auth.: ORS 410 & 411
Stats. Implemented: OL 2003 & ORS 736 §29
Hist.: OMAP 3-2005, f. & cert. ef. 2-1-05

Hospital Tax

410-050-0700
Definitions

The following definitions apply to this section of the Oregon Administrative Rules:

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

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

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

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

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

(6) "Declared Fiscal Year" means the Fiscal Year declared to the IRS.

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

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

(9) "Department" means the Oregon Department of Human Services or its successor organization.

(10) "Director" means the Director of the Oregon Department of Human Services or the Director's designee or agent.

(11) "Hospital" means a hospital with an organized medical staff, with permanent facilities that include inpatient beds and with medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for but not limited to acutely ill patients and accident victims, or to provide treatment for the mentally ill. 'Hospital', as it is used in this section, does not include special inpatient care facilities, as that term is defined in ORS 442.015(33). For pur-

poses of these rules, the Hospital shall be identified by using the federal taxpayer identification number for the Hospital.

(12) "Net Revenue":

(a) Means the total amount of Charges for Inpatient or Outpatient Care provided by the Hospital to patients, less Charity Care, Bad Debts and Contractual Adjustments;

(b) Does not include revenue derived from sources other than inpatient or outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care assessment under the Long Term Facility Tax.

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

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0710
General Administration

(1) The purpose of these rules is to implement the tax imposed on Hospitals in the State of Oregon.

(2) The Department will administer, enforce and collect the hospital tax. The Department may assign employees, auditors and such other agents as the Director may designate to assist in the administration, enforcement and collection of the taxes.

(3) The Department may make such rules and regulations, not inconsistent with legislative enactments, that it considers necessary to administer, enforce and collect the taxes.

(4) The Department may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to administer, enforce and collect the taxes.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0720
Disclosure of Information

(1) Except as otherwise specifically provided by law, the Department must not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the taxes. "Particulars" includes but is not limited to, social security numbers, employer number or other Hospital identification number, and any business records required to be submitted to or inspected by the Department or its designee to allow it to determine the amounts of any assessments, delinquencies, deficiencies, penalties or interest payable or paid, or otherwise administer, enforce or collect a health care assessment to the extent that such information would be exempt from disclosure under ORS 192.501(5) or other basis for exemption under the Oregon Public Records Law.

(2) The Department may:

(a) Furnish any Hospital, or representative authorized to represent the Hospital, upon request of the Hospital or representative, with a copy of the Hospital's report filed with the Department for any quarter, or with a copy of any report filed by the Hospital in connection with the report, or with a copy of any other information the Department considers necessary.

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

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0730
Entities Subject to the Hospital Tax

Each Hospital in the State of Oregon is subject to the hospital tax except:

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

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

(3) Waivered Hospitals, as that term is defined in OAR 410-050-0700(13).

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

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

(1) The amount of the tax equals the tax rate multiplied by the Net Revenue of the Hospital, consistent with OAR 410-050-0750 and 410-050-0860. The tax will be imposed on Net Revenues earned by the Hospital on or after January 1, 2004, based on calendar quarters. The first calendar quarter begins on January 1; the second calendar quarter begins on April 1; the third calendar quarter begins on July 1; and the fourth calendar quarter begins on October 1.

(2) The rate of the assessment will be determined in accordance with OAR 410-050-0860.

(3) The Hospital must pay the quarterly tax and file the quarterly report on a form approved by the Department on or before the 75th day following the end of the calendar quarter for which a tax is due. The Hospital must provide all information required on the report.

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

(5) The final report and final tax payment, including reconciliation report, shall be due and shall be submitted to the Department not later than the final day of the sixth calendar month after the Hospital's Declared Fiscal Year end. Failure to file and pay when due shall be a Delinquency.

(6) Any report, statement or other document required to be filed under any provision of these rules shall be certified by the Chief Financial Officer of the hospital or an individual with delegated authority to sign for the Hospital's Chief Financial Officer. The certification must attest, based on best knowledge, information and belief, to the accuracy, completeness and truthfulness of the document.

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

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

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

(1) A Hospital must submit quarterly reports and quarterly payments for the calendar quarters for which a tax is due consistent with subsection (2) of this rule, and must submit a final report that includes a reconciliation report, audited financial statement, and the final tax payment based on the Hospital's Declared Fiscal Year end consistent with subsection (3) of this rule.

(2) The quarterly reports and quarterly tax payments shall be based on estimated Net Revenue, which shall be referred to as estimated tax. Estimated tax is the amount of tax the Hospital expects to owe for the current taxable calendar quarter. The Hospital shall calculate the estimated tax based on Net Revenues using the Hospital's interim financial results for the quarter for which the tax is due. An estimated tax report and payment is due for each calendar quarter for which a tax is due, based on the rate of tax applicable to that quarter.

(3) The final report and final tax payment shall be based on the amount of tax the Hospital actually owes based on annual Net Revenue for all calendar quarters for which an estimated tax payment is due during the Hospital's Declared Fiscal Year. The Hospital shall calculate the annual Net Revenue for the Hospital's Declared Fiscal Year. The final tax payment due to the Department will be the calculated tax (using the tax rate applicable to the appropriate quarter, described in subsection (c) below for final tax calculation purposes) on the annual Net Revenue reduced by the estimated tax payments made for each taxable quarter of the Hospital's Declared Fiscal Year.

(a) When the final tax and final report are submitted, they must be accompanied by the Hospital's Declared Fiscal Year end audited financial statement for the Declared Fiscal Year on which the final report and final tax payments are based.

(b) The final report shall include a reconciliation report describing the relationship between the audited financial statement and annual Net Revenues subject to the tax. The reconciliation report may be descriptive in form and should be consistent with the accounting principles used in the audited financial statement.

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

(A) If all taxable quarters were subject to the same tax rate established in OAR 410-050-0160, then the tax rate applicable to the final reconciliation is the tax rate applicable to all such quarters. For example, if the Hospital's Declared Fiscal Year is July 1, 2004 to June 30, 2005, then the tax rate is .93 percent of annual Net Revenue.

(B) If different tax rates apply to calendar quarters in the Hospital's Declared Fiscal Year, the Hospital shall apply a blended rate to the total annual Net Revenue to determine the final tax due. A blended rate is the average of the rates applicable to all taxable quarters. The Department will notify the Hospital of the amount of the applicable blended rate. For example, if the Hospital's Declared Fiscal Year overlaps two quarters taxed at a rate of .93 percent and two quarters taxed at .50 percent, then the blended rate for purposes of the annual reconciliation is .715. For purposes of the final tax due, the Hospital shall multiply the annual Net Revenue by the blended rate.

(d) If the total estimated tax payments already paid by the Hospital for the Declared Fiscal Year exceeds the amount of the final tax actually due, the final report should identify such difference and the Hospital should adjust the final tax due amount accordingly in the final report for that tax year.

(e) The final report, audited financial statement, and final tax payment, including reconciliation report, shall be due and shall be submitted to the Department not later than the final day of the sixth calendar month after the Hospital's Declared Fiscal Year end. Failure to file and pay when due shall be a Delinquency.

(f) If the Declared Fiscal Year end audited financial statement for the Hospital is not available within the time required in subsection (e), a final tax payment and final report are still required to be submitted within the time period specified under subsection (e). The Hospital may use interim financial statements to determine that amount of the final tax due and may submit a justification statement with the final report due not later than the date specified in subsection (e) signed by the Chief Financial Officer of the Hospital informing the Department when the audited financial statement is due and certifying that an amended final report, including the reconciliation report, shall be provided to the Department within 30 days of the Hospital's receipt of the audited financial statement. Reports and payments made after the time period required in subsection (e) must be submitted in compliance with OAR 401-050-0760, Filing an Amended Report.

(g) In the event the Hospital does not receive audited financial statements, internal financial statements signed by the Hospital's Chief Financial Officer must be submitted where these rules otherwise require audited financial statements.

(h) If the effective date of the tax is not at the start of the Hospital's Declared Fiscal Year, then the annual Net Revenue for the first final tax return will be calculated based on the number of quarters subject to the tax versus the total number of quarters in the Hospital's Declared Fiscal Year. For example, if the tax is effective on July 1, 2004, for a Hospital with a Declared Fiscal Year ending December 31, 2004, the annual Net Revenues would be calculated as follows: Total Net Revenues for the Declared Fiscal Year divided by two (two of four quarters subject to the tax).

(4) The Department will not find a payment Deficiency for estimated quarterly taxes as long as the Hospital paid the estimated taxes and submitted the quarterly report not later than the quarterly due date and such estimated tax amount was not less than the equivalent of the tax payment that would have been determined based on the Hospital's annual Net Revenue for its most recent prior Declared Fiscal Year divided by four (4) and multiplied times the tax rate for the quarter in which the actual estimated tax is due. Annual Net Revenue for purposes of subsection (4) of this rule means the twelve (12) month period in which the Hospital's most recent prior Declared Fiscal Year occurred, regardless of whether the prior quarters were subject to a tax. For example, if the annual Net Revenue for the most recent prior Declared Fiscal Year was $4 million; divide that total by 4 ($1 million) and multiply the product times the current tax rate for the taxable quarter (0.93 percent). In this example, the estimated quarterly tax payment may not be less than $9,300 in order to receive the benefit of subsection (4) of this rule.

(a) If the Hospital seeks to use the process in subsection (4) of this rule, not later than the date on which the first quarterly estimated tax and report is due (for example, December 13, 2004, for the first taxable quarter), the Hospital must provide the Department with a copy of the Hospital's audited financial statement for the Hospital's most recent prior Declared Fiscal Year and identify the Hospital's annual Net Revenue amount for that Declared Fiscal Year, regardless of whether any taxes were due for that year.

(b) In the event that the Hospital does not receive audited financial statements, internal financial statements from the Hospital's most recent prior Declared Fiscal Year signed by the Chief Financial Officer may be used for this purpose.

(5) There will be a Delinquency for each quarter the Hospital fails to pay the estimated tax when due. There will be a Delinquency if the Hospital fails to pay the final tax when due.

(6) A Hospital must declare the date of the Hospital's Declared Fiscal Year end for purposes of establishing final tax reporting requirements under this rule. The declaration must be filed with the Department not later than December 13, 2004, or the first date that an estimated quarterly report and tax is due. The Hospital must notify the Department within 30 days of a change to the Hospital's Declared Fiscal Year end. Such a change in Declared Fiscal Year end shall be applied to the Hospital's next future Declared Fiscal Year for purposes of calculating the final tax and filing the final report.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0760
Filing an Amended Report

(1) A Hospital that submits a Final Report without an audited financial statement in accordance with OAR 410-050-0750(3)(f) must submit within 180 days after the due date of the Final report OAR 410-050-0750(e) an Amended Final report, an audited financial statement, and payment for taxes and deficiencies.

(1) Claim for Refund:

(a) If the amount of the tax imposed by these rules in the Amended Final Report is less than the amount paid by the Hospital, such overpayment may be refunded by the Department to the Hospital. In no event will a refund exceed the tax amount actually paid by the Hospital.

(b) The Hospital must provide all information required on the report. No refunds will be made prior to the Department receiving the Hospital audited financial statement for the Declared Fiscal Year. The Department may audit the Hospital, request additional information or request an informal conference prior to granting a refund or as part of its review.

(c) If there is an amount due from the Hospital to the Department for any past due taxes or penalties, any refund otherwise allowable will first be applied to the unpaid taxes and penalties, and the Hospital so notified.

(d) A Hospital may not deduct from current, prospective or future tax payments an amount to which it claims to be entitled as a refund for a prior period. The claim for refund must be made to the Department consistent with this rule.

(3) Payment of Delinquency:

(a) If the amount of the annual tax imposed by these rules is more than the amount paid by the Hospital, the Hospital must file an Amended Final Report and pay the tax and Deficiency. The penalty under OAR 410-050-0800 will stop accruing after the Department receives the Amended Final Report, the annual audited financial statement, and pay-

ment of the total Deficiency for year; except to the extent provided in OAR 410-050-0750(4)(a).

(b) No refunds will be made prior to the Department receiving the Hospital audited financial statement for the Declared Fiscal Year. The Department may audit the Hospital, request additional information, or request an informal conference prior to granting a refund or as part of its review.

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

(4) If the Department discovers or identifies information in the administration of these tax rules that it determines could give rise to the issuance of a Notice of Proposed Action, DHS will notify the Hospital of the information that could give rise to the issuance of a Notice of Proposed Action. The Hospital will have 30 calendar days from the date of the Department's notice to respond. It is the Hospital's responsibility to determine what response, if any, it will make. The Hospital may request a refund pursuant to subsection (2) of this rule or file an Amended Final Report pursuant to subsection (3) of this rule. Nothing in this subsection (4) prevents or limits DHS from issuing a Notice of Proposed Action pursuant to OAR 410-050-0810.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0770
Determining the Date Filed

(1) For the purposes of these rules, any reports, requests, appeals, payments or other response by the Hospital must be received by the Department either:

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

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

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0780
Departmental Authority to Audit Records

(1) The Hospital must maintain financial records necessary and adequate to determine the Net Revenue for any calendar period for which a tax may be due.

(2) The Department or its designee may audit the Hospital's records at any time for a period of five years following the date the tax is due to verify or determine the Hospital's Net Revenue.

(3) The Department may issue a Notice of Deficiency or issue a refund based upon its findings during the audit.

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0790
Assessing Tax on Failure to File

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

(2) In the case of a failure by the Hospital to file a report or to maintain necessary and adequate records, the Department will determine the tax liability of the Hospital according to the best of its information and belief. "Best of its information and belief" means that the Department will use evidence available to the Department at the time of the determination on which a reasonable person would rely in determining the tax. The Department's determination of tax liability will be the basis for the assessment due in any Notice of Proposed Action.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

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

(1) A Hospital that fails to file a report or pay a tax when due will be subject to a penalty of $500 per day of Delinquency. The penalty accrues from the date of Delinquency, notwithstanding the date of any notice under these rules.

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

(3) Penalties imposed under this section will be collected by the Department of Human Services and deposited in the Department of Human Services Account established under ORS 409.060.

(4) Penalties paid under this section are in addition to the Hospital's tax liability.

(5) If the Department determines that a Hospital is subject to a penalty under this section, it will issue a Notice of Proposed Action as described in OAR 410-050-0810.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0810
Notice of Proposed Action

(1) Prior to issuing a Notice of Proposed Action, the Department will notify the Hospital of the potential Deficiency or failure to report that could give rise to the imposition of a penalty and provide the Hospital with not less than 30 calendar days from the date of the notice to respond to the notification. The Department may consider the response, if any, and any Amended Final Report under OAR 410-050-0760 in its Notice of Proposed Action.

(2) The Department will notify the Hospital if it determines that the Hospital is subject to the imposition of a penalty.

(3) Contents of the Notice of Proposed Action must include:

(a) The applicable reporting period;

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

(c) The corrected tax due as determined by the Department;

(d) The amount of tax paid by the Hospital;

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

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of Delinquency;

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

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

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

(k) Instructions for responding to the notice, and a statement of the Hospital's right to a hearing.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0820
Required Notice

(1) Any notice required to be sent under these rules will be sent to the Hospital's main address, to the attention of the hospital administrator, as listed by the Department's Health Care Licensure and Certification Unit's "Acute Care Provider List."

(2) Any notice required to be sent to the Department under these rules shall be sent to the contact point identified on the communication from the Department to the Hospital.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0830
Hearing Process

(1) Any Hospital that receives a Notice of Proposed Action may request a contested case hearing under ORS 183.310 to 183.550.

(2) The Hospital may request a hearing by submitting a written request within 20 days of the date of the Notice of Proposed Action.

(3) Prior to the hearing, the Department and Hospital will meet for an informal conference.

(4) Except as provided in subsection (5) of this rule, if the case proceeds to a hearing, the administrative law judge will issue a proposed order with respect to the Notice of Proposed Action. The Department will issue a Final Order.

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0840
Final Order of Payment

A Final Order of Payment is a final DHS action, expressed in writing, based on a Notice of Proposed Action where a payment amount is due to the Department. The Department will issue a Final Order of Payment for Deficiencies and/or penalties when:

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

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

(3) Upon the agreement of the Hospital and the Department.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

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

Any amounts due and owing under the Final Order of Payment and any interest thereon may be recovered by the State of Oregon as a debt to the State, using any available legal and equitable remedies.

These remedies include, but are not limited to:

(1) Collection activities including but not limited to deducting the amount of the final Deficiency and/or Penalty from any sum then or later owed to the Hospital by the Department; and

(2) Every payment obligation owed by the Hospital to the Department under a Final Order of Payment shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the Final Order of Payment and continuing until the payment obligation, including interest has been discharged.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

410-050-0860
Director Determines Rate of Tax

(1) The tax rate is determined by the Director.

(2) The tax rate for the period beginning January 1, 2004 through June 30, 2004 is 0 percent. The tax rate for the period beginning July 1, 2004 through December 31, 2004 is 0.95 percent.

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

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

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 91-2004(Temp), f. & cert. ef. 12-3-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05; OMAP 28-2005(Temp), f. & cert. ef. 5-10-05 thru 11-5-05; OMAP 34-2005, f. 7-8-05, cert. ef. 7-11-05

410-050-0861
Tax Rate

The Tax rate for the period beginning January 1, 2005 and ending June 30, 2006 is 0.68 percent. The tax rate for the period beginning July 1, 2006 is .82 percent.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 28-2005(Temp), f. & cert. ef. 5-10-05 thru 11-5-05; OMAP 34-2005, f. 7-8-05, cert. ef. 7-11-05; OMAP 14-2006, f. 6-1-06, cert. ef. 7-1-06

410-050-0870
Sunset Provisions

The hospital tax applies to Net Revenue received by Hospitals on or after January 1, 2004 and before January 1, 2008.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 86-2004(Temp), f. & cert. ef. 11-9-04 thru 5-7-05; OMAP 25-2005, f. 4-15-05, cert. ef. 5-7-05

DIVISION 120

MEDICAL ASSISTANCE PROGRAMS

410-120-0000
Acronyms and Definitions

(1) AAA — Area Agency on Aging.

(2) Abuse — Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Division of Medical Assistance Programs (DMAP), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Recipient practices that result in unnecessary cost to DMAP.

(3) Acupuncturist — A person licensed to practice acupuncture by the relevant State Licensing Board.

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

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

(6) Acquisition Cost — Unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.

(7) Addiction and Mental Health Division (AMH) — An Office within DHS administering mental health and addiction programs and services.

(8) 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 rules.

(9) Administrative Medical Examinations and Reports — Examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department of Human Services (DHS) branch office or requested or approved by DMAP to establish Client eligibility for a medical assistance program or for casework planning.

(10) All Inclusive Rate — The Nursing Facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Pharmaceutical Services and the Home Enteral/Parenteral Nutrition and IV Services Provider rules, except as specified in OAR 410-120-1340, Payment.

(11) Allied Agency — Local and regional governmental agencies and regional authorities that contract with DHS to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(12) Ambulance — A specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of DHS or the licensing standards of the state in which the Provider is located.

(13) Ambulatory Surgical Center (ASC) — A facility licensed as an ASC by DHS.

(14) American Indian/Alaska Native (AI/AN) — A member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(15) American Indian/Alaska Native (AI/AN) clinic — Clinics recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(16) 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); Typically, such medical services are not identified in the definition of a Condition/Treatment Pair, but are Medically Appropriate to support a service covered under the OHP Benefit Package; Ancillary Services and limitations are specified in the OHP Managed Care Rules related to the Prioritized List of Health Services (410-141-0480 through 410-141-0520), the General Rules Benefit Packages (410-120-1210), Exclusions (410-120-1200) and applicable individual program rules.

(17) Anesthesia Services — Administration of anesthetic agents to cause loss of sensation to the body or body part.

(18) Atypical Provider — Entity able to enroll as a Billing Provider (BP) or performing Provider for medical assistance programs related non-health care services but which does not meet the definition of health care Provider for National Provider Identification (NPI) purposes.

(19) Audiologist — A person licensed to practice Audiology by the State Board of Examiners for Speech Pathology and Audiology.

(20) 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.

(21) Automated Information System (AIS) — A computer system that provides information on Clients' current eligibility status from DMAP by computerized phone or Web-based response.

(22) Benefit Package — The package of covered health care services for which the Client is eligible.

(23) Billing Agent or Billing Service — Third party or organization that contracts with a Provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the Provider.

(24) Billing Provider (BP) — A person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from DMAP on behalf of a performing Provider and has been delegated the authority to obligate or act on behalf of the performing Provider.

(25) Buying Up — The practice of obtaining Client payment in addition to the DMAP or managed care plan payment to obtain a Non-Covered Service or item. (See 410-120-1350 Buying Up)

(26) 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.

(27) Children, Adults and Families Division (CAF) — An office within DHS, responsible for administering self-sufficiency and child-protective programs.

(28) Children's Health Insurance Program (CHIP) — A federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by DMAP.

(29) Chiropractor — A person licensed to practice chiropractic by the relevant State Licensing Board.

(30) Chiropractic Services — Services provided by a licensed Chiropractor within the scope of practice, as defined under State law and Federal regulation.

(31) Citizen/Alien-Waived Emergency Medical (CAWEM) — Aliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency Services for CAWEM are defined in OAR 410-120-1210(3)(f).

(32) Claimant — a person who has requested a hearing.

(33) Client — A person who is currently receiving medical assistance (also known as a Recipient).

(34) Clinical Social Worker — A person licensed to practice clinical social work pursuant to State law.

(35) Contiguous Area — The area up to 75 miles outside the border of the State of Oregon.

(36) Contiguous Area Provider — A Provider practicing in a Contiguous Area.

(37) Copayments — The portion of a claim or medical, dental or pharmaceutical expense that a Client must pay out of their own pocket to a Provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment)

(38) Cost Effective — The lowest cost health care service or item that, in the judgment of DMAP staff or its contracted agencies, meets the medical needs of the Client.

(39) Current Dental Terminology (CDT) — A listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(40) Current Procedural Terminology (CPT) — The Physicians' CPT is a listing of descriptive terms and identifying codes for reporting Medical Services and procedures performed by Physicians and other health care Providers.

(41) Date of Receipt of a Claim — The date on which DMAP receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of Receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(42) Date of Service — The date on which the Client receives Medical Services or items, unless otherwise specified in the appropriate Provider rules. For items that are mailed or shipped by the Provider, the Date of Service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(43) Dental Emergency Services — Dental Services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(44) Dental Services — Services provided within the scope of practice as defined under State law by or under the supervision of a Dentist.

(45) Dentist — A person licensed to practice dentistry pursuant to State law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

(46) Denturist — A person licensed to practice denture technology pursuant to State law.

(47) Denturist Services — Services provided, within the scope of practice as defined under State law, by or under the personal supervision of a Denturist.

(48) Dental Hygienist — A person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(49) Dental Hygienist with Limited Access Certification (LAC) — A person licensed to practice dental hygiene with LAC pursuant to State law.

(50) Department — DHS or its Division of Medical Assistance Programs (DMAP).

(51) Department of Human Services (DHS) — The Department or DHS or any of its programs or offices means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (DMAP). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMHD). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and Families or CAF is used in contract or rule, it shall mean the Children, Adults and Families Division (CAF). Wherever the former Health Division is used in Contract or in rule, it shall mean the Public Health Division (PHD).

(52) Department Representative — A person who represents the Department in a hearing and presents the Department's position.

(53) Diagnosis Code — As identified in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the primary Diagnosis Code is shown in all billing claims, unless specifically excluded in individual Provider rule(s). Where they exist, Diagnosis Codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(54) Diagnosis Related Group (DRG) — A system of classification of diagnoses and procedures based on the ICD-9-CM.

(55) Division of Medical Assistance Programs (DMAP) — An Office within DHS; DMAP is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon

Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP –Title XXI), and several other programs.

(56) Durable Medical Equipment (DME) and Medical Supplies — Equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

(57) Electronic Data Interchange (EDI) — The exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, such other format as Oregon DHS will designate. (See OARs in Chapter 410, Division 001)

(58) EDI Submitter — The entity that establishes an electronic connection with Oregon DHS to submit or receive an electronic data transaction on behalf of a Provider.

(59) Electronic Eligibility Verification Service (EEVS) — Vendors of medical assistance eligibility information that have met the legal and technical specifications of DMAP in order to offer eligibility information to enrolled Providers of DMAP.

(60) Emergency Department — The part of a licensed Hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(61) Emergency Medical Services — (This definition does not apply to Clients with CAWEM Benefit Package. CAWEM emergency services are governed by OAR 410-120-1210 (3)(f)(B)). If an emergency medical condition is found to exist based on a medical triage screening examination, Emergency Medical Services necessary to stabilize the condition must be provided. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the Client or transfer of the Client to another facility.

(62) Emergency Transportation — Transportation necessary when a sudden, unexpected Emergency Medical Service creates a medical crisis requiring a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a Hospital, where appropriate emergency medical service is available.

(63) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (also Medicheck) — The Title XIX program of EPSDT Services for eligible Clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required Medically Appropriate health care services and to help DMAP Clients and their parents or guardians effectively use them.

(64) False Claim — A claim that a Provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and such inaccurate or misleading information would result, or has resulted, in an Overpayment.

(65) Family Planning — Services for Clients of child bearing 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.

(66) 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 CMS upon recommendation of the U.S. Public Health Service.

(67) Fee-for-Service Provider — A medical Provider who is not reimbursed under the terms of a DMAP contract with a Prepaid Health Plan (PHP), also referred to as a Managed Care Organization (MCO). A medical Provider participating in a PHP may be considered a Fee-for-Service Provider when treating Clients who are not enrolled in a PHP.

(68) Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal or state law.

(69) Fully Dual Eligible — For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare Clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by DHS for full medical assistance coverage.

(70) General Assistance (GA) — Medical Assistance administered and funded 100% with State of Oregon funds through OHP.

(71) Healthcare Common Procedure Coding System (HCPCS)- A method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. DMAP uses HCPCS codes; however, DMAP uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(72) 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.

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

(74) 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 Provider rules.

(75) 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 DHS as a Home Health Agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(76) 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 Client's home.

(77) Home Intravenous (IV) 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 rules.

(78) 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 rules.

(79) 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, accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry.

(80) Hospital — A facility licensed by the Office of Public Health Systems as a general Hospital which meets requirements for participation in the OHP under Title XVIII of the Social Security Act. Facilities licensed as Special Inpatient Care Facilities under the Office of Public Health System's definition of Hospital are not considered Hospitals by DMAP for reimbursement purposes; however, effective April 1, 2000, DMAP will reimburse a Special Inpatient Care Facility if CMS has certified the facility for participation in the Medicare Program as a Hospital. 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.

(81) 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 (DMAP 42) report for DMAP.

(82) 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 to DMAP.

(83) Indian Health Program — Any Indian Health Service facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(84) Individual Adjustment Request (DMAP 1036) Form used to resolve an incorrect payment on a previously paid claim, including underpayments or Overpayments.

(85) Inpatient — a Hospital patient who is not an Outpatient.

(86) Inpatient Hospital Services — Services that are furnished in a Hospital for the care and treatment of an Inpatient. (See Hospital Services rules for Inpatient covered services.)

(87) 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. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing

care in a Nursing Facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' (SPD) Home and Community Based Waiver.

(88) 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.

(89) International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) — Diagnosis Codes including volumes 1, 2, and 3, as revised annually.

(90) Laboratory — A facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide Laboratory Services within or a part from a Hospital. An entity is considered a Laboratory if materials are derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one Laboratory test, including waived tests for these purposes, it is considered under the Clinical Laboratory Improvement Act (CLIA), to be a Laboratory.

(91) 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.

(92) Licensed Direct Entry Midwife — A practitioner licensed by DHS' Public Health Division as a Licensed Direct Entry Midwife.

(93) 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, homeowner's Liability Insurance, malpractice insurance, product Liability Insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(94) Managed Care Organization (MCO) – Contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(95) Maternity Case Management — A program available to pregnant Clients. The purpose of Maternity Case 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 rules.

(96) Medicaid — A federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by DHS.

(97) Medical Assistance Eligibility Confirmation — Verification through the AIS, an authorized DHS representative, an EEVS vendor or through presentation of a valid Medical Care Identification that a Client has an open assistance case, which includes medical benefits.

(98) Medical Services — Care and treatment provided by a licensed medical Provider directed at preventing, diagnosing, treating or correcting a medical problem.

(99) Medical Transportation — Transportation to or from covered Medical Services.

(100) 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 OHP Client or a Provider of the service or medical supplies; and

(d) The most Cost Effective of the alternative levels of Medical Services or medical supplies which can be safely provided to a DMAP Client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(101) 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;

(c) Prescription drug coverage (Part D) — Covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). (See OAR 410, Division 121 for limitations).

(102) Medicheck for Children and Teens — See EPSDT.

(103) National Provider Identification (NPI) — Federally directed Provider number mandated for use on HIPAA covered transactions; individuals, Provider Organizations and Subparts of Provider Organizations that meet the definition of health care Provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(104) Naturopath — A person licensed to practice naturopathy pursuant to State law.

(105) Naturopathic Services — Services provided within the scope of practice as defined under State law.

(106) Non Covered Services — Services or items for which DMAP is not responsible for payment. Non-Covered Services are identified in:

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

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

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

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

(e) The individual DMAP Provider rules.

(107) 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.

(108) 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.

(109) 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.

(110) Nursing Facility — A facility licensed and certified by the DHS' SPD defined in 411-070-0005.

(111) 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.

(112) 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.

(113) Occupational Therapist — A person licensed by the State Board of Examiners for Occupational Therapy.

(114) 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.

(115) Optometric Services — Services provided, within the scope of practice of optometrists as defined under State law.

(116) Optometrist — A person licensed to practice optometry pursuant to State law.

(117) Oregon Youth Authority (OYA) — 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.

(118) 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.

(119) Outpatient — a Hospital patient who:

(a) Is treated and released the same day or is admitted to the Hospital and discharged before midnight and is not listed on the following day's census, excluding a patient who:

(A) Is admitted and transferred to another Acute care Hospital on the same day;

(B) Expires on the day of admission; or

(C) Is born in the Hospital.

(b) Is admitted for ambulatory surgery, to a birthing center, a treatment or observation room, or a short-term stay bed;

(c) Receives observation services provided by a Hospital, including the use of a bed and periodic monitoring by Hospital nursing or other staff for the purpose of evaluation of a patient's medical condition for a maximum of 48 hours; or

(d) Receives routine preparation services and recovery for diagnostic services provided in a Hospital Outpatient department.

(120) Outpatient Hospital Services — Services that are furnished in a Hospital for the care and treatment of an Outpatient. (See Hospital rules for Outpatient covered services).

(121) Overdue Claim — A Valid Claim that is not paid within 45 days of the date it was received.

(122) Overpayment — Payment(s) made by DMAP to a Provider in excess of the correct DMAP payment amount for a service. Overpayments are subject to repayment to DMAP.

(123) Overuse — Use of medical goods or services at levels determined by DMAP medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(124) Panel — The Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

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

(126) Peer Review Organization (PRO) — An entity of health care practitioners of services contracted by the State to review services ordered or furnished by other practitioners in the same professional field.

(127) 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.

(128) Pharmacist — A person licensed to practice pharmacy pursuant to state law.

(129) 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.

(130) Physical Therapist — A person licensed by the relevant State licensing authority to practice Physical Therapy.

(131) 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.

(132) Physician — A person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government.

(133) Physician Assistant — A person licensed as a Physician Assistant in accordance with ORS 677. Physician Assistants provide Medical Services under the direction and supervision of an Oregon licensed Physician according to a practice description approved by the Board of Medical Examiners.

(134) Physician Services — Services provided, within the scope of practice as defined under state law, by or under the personal supervision of a Physician.

(135) Podiatric Services — Services provided within the scope of practice of Podiatrists as defined under state law.

(136) Podiatrist — A person licensed to practice podiatric medicine pursuant to state law.

(137) Post-Payment Review — Review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(138) 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.

(139) Premium Sponsorship — Premium donations made for the benefit of one or more specified DMAP Clients (See 410-120-1390).

(140) Prepaid Health Plan (PHP) — A managed health, dental, chemical dependency, or mental health organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under OHP. PHP's may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(141) 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.

(142) Primary Care Provider (PCP) — Any enrolled medical assistance Provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified Clients. PCPs initiate Referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of Medically Appropriate Client care.

(143) Prior Authorization (PA) — Payment Authorization for specified Medical Services or items given by DMAP staff, or its contracted agencies prior to provision of the service. A Physician Referral is not a PA.

(144) Prioritized List of Health Services — Also referred to as the Prioritized List, the Oregon Health Services Commission's (HSC) listing of health services with "expanded definitions" of Ancillary Services and Preventive Services and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The Prioritized List governs medical assistance programs' health services and Benefit Packages pursuant to these General Rules (OAR 410-120-0000 et seq.) and OAR 410-141-0480 through 410-141-0520.

(145) 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.

(146) Provider — An individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing Provider, or bills, obligates and receives reimbursement on behalf of a performing Provider of services, also termed a Billing Provider (BP). The term Provider refers to both Performing Providers and BPs unless otherwise specified.

(147) Provider Organization — a group practice, facility, or organization that is:

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

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

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

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

(e) If such entity solely submits billings on behalf of Providers and payments are made to each Provider, then the entity is an agent.

(See Subparts of Provider Organization)

(148) Public Health Clinic — A clinic operated by county government.

(149) 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 DMAP Clients.

(150) Qualified Medicare Beneficiary (QMB) — A Medicare beneficiary, as defined by the Social Security Act and its amendments.

(151) Qualified Medicare and Medicaid Beneficiary (QMM) — A Medicare Beneficiary who is also eligible for DMAP coverage.

(152) Quality Improvement Organization (QIO) — An entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid Clients; formerly known as a Peer Review Organization.

(153) 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.

(154) Recipient — A person who is currently eligible for medical assistance (also known as a Client).

(155) Recoupment — An accounts receivable system that collects money owed by the Provider to DMAP by withholding all or a portion of a Provider's future payments.

(156) Referral — The transfer of total or specified care of a Client from one Provider to another. As used by DMAP, the term Referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of Clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a Referral is required before non-emergency care is covered by the PHP or DMAP.

(157) 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.

(158) Request for Hearing — A clear expression, in writing, by an individual or representative that the person wishes to appeal a Department decision or action and wishes to have the decision considered by a higher authority.

(159) Retroactive Medical Eligibility — Eligibility for medical assistance granted to a Client retroactive to a date prior to the Client's application for medical assistance.

(160) Sanction — An action against Providers taken by DMAP in cases of Fraud, misuse or Abuse of DMAP requirements.

(161) 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.

(162) Seniors and People with Disabilities Division (SPD) — An Office of DHS responsible for the administration of programs for seniors and people with disabilities.

(163) Service Agreement — An agreement between DMAP 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.

(164) 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.

(165) Social Worker — A person licensed by the Board of Clinical Social Workers to practice clinical social work.

(166) Speech-Language Pathologist — A person licensed by the Oregon Board of Examiners for Speech Pathology.

(167) 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.

(168) 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.

(169) State Facility — A Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

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

(171) Subrogation — Right of the State to stand in place of the Client in the collection of Third Party Resources (TPR).

(172) Supplemental Security Income (SSI) — A program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(173) Surgical Assistant — A person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(174) Suspension — A Sanction prohibiting a Provider's participation in DHS medical assistance programs by deactivation of the Provider's DMAP assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the Suspension. The number will be reactivated automatically after the Suspension period has elapsed.

(175) Targeted Case Management (TCM) — Activities that will assist the Client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services often provided by Allied Agency Providers.

(176) Termination — A Sanction prohibiting a Provider's participation in DMAP's programs by canceling the Provider's DMAP assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of Termination. Termination is permanent unless:

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

(b) Otherwise stated by DMAP at the time of Termination.

(177) 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 DMAP Client.

(178) Transportation — See Medical Transportation.

(179) Type A Hospital — A Hospital identified by the Office of Rural Health as a Type A Hospital.

(180) Type B AAA Unit — A Type B Area Agency on Aging (AAA) funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(181) Type B Hospital — A Hospital identified by the Office of Rural Health as a Type B Hospital.

(182) Usual Charge (UC) — The lesser of the following unless prohibited from billing by federal statute or regulation:

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

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

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

(183) 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.

(184) Valid Claim — An invoice received by DMAP or the appropriate Department office 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 TPR; and

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

(185) Vision Services — Provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82, for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 81-1982, f. 8-30-82, ef. 9-1-82; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 13-1987, f. 3-31-87, ef. 4-1-87; AFS 7-1988, f. & cert. ef. 2-1-88; AFS 69-1988, f. & cert. ef. 12-5-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0005; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2000, f. & cert. ef. 6-23-00; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-

03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

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

(1) The Department of Human Services (DHS) and its Division of Medical Assistance Programs (DMAP) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), ORS 414.725 (Prepaid Health Plans), and ORS 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, DMAP will construe them as much as possible to be complementary. In the event that DMAP policies, procedures, rules and interpretations may not be complementary, DMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to DMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, DMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted DMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, DMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the Provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service Providers or other contractors, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in DMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in OAR 410-141-0480 to 410-141-0520, and the Provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by DMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs.

(b) For purposes of contract administration solely as between DMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to DMAP Clients:

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.;

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-0080 [Renumbered to **410-120-1140**]

410-120-0250
Managed Care Organizations

(1) The Department of Human Services (DHS) provides some Oregon Health Plan (OHP) Clients with prepaid health services, through contracts with a Prepaid Health Plan (PHP), also known as a Managed Care Organization (MCO). An MCO may be a Fully Capitated Health Plan (FCHP), Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO) or Physician Care Organization (PCO).

(2) The MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law, the MCO's contract with DHS and the OHP Administrative Rules governing PHPs (OAR 410 division 141).

(3) All MCOs are required to provide benefit coverage pursuant to OAR 410-120-1210 and 410-141-0480 through 410-141-0520, however, authorization criteria may vary between MCOs. It is the Providers' responsibility to comply with the MCO's Prior Authorization requirements or other policies necessary for reimbursement from the MCO, before providing services to any OHP Client enrolled in a MCO.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 67-2005, f. 12-21-05, cert. ef. 1-1-06

410-120-1140
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 rules. There are three different types of Medical Care Identifications by which eligibility can be confirmed:

(a) Form DMAP 1417 — Division of Medical Assistance Programs (DMAP) Medical Care Identification. This is a computer-generated notice that is mailed to the Client once a month or anytime there is a change to the case (e. g., address change);

(b) Form DMAP 1086 — Temporary Medical Care Identification. The responsible branch office issues this handwritten form;

(c) Form WMMMID1C-A — Temporary Medical Care Identification. This is a computer-generated form that is signed by an authorized person in the responsible branch office.

(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 for the service provided and whether a managed care plan or DMAP is responsible for reimbursement. The Provider assumes full financial risk in serving a person not identified as eligible or not confirmed by DMAP as eligible for the service provided on the date(s) of service.

(3) Medical Care Identifications include:

(a) The name(s) of the eligible individual(s), and the eligible person(s) Recipient Identification Number;

(b) The case number;

(c) Dates of coverage, including fee-for-service and managed care enrollment dates;

(d) The benefit packages each Client is eligible for;

(e) Optional program messages (e.g., Third Party Resource information);

(f) The name of the responsible branch, the worker's identification code and the phone number of the branch;

(g) The name and phone number of the managed care Provider, if applicable;

(h) Medical Management and pharmacy restrictions, if applicable.

(4) The 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, which shows the dates on which the Client is eligible and indicates each Client's benefit package; or

(b) If a patient identifies him or herself as eligible, but does not have a valid Medical Care Identification, the Provider may either:

(A) Contact the DMAP Automated Information System (AIS), which is available on the Internet or via telephone;

(B) Providers who have contracted with an Electronic Eligibility Verification Service (EEVS) vendor can access Client eligibility data 24 hours a day, 7 days a week; or

(C) Providers may contact the local Department of Human Services (DHS) branch office during regular working hours to confirm eligibility if the information is not available electronically.

Stat. Auth.: ORS 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 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82, for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 43-1986(Temp), f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 53-1987, f. 10-29-87, ef. 11-1-87; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0040; Renumbered from 461-013-0103 & 461-013-0109; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93;

HR 32-1993, f. & cert. ef. 11-1-93; OMAP 10-1999, f. & cert. ef. 4-1-99, Renumbered from 410-120-0080; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1160
Medical Assistance Benefits and Provider Rules

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

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

(a) Acupuncture Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(b) Administrative Examinations, as described in the Administrative Examinations and Billing Services Provider rules (OAR 410 division 150);

(c) Alcohol and drug abuse treatment services:

(A) DMAP covers alcohol and drug Inpatient Services for medical detoxification when provided in an acute care Hospital and when hospitalization is considered Medically Appropriate;

(B) DMAP does not cover residential level of care provided in an Inpatient Hospital setting for alcohol and drug abuse treatment;

(C) The Addictions and Mental Health Division (AMH) covers non-hospital alcohol and drug treatment services on a residential or outpatient basis through direct contracts with counties or Providers. For information to access these services, contact the Client's managed care plan if enrolled, the community mental health program (CMHP), an outpatient alcohol and drug treatment provider, the residential treatment program or AMH.

(d) Ambulatory Surgical Center Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(e) Anesthesia Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

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

(g) Chiropractic Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(h) Dental Services, as described in the Dental/Denturist Services Provider rules (OAR 410 division 123);

(i) 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 individual program Provider rules. DMAP may authorize services in excess of limitations established in the OARs when it is Medically Appropriate to treat a condition that is identified as the result of an EPSDT screening;

(j) Family Planning Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(k) Federally Qualified Health Centers and Rural Health Clinic, as described in the Federally Qualified Health Center and Rural Health Clinic Provider rules (OAR 410 division 147);

(l) Home and Community Based Waiver Services, as described in the DHS OARs of Children, Adults and Families Division (CAF), Addictions and Mental Health Division (AMH), and Seniors and People with Disabilities Division (SPD);

(m) Home Enteral/Parenteral Nutrition and IV Services, as described in the Home Enteral/Parenteral Nutrition and IV Services Provider rules (OAR 410 division 148), and related Durable Medical Equipment and Medical Supplies rules (OAR 410 division 122) and Pharmacy rules (OAR 410 division 121);

(n) Home Health Services, as described in the Home Health Services Provider rules (OAR 410 division 127);

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

(p) Indian Health Services or tribal facility, as described in The Indian Health Care Improvement Act and its Amendments (Public Law 102-573), and the DMAP American Indian/Alaska Native Provider rules (OAR 410 division 146);

(q) Inpatient Hospital Services, as described in the Hospital Services Provider rules (OAR 410 division 125);

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

(s) Licensed Direct Entry Midwife Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(t) Maternity Case Management, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(u) Medical Equipment and Supplies, as described in the Hospital Services, Medical-Surgical Services, Durable Medical Equipment, Home Health Care Services, Home Enteral/Parenteral Nutrition and IV Services and other Provider rules;

(v) When a Client's Medical Care Identification Card indicates that he or she has a benefit package that includes mental health, the mental health services provided will be based on the Prioritized List of Health Services.;

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

(x) Nutritional Counseling as described in the Medical/Surgical Services Provider rules (OAR 410 division 130);

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

(z) Organ Transplant Services, as described in the Transplant Services Provider rules (OAR 410 division 124);

(aa) Outpatient Hospital Services, including clinic services, Emergency Department Services, Physical and Occupational Therapy services, and any other Outpatient Hospital services provided by and in a Hospital, as described in the Hospital Services Provider rules (OAR 410 division 125);

(bb) Physician, Podiatrist, Nurse Practitioner and Licensed Physician Assistant Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

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

(dd) Post Hospital Extended Care Benefit, as described in OAR 410 division 120 and 141 and SPD program rules;

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

(ff) Preventive Services, as described in the Medical-Surgical Services (OAR 410 division 130) and the Dental/Denturist Services Provider rules (OAR 410 division 123) and prevention guidelines associated with the Health Service Commission's Prioritized List of Health Services (OAR 410-141-0520);

(gg) Private Duty Nursing, as described in the Private Duty Nursing Provider rules (OAR 410 division 132);

(hh) Radiology and Imaging Services, as described in the Medical-Surgical Services (OAR 410 division 130), the Hospital Services (OAR 410 division 125), and Dental and Denturist Services Provider rules (OAR 410 division 123);

(ii) Rural Health Clinic Services, as described in the Federally Qualified Health Center and Rural Health Clinic Provider rules (OAR 410 division 147);

(jj) School-Based Health Services, as described in the School-Based Health Services Provider rules (OAR 410 division 133);

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

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

(mm) Vision Services as described in the Visual Services Provider rules (OAR 410 division 140).

(3) Other DHS units or Offices, including Vocational Rehabilitation, OMHAS, and SPD may offer services to Medicaid eligible Clients, which are not reimbursed by or available through DMAP.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; Renum-

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

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

(1) Out-of-State Providers must enroll with the Division of Medical Assistance Programs (DMAP) as described in Oregon Administrative Rules (OAR) 410-120-1260, Provider Enrollment. Out-of-State Providers must provide services and bill in compliance with all of these General Rules and the OARs for the appropriate type of service(s) provided.

(2) DMAP reimburses enrolled Out-of-State Providers in the same manner and at the same rates as in-state Providers unless otherwise specified in the individual Provider rules or by contract or Service Agreement with the individual Provider.

(3) For enrolled non-contiguous, Out-of-State Providers, DMAP reimburses for covered services under any of the following conditions:

(a) The service was emergent; or

(b) A delay in the provision of services until the Client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;

(c) DMAP authorized payment for the service in advance of the provision of services or was otherwise authorized in accordance with Payment Authorization requirements in the individual Provider rules or in the General Rules;

(d) The service was authorized by a Prepaid Health Plan (PHP) including a Fully Capitated Health Plan (FCHP), a Physician Care Organization (PCO) or a Dental Care Organization (DCO) and payment to the Out-of-State Provider is the responsibility of the PHP;

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

(4) DMAP may give Prior Authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:

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

(b) DMAP covers the service or item under the specific Client's benefit package; and

(c) The service or item is not available in the State of Oregon or provision of the service or item by an Out-of-State Provider is Cost Effective, as determined by DMAP (or, for those Clients covered by a managed care plan, the plan will make that determination); and

(d) The service or item is deemed Medically Appropriate and is recommended by a referring Oregon Physician;

(e) If a Client has coverage through a managed care plan, a PHP, the request for non-emergency services must be referred to the PHP. Payment for these services is the responsibility of the PHP.

(5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered service and does not require PA. The Laboratory must meet the same certification requirements as Oregon Laboratories and must bill in accordance with DMAP rules.

(6) DMAP makes no reimbursement for services provided to a Client outside the territorial limits of the United States, unless the country operates a Title XIX medical assistance program.

(7) DMAP will reimburse, within limits described in these General Rules and in individual Provider rules, all services provided by enrolled Providers to children:

(a) Who the Department of Human Services (DHS) has placed in foster care;

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

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

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

(9) Payment rates for Out-of-State Providers are established in the individual Provider rules, through contracts or Service Agreements and in accordance with OAR 410-120-1340, Payment.

Stat. Auth.: ORS 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 461-013-0130, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 21-1985, f. 4-2-85, ef. 5-1-85; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0045 & 461-013-0046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0120, 410-120-0140 & 410-120-0160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1190
Medically Needy Benefit Program

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist,: OMAP 2-2003, f. 1-31-03, cert. ef. 2-1-03

410-120-1195
SB 5548 Population

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

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

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

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

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

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

(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at www.dhs.state.or.us/publichealth/ hiv/careassist/frmlry.cfm.

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

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

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

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

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

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

described in subsection (3)(c) of this rule at the lesser of billed, Average Wholesale Price (AWP) minus 15% or Oregon Maximum Allowable Cost (OMAC), plus a dispensing fee of $3.50;

(c) DHS pharmacy benefits manager, First Health, will process retail pharmacy drug benefit reimbursement claims for SB 5548 Clients;

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

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

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

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

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 28-2003(Temp), f. & cert. ef. 4-1-03 thru 9-1-03; OMAP 44-2003, f. & cert. ef. 6-30-03; OMAP 45-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 89-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1200
Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of eligible Clients. If the Client accepts financial responsibility for a Non-Covered Service, payment is a matter between the Provider and the Client subject to the requirements of OAR 410-120-1280.

(2) The Division of Medical Assistance Programs (DMAP) will make no payment 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 DMAP staff, or its contracted entities, for example, the DMAP Medical Director, medical consultants, dental consultants or Quality Improvement Organizations (QIO);

(b) That are not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury;

(c) That are determined not medically or dentally appropriate by DMAP 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 or 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 Client. Examples include exams for employment or insurance purposes;

(f) That are provided by friends or relatives of eligible Clients or members of his or her household, except:

(A) When the friend, relative or household member is a health professional, acting in a professional capacity; or

(B) When the friend, relative or household member is directly employed by the Client under the Department of Human Services (DHS) Seniors and People with Disabilities Division (SPD) Home and Community Based Waiver or the SPD administrative rules, OAR 411-034-000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) When the friend, relative or household member is directly employed by the Client under the Children, Adults and Families Division (CAF) administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor Client (under the age of 18) must not be legally responsible for the Client in order to be a Provider of personal care services.

(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, except such services as designated by federal statute or regulation as permissible for coverage under DMAP administrative rules;

(h) When 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 that DMAP rented or purchased;

(i) That are related to a non-covered service; some exceptions are identified in the individual Provider rules. If DMAP determines the provision of a service related to a non-covered service is cost-effective, the related medical service may, at the discretion of DMAP and with DMAP Prior Authorization (PA), be covered;

(j) That are considered experimental or investigational, including clinical trials and demonstration projects, 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 appropriate program rules including the Hospital rules, Revenue Codes Section, as Non- Covered Services;

(l) That are requested by or for a Client whom DMAP has determined 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 DMAP for casework planning or eligibility determinations;

(n) Whose primary intent is to improve appearance;

(o) That are similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the Client will be essentially the same;

(p) That are for the purpose of establishing or reestablishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence;

(q) Items or services which are for the convenience of the Client and are not medically or dentally appropriate;

(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 Appropriate and surgery is scheduled;

(s) Educational or training classes that are not Medically Appropriate (Lamaze classes, for example);

(t) Outpatient social services except Maternity Case Management services and other social services described as covered in the individual Provider rules;

(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) 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, except for telephone calls for the purpose of tobacco cessation counseling, as described in OAR 410-130- 0190, Maternity Case Management as described in OAR 410-130-0595; and where applicable for Telemedicine as described in OAR 410-130-0610;

(z) Transsexual surgery or any related services or items;

(aa) Weight loss programs, including, but not limited to Optifast, Nutrisystem, and other similar programs. Food supplements will not be authorized for use in weight loss;

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

(cc) Immunizations prescribed for foreign travel;

(dd) Services that 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);

(ee) DUII-related services already covered by the Intoxicated Driver Program Fund as directed by ORS 813.270(1) and (5);

(ff) Transportation to meet a Client's personal choice of a Provider;

(gg) Pain center evaluation and treatment;

(hh) Alcoholics Anonymous (AA) and other self help programs;

(ii) Medicare Part D covered prescription drugs or classes of drugs, and any cost sharing for those drugs, for Medicare-Medicaid Fully Dual Eligible Clients, even if the Fully Dual Eligible Client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for Benefit Package.

Stat. Auth.: ORS 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 461-013-0030; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-82; AFS 15-1983(Temp), f. & ef. 4-20-83; AFS 31-1983(Temp), f. 6-30-83, ef. 7-1-83; AFS 43-1983, f. 9-2-83, ef. 10-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 29-1987(Temp), f. 7-15-87, ef. 7-17-87; AFS 54-1987, f. 10-29-87, ef. 11-1-87; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 70-1988, f. & cert. ef. 12-7-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0055; 461-013-0103, 461-013-

0109 & 461-013-0112; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 23-1990(Temp), f. & cert. ef. 7-20-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 27-1991 (Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0420, 410-120-0460 & 410-120-0480; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 6-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 12-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 22-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 8-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 17-2003(Temp), f. 3-13-03, cert. ef. 3-14-03 thru 8-15-03; OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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

(1) The services Clients are eligible to receive are based upon the Benefit Package for which they are eligible. The letters in field 9b "Benefit Packages" of the Medical Care ID identify each Client's Benefit Package. Some medical assistance Clients have limited benefits. The text in the box marked "Benefit Package Messages," on the Medical Care Identification, describe the package of medical benefits the Recipient is eligible to receive.

(2) The Division of Medical Assistance Programs (DMAP) Benefit Package names, and the Clients eligible to receive the various packages, are identified as follows:

(a) Oregon Health Plan (OHP) Plus Benefit Package — Clients on this Benefit Package are categorically eligible for medical assistance as defined in federal regulations and in the OHP waiver granted on October 15, 2002. A Client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program and also meets Department of Human Services' (DHS) adopted income and other eligibility criteria;

(b) Qualified Medicare Beneficiary (QMB) + OHP with limited drug Benefit Package — Clients on this Benefit package are Medicare beneficiaries who meet DHS adopted income standard and other eligibility criteria for full medical assistance coverage, and are Fully Dual Eligible for purposes of Medicare Part D; DHS identifies these Clients through the Benefit Package identifier BMM;

(c) OHP with limited drug Benefit Package — Clients on this Benefit Package are Medicare beneficiaries, other than QMBs in (2)(b) of this rule, who meet DHS adopted income standard and other eligibility criteria for full medical assistance coverage, and are Fully Dual Eligible for purposes of Medicare Part D; DHS identifies these Clients through the Benefit Package identifier BMD;

(d) OHP Standard Benefit Package — Clients on this Benefit Package are eligible for OHP through the Medicaid expansion waiver granted on October 15, 2002. These Clients are adults and childless couples who meet DHS adopted income and other eligibility criteria; DHS identifies these Clients through the program acronym, OHP-OPU;

(e) Qualified Medicare Beneficiary (QMB)-Only Benefit Package — Clients on this limited Benefit Package are Medicare beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage. These Clients have coverage through Medicare Parts A and B for most covered services;

(f) Citizen/Alien-Waived Emergency Medical (CAWEM) Benefit Package — Clients on this limited Benefit Package are certain eligible, non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070. The Medical Care Identification that the Client is issued indicates coverage. The CAWEM Benefit Package is limited to the services listed in section (3)(f) of this rule.

(3) The benefit limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in individual program Provider rules. The benefits and limitations included in each OHP Benefit Package follow:

(a) OHP Plus Benefit Package coverage includes:

(A) Services above the funding line on the Health Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

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

(C) Chemical dependency services provided through local alcohol and drug treatment Providers;

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

(E) Hospice;

(F) Post Hospital Extended Care benefit, up to a 20-day stay in a Nursing Facility for non-Medicare DMAP Clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires Prior Authorization by Pre-Admission Screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for Clients enrolled in an FCHP;

(G) Cost sharing may apply to some covered services.

(b) QMB + OHP with limited drug Benefit Package coverage includes any service covered by Medicare, except that drugs or classes of drugs covered by Medicare Part D Prescription Drug are only covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, except as limited in (E) below. This package also covers:

(A) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

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

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider;

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

(E) Cost sharing may apply to some covered services, however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the Benefit Package;

(F) DMAP will continue to coordinate benefits for drugs covered under Medicare Part B, subject to Medicare's benefit limitations and DMAP Provider rules;

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

(i) Benzodiazepines;

(ii) Over-the-Counter (OTC) drugs;

(iii) Barbiturates.

(c) OHP with limited drug Benefit Package for Fully Dual Eligible Clients includes any service covered by Medicare, except that drugs or classes of drugs covered by Medicare Part D Prescription Drug are only covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, except as limited in (E) below. This package also covers:

(A) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

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

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider;

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

(E) Cost sharing may apply to some covered services, however cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the Benefit Package;

(F) DMAP will continue to coordinate benefits for drugs covered under Medicare Part B, subject to Medicare's benefit limitations and DMAP Provider rules;

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

(i) Benzodiazepines;

(ii) Over-the-Counter (OTC) drugs;

(iii) Barbiturates.

(d) OHP Standard benefits adhere to the following provisions:

(A) OHP Standard coverage, subject to sections (B) and (C) of this section includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

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

(iii) Outpatient chemical dependency services provided through local alcohol and drug treatment Providers;

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

(v) Hospice;

(vi) Post Hospital Extended Care benefit, up to a 20-day stay in a nursing facility for non-Medicare DMAP Clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires Prior Authorization by Pre-Admission Screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for Clients enrolled in an FCHP.

(B) The following services have limited coverage for the OHP Standard benefit package (Refer to the cited OAR chapters and divisions for details):

(i) Selected Dental (OAR chapter 410 division 123);

(ii) Selected Durable Medical Equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Selected Hospital services (OAR chapter 410, division 125);

(v) Other limitations as identified in individual DMAP program administrative rules.

(C) The following services are not covered under the OHP Standard Benefit Package. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for chemical dependency treatment (OAR chapter, 410 division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home Health Services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency Medical Transportation (OAR chapter 410, division 136);

(vi) Occupational Therapy services (OAR chapter 410, division 131);

(vii) Physical Therapy services (OAR chapter 410, division 131);

(viii) Private Duty Nursing Services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and Language Therapy services (OAR chapter 410, division 129);

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

(xi) Other limitations as identified in individual DMAP program administrative rules.

(e) The QMB-Only Benefit Package provides only services that are also covered by Medicare:

(A) Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(B) Providers may bill QMB Clients for services that are not covered by Medicare. Providers may not bill QMB Clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(f) The Citizen/Alien-Waived Emergency Medical Assistance (CAWEM) Benefit Package provides limited services:

(A) Emergency medical services and labor and delivery services; CAWEM services are strictly defined by 42 CFR 440.255 (the definition does not apply a prudent layperson standard);

(B) A CAWEM Client is eligible for services only after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(C) The following services are not covered for CAWEM Clients, even if they are seeking emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home Health;

(ix) Private Duty Nursing;

(x) Dialysis;

(xi) Dental Services provided outside of an Emergency Department Hospital setting;

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

(xiii) Non-emergency Medical Transportation;

(xiv) Therapy services;

(xv) Durable Medical Equipment and medical supplies;

(xvi) Rehabilitation services.

(4) DMAP covered health services are delivered through one of several means:

(a) Prepaid Health Plan (PHP):

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

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

(C) Inpatient hospitalization services that are not the responsibility of a Physician Care Organization (PCO) are governed by the Hospital rules (OAR 410 division 125);

(D) The name and phone number of the PHP appears on the Medical Care Identification.

(b) Primary Care Managers (PCM):

(A) These Clients are enrolled with a PCM for their medical care;

(B) Most non-emergency services provided to Clients enrolled with a PCM require referral from the PCM.

(c) Fee-For-Service (FFS):

(A) These Clients are not enrolled in a PHP or assigned to a PCM;

(B) Subject to limitations and restrictions in individual program rules, the Client can receive health care from any DMAP-enrolled Provider that accepts FFS Clients. The Provider will bill DMAP directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1230
Client Copayment

(1) Oregon Health Plan (OHP) Plus Clients shall be responsible for paying a copayment for some services. This copayment shall be paid directly to the Provider.

(2) The following services are exempt from copayment:

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

(b) Family planning services and supplies;

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

(d) Any service not listed in (10) below.

(3) The following Clients are exempt from copayments:

(a) Services provided to pregnant women;

(b) Children under age 19;

(c) Any Client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR);

(d) American Indian/Alaska Native (AI/AN) Clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), tribal organization or services provided at an Urban Tribal Health Clinic as provided under P.L. 93-638.

(4) Clients enrolled in a DMAP contracted Prepaid Health Plan (PHP) will be exempt from copayments for any services paid for by their plan(s).

(5) Services to a Client cannot be denied solely because of an inability to pay an applicable copayment. This does not relieve the Client of the responsibility to pay, nor does it prevent the Provider from attempting to collect any applicable copayments from the Client; the amount is a legal debt, and is due and payable to the Provider of service.

(6) A Client must pay the copayment at the time service is provided unless exempted (see (2), (3) and (4) above).

(7) The Provider should not deduct the copayment amount from the usual and customary fee submitted on the claim. Except as provided in subsection (2) of this rule, DHS will deduct the amount of the copayment from the amount paid to the Provider (whether or not Provider collects

the copayment from the Client). If the DMAP paid amount is less than the required copayment, the copayment amount will be equal to what DMAP would have paid, unless the Client or services is exempt according to exclusions listed in (2), (3) and (4) above.

(8) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 1001.951–1001.952, DMAP does not require Providers to bill or collect a copayment from the Medicaid Client. The Provider may choose not to bill or collect a copayment from a Medicaid Client, however, DMAP will still deduct the copayment amount from the Medicaid reimbursement made to the Provider.

(9) OHP Standard copayments are eliminated for OHP Standard Clients effective June 19, 2004. Elimination of copayments by this rule shall supercede any other General Rule, 410-120-0000 et seq; any Oregon Health Plan Rule, OAR 410-141-0000 et seq; or individual DMAP program rule(s), that contain or refer to OHP Standard copayment requirements.

(10) Services which require copayments are listed in Table 120-1230-1:

(a) For the purposes of this rule, dental diagnostic services are considered oral examinations used to determine changes in the patient's health or dental status. Diagnostic visits include all routine cleanings, x-rays, laboratory services and tests associated with making a diagnosis and/or treatment. One copayment assessed per Provider/per visit /per day unless otherwise specified. Copayment applies regardless of location, i.e. Provider's office or Client's residence;

(b) Mental Health Service copayments are defined as follows:

(A) Inpatient hospitalization — includes ancillary, facility and professional fees (DRG 424-432);

(B) Outpatient hospital — Electroconvulsive (ECT) treatment (Rev code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104);

(C) Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90801);

(D) Medication Management by psychiatrist or psychiatric mental health nurse practitioner (90862);

(E) Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887).

Table 120-1230-1

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

Stat. Auth.: ORS 409

Stat. Implemented: ORS 414.065

Hist.: OMAP 73-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2004(Temp), f. 6-14-04 cert. ef. 6-19-04 thru 11-30-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1260
Provider Enrollment

(1) This rule applies only to Providers seeking reimbursement from the Division of Medical Assistance Programs (DMAP), except as otherwise provided in OAR 410-120-1295.

(2) Signing the Provider application constitutes agreement by Performing and Billing Providers to comply with all applicable DMAP Provider rules and federal and state laws and regulations.

(3) The Department of Human Services (DHS) is taking action to permit compliance with the National Provider Identification (NPI) requirements in 45 CFR Part 142 when those requirements become effective. During the transition period, the following requirements for Providers and Provider applicants will apply:

(a) Providers that obtain an NPI should update their records with DMAP's Provider Enrollment Unit. Provider applicants that have been issued an NPI should include that NPI number with the DMAP Provider enrollment application;

(b) A Provider enrolled with DMAP must bill using the DMAP assigned Provider number, in addition to the NPI, if available, and continue to bill using the DMAP assigned Provider number until the Department informs the Provider that the DMAP assigned Provider number is no longer required. Failure to use the DMAP assigned Provider number during this transition period will result in delay or rejection of claims and other transactions;

(c) The NPI number will be cross-referenced with the DMAP assigned Provider number for billing purposes;

(d) A Provider agrees to cooperate with the Department with reasonable consultation and testing procedures, if any, related to implementation of the use of NPI numbers.

(4) A Performing Provider is the Provider of a service or item. A Billing Provider is a person, agent, business, corporation, clinic, group, institution, or business entity that submits claims to and receives payment from DMAP on behalf of a Performing Provider. All references to Provider in this and other DMAP rules include both Performing and Billing Providers:

(a) A Performing Provider is responsible for identifying and keeping current the identification of their Billing Provider (if any) to DMAP. In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements, DHS requires Billing Providers to be enrolled consistent with section (11) of this rule. A Performing Provider's use of a Billing Agent or Billing Service that falls within the definition of a Billing Provider but that is not enrolled with DMAP may result in delay or rejection of claims processing or payment;

(b) If the Performing Provider uses electronic media to conduct transactions with the Department, or authorizes a Billing Agent or Billing Service to conduct such electronic transactions, the Performing Provider must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et.seq. Enrollment as a Performing or Billing Provider is a necessary requirement for submitting electronic claims, but the Provider must also register as a Trading Partner and identify the EDI Submitter.

(5) To be enrolled and able to bill as a Provider, an individual or organization must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations and rules, and must comply with all Oregon statutes and regulations for provision of Medicaid and SCHIP services. In addition, all Providers of services within the State of Oregon must have a valid Oregon business license if such a license is a requirement of the state, federal, county or city government to operate a business or to provide services.

(6) An individual or organization that is currently subject to Sanction(s) by DMAP, another state's Medicaid program, or federal government is not eligible for enrollment (see OAR 410-120-1400 Provider Sanctions). In addition, individuals or organizations that apply for enrollment are subject to the following disclosure requirements:

(a) Before DMAP issues or renews a Provider enrollment or contract for Provider services, or at any time upon written request by DHS, the Provider must disclose to the Department the identity of any person who: Has ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program since the inception of those programs;

(b) A Medicaid Provider that is an entity other than an individual Practitioner or group of Practitioners, must disclose certain information about ownership and control of the entity:

(A) The name and address of each person with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a direct or indirect ownership interest of 5 percent or more;

(B) Whether any of the persons so named is related to another as spouse, parent, child, or sibling; and

(C) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

(c) All Providers must agree to furnish to the Department or to the U.S. Department of Health and Human Services on request, information related to certain business transactions: A Provider must submit, within 35 days of the date of a request, full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request;

(d) DMAP may refuse to enter into or renew a Provider's enrollment agreement, or contract for Provider services, with a Provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX services program;

(e) DMAP may refuse to enter into or may Terminate a Provider enrollment agreement, or contract for Provider services, if it determines that the Provider did not fully and accurately make any disclosure required under this section (6) of this rule.

(7) Enrollment of Performing Providers. An DMAP assigned 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 Performing Provider or a person authorized by the Performing Provider to legally 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 DMAP or the DHS unit responsible for enrolling the Provider.

(8) Performing Providers may be enrolled retroactive to the date services were provided to an DMAP Client only if:

(a) The Provider was appropriately licensed, certified and otherwise met all DMAP requirements for Providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date the application for Provider status was received by DMAP as evidenced by the date stamp placed on the application;

(c) DMAP reserves the right to retroactively enroll the Provider outside the 12 month period in (b) based upon extenuating circumstances outside the control of the Provider, and consistent with federal Medicaid regulations.

(9) Issuance of an DMAP assigned Provider number establishes enrollment of an individual or organization as a Provider for the specific category (ies) of services covered by the DMAP enrollment application. For example, a pharmacy Provider number applies to pharmacy services but not to Durable Medical Equipment, which requires a separate Provider application and establishes a separate DMAP assigned Provider number.

(10) Required Updates: A Provider is responsible for providing, and continuing to provide, to the Department accurate, complete and truthful information concerning their qualification for enrollment. An enrolled Provider must notify DMAP in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including but not limited to a change in any of the following information: address, business affiliation, licensure, certification, Billing Provider, NPI, or Federal Tax Identification Number, or if the Provider's ownership or control information changes; or if the Provider or a person with an ownership or control interest, or an agent or managing employee of the Provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program. The Provider must notify DMAP of changes in any of this information in writing within 30 calendar days of the change.

(a) Failure to notify DMAP of a change of Federal Tax Identification Number may result in the imposing of a $50 fine;

(b) In addition to section(10)(a) of this rule, if DMAP notifies a Provider about an error in Federal Tax Identification Number, the Provider must supply a valid Federal Tax Identification Number within 30 calendar days of the date of DMAP's notice. Failure to comply with this requirement may result in DMAP imposing a fine of $50 for each such notice. Federal Tax Identification Number requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(c) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a new application;

(d) Claims submitted by, or payments made to, Providers who have not furnished the notification required by this rule or to a Provider that has failed to submit a new application as required by DMAP under this rule may be denied or recovered.

(11) Enrollment of Out-of-State Providers: Providers of services outside the state of Oregon will be enrolled as a Provider under section (7) of this rule if they comply with the requirements of section (7) and under the following conditions:

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

(b) Noncontiguous Out-of-State pharmacy Providers must be licensed to provide pharmacy services by the Oregon Board of Pharmacy;

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

(d) For noncontiguous Out-of-State Providers, the services provided must be authorized, in the manner required under these rules for Out-of-State Services (OAR 410-120-1180) or other applicable DHS rules:

(A) For a specific Oregon Medicaid Client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) For foster care or subsidized adoption children placed out of state; or

(C) The Provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) Clients.

(e) The services for which the Provider bills are covered services under the Oregon Health Plan (OHP);

(f) 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;

(g) Out-of-State Providers may provide contracted services per OAR 410-120-1880.

(12) Enrollment of Billing Providers:

(a) A person or business entity that submits claims to DMAP and receives payments from DMAP on the behalf of a professional Performing Provider (e.g., Physician, Physical Therapist, Speech Therapist) must be enrolled as a Billing Provider with DMAP and meet all applicable federal and state laws and regulations. A Billing Agent or Billing Service submitting claims or providing other business services on behalf of a Performing Provider but not receiving payment in the name of or on behalf of the performing Provider does not meet the requirements for Billing Provider enrollment and is not eligible for enrollment as a Billing Provider;

(b) An DMAP assigned Billing Provider number will be issued only to Billing Providers that have a contract with an enrolled performing Provider to conduct billing and receive payments on behalf of the Performing Provider, that have met the standards for enrollment as a Billing Provider and that have been delegated the authority to act on behalf of the Performing Provider and to submit claims and receive payment on behalf of the Provider of services. A Billing Provider that submits claims and conducts electronic transactions on behalf of the Performing Provider must register with the Department as an EDI Submitter; however, not all EDI Submitters qualify to enroll as Billing Providers, e.g., Billing Agents or Billing Services, that are not authorized to receive payment on behalf of the Performing Provider;

(A) A corporate or business entity related to the Performing Provider under one of the relationships authorized by 42 CFR 447.10(g) may have the authority to submit the Performing Provider enrollment application and supporting documentation on behalf of the Performing Provider, and such entities with the authority to submit claims and obtain payment on behalf of the Performing Provider must enroll as a Billing Provider;

(B) Any other contracted Billing Agent or Billing Service except as are described in section (12)(b) (A) of this rule only has such authority to submit claims and to receive payment in the name of the Performing Provider pursuant to 42 CFR 447.10(f), and such entities meeting the definition and requirements of Billing Provider must enroll as a Billing Provider;

(C) These Billing Provider enrollment requirements do not apply to the staff directly employed by an enrolled Performing Provider, rather than pursuant to a contractual arrangement. Nothing in this rule is meant to prevent an enrolled Performing Provider from submitting his or her own claims and receiving payment in his or her own name. Notwithstanding this provision, if the Performing Provider is conducting electronic transactions, the DHS EDI rules will apply, consistent with section (4) of this rule.

(c) A Billing Provider must maintain, and make available to DMAP, upon request, records indicating the Billing Provider's relationship with the Provider of service;

(d) Prior to submission of any claims or receipt of any payment from DMAP, 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 and receive payment on behalf of the Performing Provider. This authorization, and any limitations or termination of such authorization, must be maintained in the Billing Provider's files for at least five years, following the submission of claims to DMAP;

(e) The Billing Provider fee must not be based on a percentage of the amount billed or collected or whether or not they collect the subject's payment (42 CFR 447 subpart A).

(f) If the Billing Provider is authorized to use electronic media to conduct transactions on behalf of the Performing Provider, the Performing Provider must register with the Department as a Trading Partner and authorize the Billing Provider to act as an EDI Submitter, as required in the Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq. Enrollment as a Billing Provider does not provide that authority. If the Performing Provider uses electronic media to conduct transactions, and authorizes a Billing Agent or Billing Service that is not authorized to receive reimbursement or otherwise obligate the Performing Provider, the Billing Agent or Billing Service does not meet the requirements of a Billing Provider. The Performing Provider and Billing Agent or Billing Service must comply with the DHS EDI rules, OAR 410-001-0100 et.seq.;

(g) Out-of-state Billing Providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon.

(13) Utilization of Locum Tenens:

(a) For purposes of this rule, a locum tenens means a substitute Physician retained to take over another Physician's professional practice while he or she is absent (i.e., absentee Physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.

(b) Locum tenens are not required to enroll with DMAP; however, in no instance may an enrolled absentee Physician utilize a substitute Physician who is, at that time, excluded from participation in or under Sanction by Medicaid or federally funded or federally assisted health programs.

(c) The absentee Physician must be an enrolled DMAP Provider and must bill with their individual DMAP assigned Provider number and receive payment for covered services provided by the locum tenens Physician. Services provided by the locum tenens must be billed with a modifier Q6:

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

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

(14) Reciprocal Billing Arrangements:

(a) For purposes of this rule, reciprocal billing arrangements are similar in nature to a locum tenens in that a substitute Physician is retained to take over another Physician's professional practice on an occasional basis if the regular Physician is unavailable (absentee Physician);

(b) Providers with reciprocal billing arrangements are not required to enroll with DMAP; however, in no instance may an enrolled absentee Physician utilize a substitute Physician who is, at that time, excluded from participation in or under Sanction by Medicaid or federally funded or federally assisted health programs;

(c) The absentee Physician must be an enrolled DMAP Provider and must bill with his or her individual DMAP assigned Provider number and receive payment for covered services provided by the substitute Physician. The absentee Physician identifies the services provided by the substitute Physician by using modifier Q5:

(A) In entering the Q5 modifier, the absentee Physician is certifying that the services are provided by a substitute Physician identified in a record of the absentee Physician that is available for inspection, and are services for which the absentee Physician is authorized to submit a claim.

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

(d) These requirements do not apply to substitute arrangements among Physicians in the same medical practice when claims are submitted in the name of the Billing Provider or group name. Nothing in this rules prohibits Physicians sharing call responsibilities from opting out of the reciprocal billing (substitute Provider) arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled Performing Providers and as long as duplicate claims for services are not submitted.

(15) Provider Termination:

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

(b) DMAP Provider Terminations or Suspensions may be for, but are not limited to the following reasons:

(A) Breaches of Provider agreement;

(B) Failure to comply with the statutes, regulations and policies of DHS, Federal or State regulations that are applicable to the Provider.

(C) When no claims have been submitted in an 18-month period. The Provider must reapply for enrollment.

(16) When a Provider fails to meet one or more of the requirements governing a Provider's participation in Oregon's medical assistance programs, the Provider's DMAP assigned 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 DMAP assigned number will be revoked.

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

(18) In the event of bankruptcy proceedings, the Provider must immediately notify the DMAP Administrator in writing.

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

410-120-1280
Billing

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

(2) For Medicaid covered services the Provider must not bill DMAP more than the Provider's Usual Charge (see definitions) or the reimbursement specified in the applicable Provider rules:

(a) A Provider enrolled with DMAP or providing services to a Client in a managed care plan under the Oregon Health Plan (OHP) must not seek payment for any services covered by Medicaid fee-for-service or through contracted managed care plans, except any coinsurance, copayments, and deductibles expressly authorized by the General Rules, OHP Rules or individual Provider rules:

(A) A DMAP Client for covered benefits; or

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

(b) Exceptions under which an enrolled Provider may seek payment from an eligible Client or Client representative are described below:

(A) The Provider may seek any applicable coinsurance, Copayments and deductibles expressly authorized by DMAP rules in OAR 410 division 120, OAR 410 division 141, or any other individual Provider rules;

(B) The Client did not inform the Provider of OHP eligibility, of OHP managed health plan enrollment, or of other third party insurance coverage, either at the time the service was provided or subsequent to the provision of the service or item, and as a result the Provider could not

bill DMAP, the managed health care plan, or third party payer for any reason, including timeliness of claims, lack of Prior Authorization, etc. The Provider must document attempts to obtain information on eligibility or enrollment;

(C) The Client became eligible for DMAP benefits retroactively but did not meet other established criteria described in these General Rules and the appropriate Provider rules (i.e., retroactive authorization);

(D) A Third Party Resource made payments directly to the Client for services provided;

(E) The Client did not have full DMAP benefits. Clients receiving a limited Medicaid coverage, such as the Citizen Alien Waived Emergency Medical Program, may be billed for services that are not benefits of those programs. The Provider must document pursuant to section (3) of this rule that the Client was informed that the service or item would not be covered by DMAP;

(F) The Client has requested continuation of benefits during the Administrative Hearing process and final decision was not in favor of the Client. The Client will be responsible for any charges since the effective date of the initial notice of denial;

(G) A Client cannot be billed for services or treatment that has been denied due to Provider error (e.g., required documentation not submitted, Prior Authorization not obtained, etc.);

(H) The charge is for a Copayment when a Client is required to make a Copayment as outlined in DMAP General Rules (410-120-1230) and individual Provider rules;

(I) In exceptional circumstances, a Client may request continuation of a covered service while asserting the right to privately pay for that service. Under this exceptional circumstance, a Client can be billed for a covered service if the Client is informed in advance of receiving the specific service of all of the following:

(i) That the requested service is a covered service and that the Provider would be paid in full for the covered service if the claim is submitted to DMAP or the Client's managed care plan, if the Client is a member of a managed care plan; and

(ii) The estimated cost of the covered service, including all related charges, the amount that DMAP, and that the Client cannot be billed for an amount greater than the maximum DMAP reimbursable rate or managed care plan rate, if the Client is a member of a managed care plan; and

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

(iv) That, if the Client knowingly and voluntarily agrees to pay for the covered service, the Provider must not submit a claim for payment to DMAP or the Client's managed care plan; and

(v) The Provider must be able to document in writing, signed by the Client or the Client's representative, that the Client was provided the information described above; that the Client was provided an opportunity to ask questions, obtain additional information and consult with the Client's caseworker or Client representative; and the Client agreed to be responsible for payment by signing an agreement incorporating all of the information described above. The Client must be given a copy of the signed agreement. A Provider must not submit a claim for payment for covered services to DMAP or to the Client's managed care plan that is subject to such agreement.

(3) Non-Covered Medicaid Services:

(a) A Provider may bill a Client for services that are not covered by DMAP or the managed care plan. However, the Client must be informed in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the Client or Client's representative is financially responsible for payment for the specific service. Providers must be able to document in writing signed by the Client or Client's representative, that the Client was provided this information and the Client knowingly and voluntarily agreed to be responsible for payment;

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

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

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

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

(D) Applicable Provider rules.

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

(4) All claims must be billed on the appropriate form as described in the individual Provider rules or submitted electronically in a manner authorized by the Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq.

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

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

(7) It is the responsibility of the Provider to submit true and accurate information when billing DMAP. Use of a Billing Provider does not abrogate the Performing Provider's responsibility for the truth and accuracy of submitted information.

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

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

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

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

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

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

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

(11) Diagnosis Code Requirement:

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

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

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

(12) For claims requiring a procedure code the Provider must bill as instructed in the appropriate DMAP Provider rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the Client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Provider rules. Hospitals must follow national coding guidelines:

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

(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 DMAP using that code rather than

itemizing the services under multiple codes. Providers must not "unbundled" services in order to increase DMAP payment.

(13) No Provider or its contracted agency (including Billing Providers) shall submit or cause to be submitted to DMAP:

(a) Any false claim for payment;

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

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

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

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

(15) A Provider who, after having been previously warned in writing by DMAP 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 DMAP for up to triple the amount of the DMAP established overpayment received as a result of such violation.

(16) Third Party Resources (TPR):

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

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include, but are not limited to:

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

(B) Using an insurance database such as Electronic Eligibility Verification Services (EEVS) available to the Provider;

(C) Verifying the Client's insurance coverage through the Automated Information System (AIS) or the Medical Care Identification on each date of service and at the time of billing.

(c) Except as noted in (16)(d)(A through E), when third party coverage is known to the Provider, as indicated on the Medical Care Identification or through AIS, or any other means available, prior to billing DMAP the Provider must:

(A) Bill the TPR; and

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

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

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

(d) In accordance with federal regulations the Provider must bill the TPR prior to billing DMAP, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility Services for the Mentally Retarded (ICF/MR);

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

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

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

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

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

(i) In the circumstances outlined in (16)(d)(A through E) above, the Provider may choose to bill the primary insurance prior to billing DMAP. Otherwise, DMAP will process the claim and, if applicable, will pay the DMAP allowable rate for these services and seek reimbursement from the liable third party insurance plan;

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

(e) The Provider may bill DMAP directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant Provider rules. Documentation must be on file in the Provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual Provider rules for further information on services that must be billed to Medicare first;

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

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

(B) Except as described in (15), any Provider who accepts third party payment for furnishing a service or item to a DMAP Client shall:

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

(ii) When the Provider has already accepted payment from DMAP for the specific service or item, the Provider shall make direct payment of the amount of the third party payment to DMAP. When the Provider chooses to directly repay the amount of the third party payment to DMAP, the Provider must indicate the reason the payment is being made and must submit with 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 DMAP payment.

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

(h) For services rendered to a Medicare and Medicaid dual eligible Client, DMAP may request the Provider to submit a claim for Medicare payment and the Provider must honor that request. Under federal regulation, a Provider agrees not to charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a Provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so.

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

(17) Full Use of Alternate Resources:

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

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

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

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

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

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

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

(iii) Medicare Parts A and B.

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

(E) Through other reasonably available resources.

(18) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 35.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under a section 638 agreement are payors of last resort, and are not considered an alternate resource or TPR;

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

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

Stat. Auth.: ORS 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 461-013-0050, 461-013-0060, 461-013-0090 & 461-013-0020; AFS 47-1982, f. 4-30-82, & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 45-1983, f. 9-19-83, ef. 10-1-83; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 36-1984, f. & ef. 8-20-84; AFS 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; AFS 43-1986, f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 14-1987, f. 5-31-87, ef. 4-1-87; AFS 38-1988, f. 5-17-88, cert. ef. 6-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0140, 461-013-0150, 461-013-0175 & 461-013-0180; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0260, 410-120-0280, 410-120-0300 & 410-120-0320; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-10-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 30-2001, f. 9-24-01, cert. ef 10-1-01; OMAP 23-2002, f. 6-14-02 cert. ef. 8-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 73-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 67-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

410-120-1295
Non-Participating Provider

(1) For purposes of this rule, a Provider enrolled with the Division of Medical Assistance Programs (DMAP) that does not have a contract with an DMAP-contracted Prepaid Health Plan (PHP) is referred to as a Non-Participating Provider.

(2) For covered services that are subject to reimbursement from the PHP, a Non-Participating Provider, other than a hospital governed by (3)(b) below, must accept from the DMAP-contracted PHP, as payment in full, the amount that the provider would be paid from DMAP if the client was fee-for-service (FFS).

(3) The DMAP-contracted Fully Capitated Health Plan (FCHP) that does not have a contract with a Hospital, is required to reimburse, and Hospitals are required to accept as payment in full the following reimbursement:

(a) The FCHP will reimburse a non-participating Type A and Type B Hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the capitation rates paid to the FCHP for the contract period (ORS 414.727);

(b) All other non-participating hospitals, not designated as a rural access or Type A and Type B Hospital, for dates of service on or after October 1, 2003 reimbursement will be based upon the following:

(i) Inpatient service rates are based upon the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925;

(ii) Outpatient service rates are based upon the capitation rates developed for the budget period, at the level of charges, multiplied by the statewide average cost to charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(4) The geographic factor, and the statewide average unit costs for inpatient service rates for subsection (3)(b)(i) and for outpatient service rates for subsection (3)(b)(ii), are calculated by the Department's contracted actuarial firm. The FCHP Non-Contracted DRG Hospital Reimbursement Rates are on the Department's Web site at: www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html. Each document shows rates for a specific date range. The document dated:

(a) October 1, 2003, is effective for dates of service October 1, 2003 through September 30, 2004;

(b) October 1, 2004, is effective for dates of service October 1, 2004 through September 30, 2005;

(c) October 1, 2005, is effective for dates of service October 1, 2005 through December 31, 2005; (corrected December 23, 2005);

(d) January 1, 2006, is effective for dates of service January 1, 2006 through December 31, 2006 (corrected December 23, 2005);

(e) January 1, 2007, is effective for dates of service January 1, 2007 through December 31, 2007.

(5) A non-participating hospital must notify the FCHP within 2 business days of an FCHP patient admission when the FCHP is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The FCHP is required to review the hospital claim for:

(a) Medical appropriateness;

(b) Compliance with emergency admission or prior authorization policies;

(c) Member's benefit package

(d) The FCHP contract and DMAP Administrative Rules.

(6) After notification from the non-participating hospital, the FCHP may:

(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the FCHP has secured another facility to accept the patient;

(b) Perform concurrent review; and/or

(c) Perform case management activities.

(7) In the event of a disagreement between the FCHP and Hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.743

Hist.: OMAP 10-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 22-2004, f. & cert. ef. 3-22-04; OMAP 23-2004(Temp), f. & cert. ef. 3-23-04 thru 8-15-04; OMAP 33-2004, f. 5-26-04, cert. ef. 6-1-04; OMAP 75-2004(Temp), f. 9-30-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 4-2005(Temp), f. & cert. ef. 2-9-05 thru 7-1-05; OMAP 33-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 35 2005, f. 7-21-05, cert. ef. 7-22-05; OMAP 49-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-15-06; OMAP 63-2005, f. 11-29-05, cert. ef. 1-1-06; OMAP 66-2005(Temp), f. 12-13-05, cert. ef. 1-1-06 thru 6-28-06; OMAP 72-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-28-06; OMAP 28-2006, f. 6-22-06, cert. ef. 6-23-06; OMAP 42-2006(Temp), f. 12-15-06, cert. ef. 1-1-07 thru 6-29-07; DMAP 2-2007, f. & cert. ef. 4-5-07

410-120-1300
Timely Submission of Claims

(1) All claims for services must be submitted within 12 months of the date of service. The date of service for an Inpatient Hospital stay is considered the date of discharge.

(2) A claim that was submitted within 12 months of the date of service, but that was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to the Division of Medical Assistance Programs (DMAP) at the address listed in the Provider Contacts document. The Provider must present documentation acceptable to DMAP verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual Provider rules. Acceptable documentation is:

(a) A remittance advice from DMAP that shows the claim was submitted before the claim was one year old;

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

(3) Exceptions to the 12-month requirement that may be submitted to DMAP are as follows:

(a) When DMAP or the Client's branch office has made an error that caused the Provider not to be able to bill within 12 months of the date of service. DMAP must confirm the error;

(b) When a court or an Administrative Law Judge has ordered DMAP to make payment;

(c) When the Department determines a Client is retroactively eligible for DMAP medical coverage and more than 12 months have passed between the date of service and the determination of the Client's eligibility.

Stat. Auth.: ORS 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 461-013-0080, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 17-1985, f. 3-27-85, ef. 5-1-85; AFS 55-1987, f. 10-29-87, ef. 11-1-87; HR 2-1990, f. 12-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0145; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0340; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1320
Authorization of Payment

(1) Some of the services or items covered by the Division of Medical Assistance Programs (DMAP) require authorization before payment

will be made. Some services require authorization before the service can be provided. See the appropriate Provider rules for information on services requiring authorization and the process to be followed to obtain authorization. Services (except Medical Transportation) for Clients identified by DMAP as "medically fragile children," shall be authorized by the Department of Human Services (DHS) Medically Fragile Children's Unit.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in the appropriate Provider rules.

(3) The authorizing agency will authorize for the level of care or type of service that meets the Client's medical need. Only services which are Medically Appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the Provider to determine medical appropriateness or appropriateness of the service.

(4) The Department and its 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) The Provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency;

(c) The service has not been adequately documented (see 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the Provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the Provider's files;

(d) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be medically appropriate;

(e) The services billed are not consistent with those provided;

(f) The services were not provided within the timeframe specified on the authorization of payment document;

(g) The services were not authorized or provided in compliance with the rules in these General Rules and in the appropriate Provider rules.

(5) 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 when Clients are made retroactively eligible, authorization for payment may be given if (6)(b)(A) through (C) of this rule are met;

(b) Services provided when a Title XIX Client is retroactively disenrolled from a Prepaid Health Plan (PHP) or services provided after the Client was disenrolled from a PHP may be authorized if (6)(b)(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 DHS branch or DMAP 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) Payment Authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the Client's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.

(8) Payment Authorization for Clients with other insurance or for Medicare beneficiaries:

(a) When Medicare is the primary payer for a service, no Payment Authorization from DMAP is required, unless specified in the appropriate program Provider rules;

(b) For Clients who have private insurance or other Third Party Resources (TPRs), such as Blue Cross, CHAMPUS, etc., DMAP requires Payment Authorization as specified above and in the appropriate Provider rules when the other insurer or resource does not cover the service or when the other insurer reimburses less than the DMAP rate;

(c) For Clients in a Medicare's Social Health Maintenance Organization (SHMO), the SHMO requires Payment Authorization for some services. DMAP requires Payment Authorization for services which are covered by DMAP but which are not covered under the SHMO as specified above and in the appropriate Provider rules.

Stat. Auth.: ORS 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 461-013-0060; AFS 13-1981, f. 2-27-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0041, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 7-1984(Temp), f. 2-28-84, ef. 3-15-84; AFS 11-1984(Temp), f. 3-14-84, ef. 3-15-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 38-1986, f. 4-29-86, ef. 16-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0106 & 461-013-0180; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0180; HR 22-1994, f. 5-31-94, cert. ef. 6-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 6-1996, f. 5-31-96, cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1340
Payment

(1) The Division of Medical Assistance Programs (DMAP) will make payment only to the enrolled Provider who actually performs the service or to the Provider's enrolled Billing Provider for covered services rendered to eligible Clients. Any contracted Billing Agent or Billing Service submitting claims on behalf of a Provider but not receiving payment in the name of or on behalf of the Provider does not meet the requirements for Billing Provider enrollment. If electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et.seq. DMAP may require that payment for services be made only after review by DMAP.

(2) DMAP or the Department of Human Services (DHS) office administering the program under which the billed services or items are provided sets Fee-for-Service (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the DMAP maximum allowable amount or the reimbursement specified in the individual program Provider rules:

(a) Amount billed may not exceed the Provider's Usual Charge (see definitions);

(b) DMAP's maximum allowable rate setting process uses the following methodology. The rates are posted on the DMAP web site at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml, and updated periodically:

(A) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight DMAP converted to the 2006 Fully Implemented Non-Facility Total RVU weights published in the Federal Register November 21, 2005 to be effective January 1, 2006:

(i) The base rate for labor and delivery (59400-59622) is $38.80;

(ii) CPT codes 92340-92342 and 92352-92353 remain at a flat rate of $25.00;

(iii) All remaining RVU weight based CPT/HCPCS codes have a base rate of $25.95;

(B) Surgical assist reimburses at 20% of the surgical rate;

(C) The base rate for anesthesia services 00100-01996 is $23.35 and is based on per unit of service;

(D) Non-RVU weight based Lab are paid at 97% of 62% or Medicare's rates or as minimally required by Medicare. Other non-RVU Lab services are priced based on the Centers for Medicare and Medicaid Service (CMS) mandates;

(E) All approved Ambulatory Surgical Center (ASC) procedures are priced using Medicare's Group assignment for each surgical procedure;

(F) Physician administered drugs billed under a HCPCS code are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate will be based upon Average Wholesale Price (AWP). Pricing information for AWP is provided by First Data Bank. These rates may change periodically based on drug costs;

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

(c) Individual Provider rules may specify reimbursement rates for particular services or items.

(4) DMAP reimburses Inpatient Hospital service under the DRG methodology, unless specified otherwise in the Hospital services rules. Reimbursement for services, including claims paid at DRG rates, will not exceed any Upper Limits established by federal regulation.

(5) DMAP reimburses all out-of-state Hospital services at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 division 125) unless the Hospital has a contract or Service Agreement with DMAP to provide highly specialized services.

(6) Payment rates for in-home services provided through DHS Seniors and People with Disabilities Division (SPD) will not be greater than the current DMAP rate for Nursing Facility payment.

(7) DHS sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities 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 Programs in that state for that service; or

(c) Is the rate established by SPD for out-of-state Nursing Facilities.

(8) DMAP will not make payment on claims that have been assigned, sold, or otherwise transferred or on which the Billing Provider, Billing Agent or Billing Service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a Provider for accounts receivable.

(9) DMAP will not make a separate payment or copayment to a Nursing Facility or other Provider for services included in the Nursing Facility's All-Inclusive Rate. The following services are not included in the All-Inclusive Rate (OAR 411-070-0085) and may be separately reimbursed:

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

(b) Physical Therapy, Speech Therapy, and Occupational Therapy provided by a non-employee of the Nursing Facility within the appropriate program Provider rules, (OAR 410 division 131 and 129);

(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 rules, (OAR 410 division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Provider rules, (OAR 410 division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(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 rules, (OAR 410 division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122).

(10) DMAP reimburses Hospice services on a per diem basis dependent upon the level of care being provided. A separate payment will not be made for services included in the core package of services as outlined in OAR 410 division 142.

(11) Payment for DMAP Clients with Medicare and Medicaid:

(a) DMAP limits payment to the Medicaid allowed amount less the Medicare payment up to the DMAP allowable rate. DMAP payment cannot exceed the co-insurance and deductible amounts due;

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

(12) For Clients with Third-Party Resources (TPR), DMAP pays the DMAP allowed rate less the TPR payment but not to exceed the billed amount.

(13) DMAP payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For DMAP such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding DMAP'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 individual Provider rules.

(14) Payment by DMAP does not limit DHS or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 461-013-0061; PWC 833, f. 3-18-77, ef. 4-1-77; Renumbered from 461-013-0061; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 50-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0081, 461-013-0085, 461-013-0175 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0220, 410-120-0200, 410-120-0240 & 410-120-0320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

410-120-1350
Buying-Up

(1) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (DMAP) or a managed care plan for a covered service:

(a) When a Non-Covered Service has been provided; and

(b) Additional payment is sought or accepted from the DMAP Client.

(2) Examples include, but are not limited to, charging the Client an additional payment to obtain a gold crown (non covered) instead of the stainless steel crown (covered) or charging an additional Client payment to obtain eyeglass frames not on the DMAP or managed care plan contract.

(3) If a Client wants to purchase a Non-Covered Service or item, the Client must be responsible for full payment. DMAP or managed care plan payment for a covered service cannot be credited toward the Non-Covered Service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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

The Department of Human Services (DHS) is responsible for analyzing and monitoring the operation of the Division of Medical Assistance Programs (DMAP) and for auditing and verifying the accuracy and appropriateness of payment, utilization of services, medical necessity, medical appropriateness, the quality of care, and access to care. The Provider 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 that are adequately documented. Documentation must be completed before the service is billed to DMAP:

(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 rules and any pertinent contracts;

(c) Have policies and procedures to ensure the maintenance of the confidentiality of medical record information. These procedures ensure the Provider may release such information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50, including ORS 433.045(3) with respect to HIV test information.

(2) Retain clinical records for seven years and financial 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 DHS, the Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services (DHHS), or their authorized representatives, furnish requested documentation immediately or within the time-frame specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of DHS, Medicaid Fraud Unit, or DHHS, may review and copy the original documentation in the Provider's place of business. Upon the written request of the Provider, the Program or the Unit may, at their sole discretion, modify or extend the time for 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 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 DHHS; 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 time-frames means that the records subject to the request may be deemed by DHS not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination, and accordingly subjects the Provider to possible denial or recovery of payments made by DMAP or to sanctions.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 461-013-0060; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1380
Compliance with Federal and State Statutes

(1) When a Provider submits a claim for medical services or supplies provided to an Division of Medical Assistance Programs (DMAP) Client, DMAP will deem the submission as a representation by the medical Provider to the Medical Assistance Program of the medical Provider's compliance with the applicable sections of the federal and state statutes referenced in this rule:

(a) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973;

(b) 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories).

(c) Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, the Provider must comply and, as indicated, cause all sub-contractors to comply with the following federal requirements to the extent that they are applicable to the goods and services governed by these rules. For purposes of these rules, all references to federal and state laws are references to federal and state laws as they may be amended from time to time:

(A) The Provider must comply and cause all subcontractors to comply with all federal laws, regulations, executive orders applicable to the goods and services provided under these rules. Without limiting the generality of the foregoing, the Provider expressly agrees to comply and cause all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the goods and services provided under these rules:

(i) Title VI and VII of the Civil Rights Act of 1964, as amended;

(ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended;

(iii) The Americans with Disabilities Act of 1990, as amended;

(iv) Executive Order 11246, as amended;

(v) The Health Insurance Portability and Accountability Act of 1996;

(vi) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended;

(vii) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (viii) all regulations and administrative rules established pursuant to the foregoing laws;

(viii) All other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations;

(ix) All federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the goods and services governed by these rules and required by law to be so incorporated. No federal funds may be used to provide services in violation of 42 USC 14402.

(B) Any Provider entity that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall:

(i) Establish written policies for all employees of the entity (including management), and of any contractor, subcontractor, or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistle-blowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(B) If the goods and services governed under these rules exceed $10,000, the Provider must comply and cause all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in DHS of Labor regulations (41 CFR Part 60);

(C) If the goods and services governed under these rules exceed $100,000, the Provider must comply and cause all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act — 33 U.S.C. 1251 to 1387), specifically including, but not limited to, Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations must be

reported to the Department of Human Services (DHS), the federal Department of Health and Human Services (DHHS) and the appropriate Regional Office of the Environmental Protection Agency. The Provider must include and cause all subcontractors to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section;

(D) The Provider must comply and cause all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163);

(E) The Provider certifies, to the best of the Provider's knowledge and belief, that:

(i) No federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement;

(ii) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Provider must complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions;

(iii) The Provider must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients and subcontractors must certify and disclose accordingly;

(iv) This certification is a material representation of fact upon which reliance was placed when this Provider agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Provider agreement imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(F) If the goods and services funded in whole or in part with financial assistance provided under these rules are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), the Provider agrees to deliver the goods and services in compliance with HIPAA. Without limiting the generality of the foregoing, goods and services funded in whole or in part with financial assistance provided under these rules are covered by HIPAA. The Provider must comply and cause all subcontractors to comply with the following:

(i) Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between the Provider and DHS for purposes directly related to the provision to Clients of services that are funded in whole or in part under these rules. However, the Provider must not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate DHS Privacy Rules, OAR 410-014-0000 et. seq., or DHS Notice of Privacy Practices, if done by DHS. A copy of the most recent DHS Notice of Privacy Practices is posted on the DHS Web site or may be obtained from DHS;

(ii) If the Provider intends to engage in Electronic Data Interchange (EDI) transactions with DHS in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, the Provider must execute an EDI Trading Partner Agreement with DHS and must comply with the DHS EDI rules;

(iii) If a Provider reasonably believes that the Provider's or the DHS' data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, the Provider must promptly consult the DHS Privacy Officer. The Provider or DHS may initiate a request to test HIPAA transactions, subject to available resources and the DHS testing schedule.

(G) The Provider must comply and cause all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Parts 247;

(H) The Provider must comply and, if applicable, cause a subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations;"

(I) The Provider must not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and Providers and subcontractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold must provide the required certification regarding their exclusion status and that of their principals prior to award;

(J) The Provider must comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace:

(i) The Provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in the Provider's workplace or while providing services to DHS Clients. The Provider's notice must specify the actions that will be taken by the Provider against its employees for violation of such prohibitions;

(ii) Establish a drug-free awareness program to inform its employees about the dangers of drug abuse in the workplace, the Provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

(iii) Provide each employee to be engaged in the performance of services under these rules a copy of the statement mentioned in paragraph (J)(i) above;

(iv) Notify each employee in the statement required by paragraph (J)(i) that, as a condition of employment to provide services under these rules, the employee will abide by the terms of the statement and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

(v) Notify DHS within ten (10) days after receiving notice under subparagraph (J)(iv) from an employee or otherwise receiving actual notice of such conviction;

(vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

(vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (J)(i) through (J)(vi);

(viii) Require any subcontractor to comply with subparagraphs (J)(i) through (J)(vii);

(ix) Neither the Provider, nor any of the Provider's employees, officers, agents or subcontractors may provide any service required under these rules while under the influence of drugs. For purposes of this provision, "under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Provider or Provider's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Provider or Provider's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to DHS Clients or others. Examples of abnormal behavior include, but are not limited to hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech, difficulty walking or performing job activities;

(x) Violation of any provision of this subsection may result in termination of the Provider agreement under these rules.

(K) The Provider must comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.);

(L) The Provider must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. Seq., including without limitation:

(i) Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and must furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR 431.107(b)(1) & (2);

(ii) Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B);

(iii) Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I;

(iv) Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. The Provider must acknowledge Provider's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(2) Hospitals, Nursing Facilities, Home Health Agencies (including those providing personal care), Hospices and Health Maintenance Organizations will comply with the Patient Self-Determination Act as set forth in Section 4751 of OBRA 1991. To comply with the obligation under the above listed laws to deliver information on the rights of the individual under Oregon law to make health care decisions, the named Providers and organizations will give capable individuals over the age of 18 a copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1993, by the Oregon State Bar Health Law Section. Out-of-State Providers of these services should comply with Medicare and Medicaid regulations in their state. Submittal to DMAP of the appropriate billing form requesting payment for medical services provided to a Medicaid eligible Client shall be deemed representation to DMAP of the medical Provider's compliance with the above-listed laws.

(3) Providers described in ORS chapter 419B are required to report suspected child abuse to their local DHS Children, Adults and Families office or police, in the manner described in ORS 419.

(4) The Clinical Laboratory Improvement Act (CLIA), requires all entities that perform even one laboratory test, including waived tests on, "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain federal requirements. If an entity performs tests for these purposes, it is considered, under CLIA to be a laboratory.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0160 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040 & 410-120-0400; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

410-120-1385
Compliance with Public Meetings Law

(1) Advisory committees with the authority to make decisions for, conduct policy research for, or make recommendations on administration or policy related to the medical assistance programs operated by the Department of Human Services (DHS) pursuant to ORS Chapter 414 must comply with provisions of ORS 192.610 to 192.690 — Public Meetings Law.

(2) This rule applies to those advisory committees of the medical assistance programs operated under ORS Chapter 414 that are both:

(a) Created by state constitution, statutes, administrative rule, order, intergovernmental agreement, or other official act, including direct or delegated authority from the Director of DHS; and

(b) Comprised of at least two committee members who are not employed by a public body.

(3) Advisory committees subject to this rule must comply with the following provisions:

(a) Meetings must be open to public attendance unless an executive session is authorized. Committees must meet in a place accessible to persons with disabilities and, upon request, shall make a good faith effort to provide a sign language interpreter for persons with hearing impairment;

(b) Groups must provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the DHS Division of Medical Assistance Programs (DMAP) will be sufficient compliance of the advanced notice requirement. Interested persons, including news media, may request hard copy notices by contacting the DMAP Communications Unit;

(c) Groups must take minutes at meetings and make them available to the public upon request to the contact person identified on the public notice;

(d) Any meeting that is held through the use of telephone or other electronic communication must be conducted in accordance with the Public Meetings Law.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1390
Premium Sponsorships

(1) Premium donations made for the benefit of one or more specified Division of Medical Assistance Programs (DMAP) Clients will be referred to as a Premium Sponsorship and the donor shall be referred to as a sponsor.

(2) The Department of Human Services (DHS) may accept Premium Sponsorships consistent with the requirements of this rule. DHS may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to carry out its functions under this rule. DHS may identify one or more designees to perform one or more of the functions of DHS under this rule.

(3) This rule does not create or establish any Premium Sponsorship program. DHS does not operate or administer a Premium Sponsorship program. DHS does not find sponsors for Clients or take requests or applications from Clients to be sponsored.

(4) This rule does not create a right for any DMAP Client to be sponsored. Premium Sponsorship is based solely on the decisions of sponsors. DHS only applies the Premium Sponsorship funds that are accepted by DHS as instructed by the sponsor. DHS does not determine who may be sponsored. Any operations of a Premium Sponsorship program are solely the responsibility of the sponsoring entity.

(5) A Premium Sponsorship amount that is not actually received by the DMAP Client will not be deemed to be cash or other resource attributed to the DMAP Client, except to the extent otherwise required by federal law. A DMAP Client's own payment of his or her obligation, or payment made by an authorized representative of the DMAP Client, is not a sponsorship except to the extent that the authorized representative is otherwise subject to subsection (8) of this rule.

(6) Nothing in this rule alters the DMAP Client's personal responsibility for assuring that his or her own payments (including current or past due premium payments) are made on time as required under any DHS rule

(7) If DHS accepts a Premium Sponsorship payment for the benefit of a specified Client, DHS or its designee will credit the amount of the sponsorship payment toward any outstanding amount owed by the specified Client. DHS or its designee is not responsible for notifying the Client that a Premium Sponsorship payment is made or that a sponsorship payment has stopped being made.

(8) If a sponsor is a health care Provider, or an entity related to a health care Provider, or an organization making a donation on behalf of such Provider or entity, the following requirements apply:

(a) DHS will decline to accept Premium Sponsorships that are not "bona fide donations" within the meaning of 42 CFR 433.54. A Premium Sponsorship is a "bona fide donation" if the sponsorship has no direct or indirect relationship to Medicaid payments made to a health care Provider, a related entity providing health care items or services, or other Providers furnishing the same class of items or services as the Provider or entity;

(b) For purposes of this rule, terms "health care Provider," "entity related to a health care Provider" and "Provider-related donation" will have the same meaning as those terms are defined in 42 CFR 433.52. A

health care Provider includes but is not limited to any Provider enrolled with DMAP or contracting with a Prepaid Health Plan for services to Oregon Health Plan Clients.

(c) Premium Sponsorships made to DHS by a health care Provider or an entity related to a health care Provider do not qualify as a "bona fide donation" within the meaning of subsection (a) of this section, and DHS will decline to accept such sponsorships;

(d) If a health care Provider or an entity related to a health care Provider donates money to an organization, which in turn donates money in the form of a Premium Sponsorship to DHS, the organization will be referred to as an organizational sponsor. DHS may accept Premium Sponsorship from an organizational sponsor if the organizational sponsor has completed the initial DHS certification process and complies with this rule. An organizational sponsor may not itself be a health care Provider, Provider-related entity, or a unit of local government;

(e) All organizational sponsors that make Premium Sponsorships to DHS may be required to complete at least annual certifications, but no more frequently than quarterly. Reports submitted to DHS will include information about the percentage of its revenues that are from donations by Providers and Provider-related entities. The organization's chief executive officer or chief financial officer must certify the report. In its certification, the organizational sponsor must agree that its records may be reviewed to confirm the accuracy, completeness and full disclosure of the donations, donation amounts and sources of donations. DHS will decline to accept donations or gifts from an organization that refuses or fails to execute necessary certifications or to provide access to documentation upon request;

(f) DHS will decline to accept Premium Sponsorships from an organizational sponsor if the organization receives more than 25 percent of its revenue from donations from Providers or Provider-related entities during the State's fiscal year;

(g) Any health care Provider or entity related to a health care Provider making a donation to an organizational sponsor, or causing another to make a Premium Sponsorship on its behalf, and any organizational sponsor, is solely responsible for compliance with laws and regulations applicable to any donation, including but not limited to 42 CFR 1001.951 and 1001.952.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 38-2004(Temp), f. 5-28-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 72-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

410-120-1395
Program Integrity

(1) The Department of Human Services (DHS) uses several approaches to promote program integrity. These rules describe program integrity actions related to Provider payments. Our program integrity goal is to pay the correct amount to a properly enrolled Provider for covered, Medically Appropriate services provided to an eligible Client according to the Client's benefit package of health care services in effect on the date of service. Types of program integrity activities include but are not limited to the following activities:

(a) Medical review and Prior Authorization processes, including all actions taken to determine the medical appropriateness of services or items;

(b) Provider obligations to submit correct claims;

(c) Onsite visits to verify compliance with standards;

(d) Implementation of Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;

(e) Provider credentialing activities;

(f) Accessing federal Department of Health and Human Services database (exclusions);

(g) Quality improvement activities;

(h) Cost report settlement processes;

(i) Audits;

(j) Investigation of fraud or prohibited kickback relationships;

(k) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities.

(2) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, the General Rules, the Oregon Health Plan Administrative Rules, and the rules applicable to the service or item.

(3) The following people may review a request for services or items, or audit a claim for care, services or items, before or after payment, for assurance that the specific care, item or service was provided in accordance with the Division of Medical Assistance Program's (DMAP's) rules and the generally accepted standards of a Provider's field of practice or specialty:

(a) DHS staff or designee; or

(b) Medical utilization and review contractor; or

(c) Dental utilization and review contractor; or

(d) Federal or state oversight authority.

(4) Payment may be denied or subject to recovery if the review or audit determines the care, service or item was not provided in accordance with DMAP rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment. Related Provider and Hospital billings will also be denied or subject to recovery.

(5) When the Department determines that an Overpayment has been made to a Provider, the amount of Overpayment is subject to recovery.

(6) The Department may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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

(1) The Department of Human Services (DHS) requires Providers to submit true, accurate, and complete claims or encounters. The Division of Medical Assistance Programs (DMAP) treats the submission of a claim or encounter, whether on paper or electronically, as certification by the Provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws."

(2) DHS staff or a medical or dental utilization and review contractor may review or audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with the rules and policies of DMAP and the generally accepted standards of a Provider's field of practice or specialty.

(3) DMAP may deny payment or may deem payments subject to recovery if a medical review or audit determines the service was not provided in accordance with DMAP's policy and rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment. Related Provider and Hospital billings will also be denied or subject to recovery.

(4) If a Provider determines that a submitted claim or encounter is incorrect, the Provider is obligated to submit an Individual Adjustment Request and refund the amount of the Overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the Provider determines that an Overpayment has been made, the Provider must notify and reimburse the Department immediately, following one of the reimbursement procedures described below:

(a) Submitting a Medicaid adjustment form (DMAP 1036 — Individual Adjustment Request). It is not necessary to refund with a check;

(b) Providers preferring to make a refund by check will attach a copy of the remittance statement page indicating the Overpayment information. If the Overpayment involves an insurance payment or another Third Party Resource, Providers will attach a copy of the remittance statement from the insurance payer:

(A) Refund checks not involving Third Party Resource payments will be made payable to DMAP Receipting — Checks in Salem;

(B) Refunds involving Third Party Resource payments will be made payable and submitted to DMAP Receipting — MPR Checks in Salem.

(5) The Department may determine, as a result of review or other information, that a payment should be denied or that an Overpayment has been made to a Provider, which indicates that a Provider may have submitted claims or encounters, or received payment to which the Provider is not properly entitled. Such payment denial or Overpayment determinations may be based on, but not limited to, the following grounds:

(a) The Department paid the Provider an amount in excess of the amount authorized under the state plan or other DHS policy;

(b) A third party paid the Provider for services (or a portion thereof) previously paid by the Department;

(c) The Department paid the Provider for services, items, or drugs that the Provider did not perform or provide;

(d) The Department paid for claims submitted by a data processing agent for whom a written Provider or Billing Agent/Billing Service agreement was not on file at the time of submission;

(e) The Department paid for services and later determined they were not part of the client's benefit package;

(f) Data processing submission or data entry errors;

(g) Medical review determines the service was not provided in accordance with DMAP's rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment;

(h) The Department paid the Provider for services, items, or drugs when the Provider did not comply with DMAP's rules and requirements for reimbursement.

(6) When an Overpayment is identified, DMAP will notify the Provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the Overpayment, and any further action that the Department may take in the matter.

(7) The Department may recover Overpayments made to a Provider by direct reimbursement, offset, civil action, or other actions authorized by law:

(a) The Provider must make a direct reimbursement to DMAP within thirty (30) calendar days from the date of the notice of the Overpayment, unless other regulations apply;

(b) The Department may grant the Provider an additional 30-day grace period upon request;

(c) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due;

(d) DMAP may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when Overpayments are not paid as a result of Section (7)(a);

(e) DMAP may file a civil action in the appropriate Court and exercise all other civil remedies available to DHS in order to recover the amount of an overpayment.

(8) In addition to any Overpayment, the Department may impose a Sanction on the Provider in connection with the actions that resulted in the Overpayment. The Department may, at its discretion, combine a notice of Sanction with a notice of Overpayment.

(9) Voluntary submission of an Individual Adjustment Request or Overpayment amount after notice from the Department does not prevent the Department from issuing a notice of Sanction, but the Department may take such voluntary payment into account in determining the Sanction.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.010
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1400
Provider Sanctions

(1) The Department of Human Services (DHS) recognizes two classes of Provider Sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.

(2) Except as otherwise noted, DHS will impose Provider Sanctions at the discretion of the DHS Director or the Administrator of the DHS Office whose budget includes payment for the services involved.

(3) The Division of Medical Assistance Programs (DMAP) will impose mandatory Sanctions and suspend the Provider from participation in Oregon's medical assistance programs:

(a) When a Provider of Medical Services has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws;

(b) When a Provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services or from the Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services. The Provider will be excluded and suspended from participation with DMAP for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General;

(c) If the Provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the Provider submits a Provider enrollment application or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(4) DMAP may impose discretionary Sanctions when DMAP determines that the Provider fails to meet one or more of DMAP's requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary Sanction include, but are not limited to, when a Provider has:

(a) Been convicted of Fraud related to any federal, state, or locally financed health care program or committed Fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;

(b) Been convicted of interfering with the investigation of health care Fraud;

(c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(d) By actions of any state licensing authority for reasons relating to the Provider's professional competence, professional conduct, or financial integrity either:

(A) Had his or her health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrendered his or her license while a formal disciplinary proceeding is pending before such licensing authority.

(e) Been suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(f) Billed excessive charges (i.e., charges in excess of the Usual Charge); furnished items or services substantially in excess of the DMAP Client's needs or in excess of those services ordered by a medical Provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;

(g) Failed to furnish medically necessary services as required by law or contract with DMAP if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the DMAP Client;

(h) Failed to disclose required ownership information;

(i) Failed to supply requested information on subcontractors and suppliers of goods or services;

(j) Failed to supply requested payment information;

(k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of DMAP 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 DMAP, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by DMAP;

(m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the Provider's health profession education. DMAP:

(A) Must have made a reasonable effort to secure payment;

(B) Must take into account access of beneficiaries to services; and

(C) Will not exclude a community's sole physician or source of essential specialized services.

(n) Repeatedly submitted a claim with required data missing or incorrect:

(A) When the missing or incorrect data has allowed the Provider to:

(i) Obtain greater payment than is appropriate;

(ii) Circumvent Prior Authorization requirements;

(iii) Charge more than the Provider's Usual Charge to the general public;

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

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

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

(o) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;

(p) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a Client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records that support information submitted on a cost report;

(r) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;

(s) Submitted claims or written orders contrary to generally accepted standards of medical practice;

(t) Submitted claims for services that exceed that requested or agreed to by the Client or the responsible relative or guardian or requested by another medical Provider;

(u) Breached the terms of the Provider contract or agreement. This includes failure to comply with the terms of the Provider certifications on the medical claim form;

(v) Rebated or accepted a fee or portion of a fee or charge for a DMAP Client referral; or collected a portion of a service fee from the Client, and billed DMAP for the same service;

(w) Submitted false or fraudulent information when applying for a DMAP assigned Provider number, or failed to disclose information requested on the Provider enrollment application;

(x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from DMAP;

(y) Submitted any claim for payment for which payment has already been made by DMAP 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 DMAP;

(aa) Failed to properly account for a DMAP Client's Personal Incidental Funds; including but not limited to using a Client's Personal Incidental Funds for payment of services which are included in a medical facility's All-Inclusive Rates;

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

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

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

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

(ff) Collected or made repeated attempts to collect payment from Clients for services covered by DMAP, per OAR 410-120-1280, Billing.

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

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

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

Stat. Auth.: ORS 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 461-013-0095; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0600; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1460
Type and Conditions of Sanction

(1) The Division of Medical Assistance Programs (DMAP) may impose mandatory Sanctions on a Provider pursuant to OAR 410-120-1400(3), in which case:

(a) The Provider will be either Terminated or Suspended from participation in Oregon's medical assistance programs;

(b) If Suspended, the minimum duration of Suspension will be determined by the Secretary of the Department of Health and Human Services (DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The State may suspend a Provider from participation in Oregon's medical assistance programs longer than the minimum Suspension determined by the DHHS Secretary.

(2) DMAP may impose the following discretionary Sanctions on a Provider pursuant to OAR 410-120-1400(4):

(a) The Provider may be Terminated from participation in Oregon's medical assistance programs;

(b) The Provider may be Suspended from participation in Oregon's medical assistance programs for a specified length of time, or until specified conditions for reinstatement are met and approved by DMAP;

(c) DMAP may withhold payments to a Provider;

(d) The Provider may be required to attend Provider education sessions at the expense of the Sanctioned Provider;

(e) DMAP may require that payment for certain services are made only after DMAP has reviewed documentation supporting the services;

(f) DMAP may recover investigative and legal costs;

(g) DMAP may provide for reduction of any amount otherwise due the Provider; and the reduction may be up to three times the amount a Provider sought to collect from a Client in violation of OAR 410-120-1280;

(h) Any other Sanctions reasonably designed to remedy or compel future compliances with federal, state or DMAP regulations.

(3) DMAP will consider the following factors in determining the Sanction(s) to be imposed (this list includes but is not limited to these factors):

(a) Seriousness of the offense(s);

(b) Extent of violations by the Provider;

(c) History of prior violations by the Provider;

(d) Prior imposition of Sanctions;

(e) Prior Provider education;

(f) Provider willingness to comply with program rules;

(g) Actions taken or recommended by licensing boards or a Quality Improvement Organization (QIO); and

(h) Adverse impact on the health of DMAP Clients living in the Provider's service area.

(4) When a Provider fails to meet one or more of the requirements identified in this rule DMAP, at its sole discretion, may immediately suspend the Provider's DMAP assigned billing number to prevent public harm or inappropriate expenditure of public funds:

(a) The Provider subject to immediate Suspension is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1700 to determine whether the Provider's DMAP assigned number will be revoked;

(b) The notice requirements described in section (5) of this rule do not preclude immediate suspension at DMAP's sole discretion to prevent public harm or inappropriate expenditure of public funds. Suspension may be invoked immediately while the notice and contested case hearing rights are exercised.

(5) If DMAP decides to Sanction a Provider, DMAP will notify the Provider by certified mail or personal delivery service of the intent to Sanction. The notice of immediate or proposed Sanction will identify:

(a) The factual basis used to determine the alleged deficiencies;

(b) Explanation of actions expected of the Provider;

(c) Explanation of subsequent actions DMAP intends to take;

(d) The Provider's right to dispute DMAP's allegations, and submit evidence to support the Provider's position; and

(e) The Provider's right to appeal DMAP's proposed actions pursuant to OARs 410-120-1560 through 410-120-1700.

(6) If DMAP makes a final decision to Sanction a Provider, DMAP will notify the Provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(7) The Provider may appeal DMAP's immediate or proposed Sanction(s) or other action(s) the Department intends to take, including but not limited to the following list. The Provider must appeal these actions separately from any appeal of audit findings and overpayments:

(a) Termination or Suspension from participation in the Medicaid-funded medical assistance programs;

(b) Termination or Suspension from participation in DMAP's state-funded programs;

(c) Revocation of the Provider's DMAP assigned Provider number.

(8) Other provisions:

(a) When a Provider has been Sanctioned, all other Provider entities in which the Provider has ownership (five percent or greater) or control of, may also be Sanctioned;

(b) When a Provider has been Sanctioned, DMAP may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon Health Plan Prepaid Health Plans and the

National Practitioner Data Base of the findings and the Sanctions imposed;

(c) At the discretion of DMAP, Providers who have previously been Terminated or Suspended may or may not be re-enrolled as DMAP Providers;

(d) Nothing in this rule prevents the Department from simultaneously seeking monetary recovery and imposing Sanctions against the Provider;

(e) If DMAP discovers continued improper billing practices from a Provider who, after having been previously warned in writing by DMAP or the Department of Justice about improper billing practices and has had an opportunity for a contested case hearing, that Provider will be liable to DMAP for up to triple the amount of DMAP's established overpayment received as a result of such violation.

Stat. Auth.: ORS 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 461-013-0050, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0095 & 461-013-0140; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0260 & 410-120-0660; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1505
Provider Audits

(1) Providers receiving payments from the Division of Medical Assistance Programs (DMAP) are subject to audit for all payments applicable to services rendered or items supplied to or on behalf of DMAP Clients. The audit ensures that proper payments were made on the basis of the requirements applicable to covered services, to recover Overpayments, and to discover possible instances or Fraud and Abuse.

(2) The Department may employ such staff, consultants, contractors or other designee, as it deems appropriate, to conduct an audit. The Department will identify one or more persons assigned to conduct the audit. For purposes of these rules, the person assigned to conduct the audit will be referred to as the Auditor.

(3) The Auditor determines the scope and time period covered by the audit.

(4) The Auditor may conduct an on-site visit, examine and copy records and documents, interview employees, and conduct such field work as it determines will provide a sufficient and competent evidential basis for drawing conclusions about the subject matter of the audit.

(5) The Auditor may consider other audits of the Provider, including but not limited to the Provider's independent auditors of the Provider's financial statements, but may include those performed by internal auditors or audit organizations established by the federal or state government for programs other than Medicaid. The Auditor may also consider other indicators such as Prior Authorization issues related to program integrity activities, and whether past or present program integrity activities such as those listed in OAR 410-120-1395 have identified the same or similar instances of non-compliance. The Auditor is responsible for evaluating the reliability of the other audit work, and to consider the scope of the other audit and its relationship to the scope and objective of the audit being conducted by the Department, in determining the weight to be given to the other audit work.

(6) The Auditor may use a 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., (a.k.a., Calvin Paper). The Department of Human Services (DHS) hereby adopts by reference, but is not limited to, the method of random sampling and calculation of Overpayment described in the Calvin Paper:

(a) In determining whether to use the Overpayment calculation method set forth in subsection (6) of this rule, the Department may consider:

(A) The Provider's overall error rate identified in the audit;

(B) Whether past audits have identified same or similar instances of non-compliance;

(C) The severity of the errors;

(D) Adverse impact on the health of DMAP Clients and their access to services in the Provider's service area.

(b) If the Auditor determines an Overpayment amount by the random sampling and Overpayment calculation method set forth in subsection (6) of this rule, the Provider may request a 100 percent audit of all billings submitted to DMAP for services provided during a period specified by the DHS Auditor. 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 an Auditor (such as a certified public accountant or other person designated as the Auditor) whose qualifications DHS has determined, in writing, to be acceptable, who is knowledgeable with the Oregon Administrative Rules covering the payments in question, and the Provider must waive any privilege in relation to the work papers and work product of the Auditor; and

(C) The audit must be conducted within 120 calendar days of the Provider's request to use such audit in lieu of the Department's random sample.

(7) The Auditor will prepare a preliminary audit report and send it to the Provider for review and comment. The preliminary audit report will inform the Provider of the opportunity to provide additional information to the Auditor about the information within the scope of the audit report, and to permit the Provider to request a meeting with the Auditor to review the preliminary audit report.

(8) The Auditor will prepare a final audit report and include an Overpayment assessment, where applicable. The amount of audit Overpayment to be recovered:

(a) Will be the entire amount determined or agreed to by the Department; 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.

(9) The final audit report will be delivered to the Provider in person or by registered or certified mail.

(10) If the Provider disagrees with the final audit report or the amount of Overpayment, the Provider may appeal the decision by requesting an administrative review from DMAP, unless DMAP declines to conduct an administrative review, then the Provider may appeal to a contested case hearing. In general, appeals limited to legal or policy issues may be appropriate for administrative review. Appeals that require the decision-maker to resolve disputed factual issues and the development of a factual record should be appealed as a contested case:

(a) The Provider must submit to DMAP a written request for hearing or administrative review of the decision being appealed pursuant to OAR 410-120-1560, Provider Appeals. The request must specify the area(s) of disagreement;

(b) Failure to request either a hearing or an administrative review in a timely manner constitutes acceptance by the Provider of the final audit report, the amount of the Overpayment, and any Sanctions, if combined with the final audit report.

(11) The Overpayment is due and payable 30 calendar days from the date of the Department's decision:

(a) The Department may grant the Provider an additional 30-day grace period upon request;

(b) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due.

(12) The Department may extend the reimbursement period or accept an offer of repayment terms. The Department must make any change in reimbursement period or terms in writing.

(13) If the Provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Department may:

(a) Recoup future Provider payments up to the amount of the overpayment; and

(b) Pursue civil action to recover the overpayment.

(14) As the result of a hearing or review, the amount of the overpayment may be reduced in part or in full.

(15) The Department may, at any time, change the amount of the Overpayment upon receipt of additional information. The Department will verify any changes in writing. DMAP will refund to the Provider any monies paid to DMAP that exceed an Overpayment.

(16) If a Provider is terminated or sanctioned for any reason, the Department may pursue civil action to recover any amounts due and payable to DMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.010
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1510
Fraud and Abuse

(1) This rule sets forth requirements for detecting and investigating Fraud and Abuse. The terms Fraud and Abuse in this rule are defined in OAR 410-120-0000. As used in these rules, terms have the following meanings:

(a) "Conviction" or "convicted" means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending;

(b) "Exclusion" means that the Division of Medical Assistance Programs (DMAP) will not reimburse a specific Provider who has defrauded or abused DMAP for items or services that Provider furnished;

(c) "Prohibited kickback relationships" means remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 CFR 1001.951;

(d) "Suspension" means DMAP will not reimburse a specified Provider who has been convicted of a program-related offense in a federal, state or local court for items or services that Provider furnished.

(2) Provider is required to promptly refer all suspected Fraud and Abuse, including Fraud or Abuse by its employees or in DMAP administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice or to the Department of Human Services (DHS) Audit Unit. The Department of Justice Medicaid Fraud Control Unit (MFCU) phone number is (503) 229-5725, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax is (503) 229-5459. The Department of Human Services Audit Unit phone number is (503) 945-6691, address 500 Summer St. NE, Salem, Oregon 97301-1097, and fax is (503) 947-5400.

(3) Provider shall permit the MFCU or DHS or both to inspect, copy, evaluate or audit books, records, documents, files, accounts, and facilities, without charge, as required to investigate an incident of Fraud or Abuse.

(4) Provider, if aware of suspected Fraud or Abuse by a DMAP Client (i.e., Provider reporting DMAP Client Fraud and Abuse) must report the incident to the Department Fraud Unit. Address suspected DMAP Client Fraud and Abuse reports to the Department Fraud Investigation Unit, P.O. Box 14150, Salem, Oregon 97309-5027, or phone (503) 378-1872, or fax (503) 373-1525.

(5) The Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.

(6) The Department is authorized to take the actions necessary to investigate and respond to substantiated allegations of Fraud and Abuse, including but not limited to suspending or terminating the Provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the Provider, or imposing other Sanctions provided under state law or regulations. Such actions by the Department may be reported to the Centers for Medicare and Medicaid Services, or other federal or state entities as appropriate.

(7) Providers and their fiscal agents must disclose ownership and control information, and disclose information on a Provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or the Title XX services program. Such disclosure and reporting is made a part of the Provider enrollment agreement, and the Provider is obligated to update that information with an amended Provider enrollment agreement if any of the information materially changes. The Department will use that information to meet the requirements of 42 CFR 455.100 to 455.106, and this rule must be construed in a manner that is consistent with the Department acting in compliance with those requirements.

(8) The Department will not pay for covered services provided by persons who are currently suspended, debarred or otherwise excluded from participating in Medicaid, Medicare, or SCHIP, or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1560
Provider Appeals

Effective for services provided on or after October 1, 2005.

(1) An enrolled Provider may appeal a claim payment, claim decision including Prior Authorization (PA) decisions, Overpayment determination, Sanction decision or other decision in which the Provider is directly adversely affected in the manner provided in this rule:

(a) Client appeals of Actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865;

(b) An Division of Medical Assistance Programs (DMAP) denial of or limitation of payment allowed, claim decision including PA decision, or DMAP overpayment determination for services or items provided to a Client must be appealed as Claim Reconsideration under OAR 410-120-1570;

(c) A DMAP denial of a Provider's application for participation in the Department's medical assistance programs must be appealed as administrative review under OAR 410-120-1580; or

(d) A notice of Sanctions imposed, or intended to be imposed, on a Provider, or denial of continued participation as an enrolled Provider, must be appealed as administrative review under OAR 410-120-1580, unless the effect of the notice of Sanction is, or will be, to suspend or revoke a right of privilege of the Provider which must be appealed as a contested case hearing under OAR 410-120-1600. A Provider that is entitled to appeal a notice of Sanction as a contested case may request administrative review instead of contested case hearing under the following circumstances:

(i) The Provider submits a written request for administrative review of the notice of Sanction and agrees in writing to waive the right to a contested case hearing; and

(ii) DMAP agrees to review the appeal of the notice of Sanction as an administrative review.

(e) Final audit report Overpayment determinations as a result of an audit may be appealed by requesting either a contested case hearing or an administrative review from DMAP as provided in OAR 410-120-1505 (Provider Audits). If a final audit report is combined with a notice of Sanction, the procedure in subsection (d) will apply to the appeal of the audit report and the notice of Sanction;

(f) Some decisions that adversely affect a Provider may be made by other program areas within the Department of Human Services (DHS) such as the audits unit or the information security office, or by DHS contractors such as DMAP's pharmacy benefits manager, or by entities performing statutory functions related to the medical assistance programs such as the Drug Use Review Board, in the conduct of program integrity activities applicable to the administration of the medical assistance programs. However, other program areas within DHS that have responsibility for administering medical assistance funding, such as nursing home care or community mental health and developmental disabilities program services, may make decisions that adversely affect a Provider. Those Providers are subject to the Provider grievance or appeal processes applicable to those program areas. Only if DMAP has legal authority to make the final decision in the matter, a Provider may appeal such a decision to DMAP as an administrative review and DMAP may accept such review.

(2) For Prepaid Health Plan (PHP) Providers of services, supplies or items to Clients in a PHP, the PHP Provider must exhaust all levels of the appeals process outlined by the Participating Provider's contract, or the rules applicable to claims submission or payment by a Non-Participating Provider, with the PHP prior to submitting an appeal to DMAP. PHP Provider appeals to DMAP must be appealed as an administrative review under OAR 410-120-1580.

(3) This rule does not apply to contract administration issues that may arise solely between DMAP and a PHP. Such issues shall be governed by the terms of the applicable contract.

(4) A Provider appeal is initiated by filing a request for review with DMAP on time:

(a) A request for review does not have to follow a specific format as long as it provides a clear written expression from a Provider or Provider applicant expressing disagreement with a DMAP decision or from a PHP Provider expressing disagreement with a decision by a PHP. The request should identify the decision made by DMAP or a PHP that is being appealed and the reason the Provider disagrees with that decision;

(b) A request for review should specify the type of appeal being requested, such as claim reconsideration, administrative review, or contested case hearing as provided for in these Provider appeal rules. Failure to correctly identify the proper type of appeal will not be used to invalidate a request for review. If DMAP determines at any time prior to a claim reconsideration, administrative review meeting or contested case hearing that a different type of appeal applies to the request, DMAP will notify the Provider and refer the appeal to the appropriate procedure as long as the request for review is otherwise timely filed and eligible for appeal.

(5) In the event a request for review is not timely, DMAP will determine whether the failure to file the request was caused by circumstances beyond the control of the Provider, and enter an order accordingly. In determining whether to accept a late request for review, DMAP requires the request to be supported by a written statement that explains why the request for review is late. DMAP may conduct such further inquiry as DMAP deems appropriate. In determining timeliness of filing a request for review, the amount of time that DMAP determines accounts for circumstances beyond the control of the Provider is not counted. DMAP may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.

(6) For purposes of these Provider appeal rules, the following terms have these meanings:

(a) "Provider" means a person or entity enrolled with DMAP that has requested an appeal in relation to health care services, supplies or items provided or requested to be provided to a Client on a fee-for-service basis or under contract with DMAP where that contract expressly incorporates these rules;

(b) "Provider Applicant" means a person or entity that has submitted an application to become an enrolled Provider with DMAP but the application has not been approved;

(c) "Prepaid Health Plan" has the meaning in OAR 410-141-0000, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to Provider grievances and appeals;

(d) "Prepaid Health Plan Provider" means a person or entity providing health care services, supplies or items to a Client enrolled with a PHP, including both Participating Providers and Non-participating Providers as those terms are defined in OAR 410-141-0000, except that services provided to a Client enrolled with an MHO shall be governed by the Provider grievance and appeal procedures administered by the Office of Mental Health and Addiction Services;

(e) The "Provider Appeal Rules" refers to the rules in OAR 410-120-1560 to 410-120-1700, describing the availability of appeal procedures and the procedures applicable to each appeal procedure.

(7) The burden of presenting evidence to support a fact or position rests on the proponent of the fact or position. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(8) Administrative review and contested case hearings will be held in Salem, unless otherwise stipulated to by all parties and agreed to by DMAP.

Stat. Auth.: ORS 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 461-013-0191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0780; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1570
Provider Appeals — Claims Reconsideration

(1) A Provider disputing an Division of Medical Assistance Programs (DMAP) claim payment, or claim decision, including Prior Authorization issues, or DMAP overpayment notice (other than Overpayment determinations made in an audit report) may request claim reconsideration. The Provider must submit a request for review in writing to DMAP, Provider Services Unit within one year from DMAP's decision. If the request for claim reconsideration is filed late, DMAP will determine whether to accept a late filing in accordance with OAR 410-120-1560(5).

(2) The request for review must include the specific service, supply or item for which claim reconsideration is being requested and why the Provider disagrees with that determination. The Provider should include a copy of the denial decision or Remittance Advice that describes the basis for the claim denial under reconsideration, and any information pertinent to the resolution of the dispute.

(3) DMAP will complete an additional review, which may include such further inquiry as DMAP deems appropriate. DMAP will respond back to the Provider in writing.

(4) If the Provider disagrees with the results of the claim reconsideration on the basis of the application of law or policy to the claim or authorization denial, the Provider may request an administrative review as outlined in OAR 410-120-1580 if the request for administrative review is made within 30 calendar days of the date the decision on claim reconsideration is issued.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1580
Provider Appeals — Administrative Review

(1) An administrative review allows an opportunity for the Administrator of the Division of Medical Assistance Programs (DMAP) or designee to review a decision affecting the Provider, Provider Applicant, or Prepaid Health Plan (PHP) Provider, where administrative review is appropriate and consistent with these Provider appeal rules. The administrative review may include the provision of new information or other actions that may result in DMAP, or the PHP, changing its decision. The request for an administrative review:

(a) Must be in writing to the DMAP Administrator;

(b) Must specify the issues or decisions being appealed and the reason for the appeal on each issue or decision. Give specifics for each claim such as procedure code, diagnosis code, reason for denial, administrative rule(s) or other authority applicable to the issue, and why the Provider, Provider Applicant, or PHP Provider disagrees with the decision. If this information is not included in the request, in a manner that reasonably permits DMAP to understand the decision being appealed and the basis for the appeal the request for review will be returned and will need to be resubmitted within the time specified by DMAP in writing;

(c) PHP Providers must exhaust all levels of the appeals process outlined by the PHP prior to submitting an appeal to the Administrator (Participating and Non-Participating Providers). The PHP will be contacted to provide information about their decision. The PHP Provider must submit documentation that reflects completion of the review with the PHP, in addition to the information specified in subsection (b);

(d) Must be filed and received by the DMAP Administrator within 30 calendar days of decision from DMAP or the final decision from the PHP. In the event a request for review is late, DMAP will determine whether to accept a late filing in accordance with OAR 410-120-1560(5).

(2) The DMAP Administrator or designee will decide which decisions may be suitable for review as administrative review, taking into consideration the issues presented in the request for review and such other inquiry as DMAP deems appropriate:

(a) In general, appeals presenting legal or policy issues may be appropriate to administrative review. Appeals that require the decision-maker to resolve disputed factual issues and to develop a factual record may be determined to be appropriate for contested case hearing;

(b) If the Administrator denies a request for an administrative review that was timely filed on the basis that the appeal should be heard as a contested case hearing, the Administrator or designee will notify the Provider or PHP Provider and refer the appeal directly for a contested case hearing under these rules;

(c) A decision to deny review of a decision previously reviewed as Claim Reconsideration under OAR 410-120-1570 is a final decision on administrative review; but if the appeal has not been reviewed first as a Claim Reconsideration but DMAP determines that Claim Reconsideration is appropriate, the Administrator may refer the request for review to the procedures established under OAR 410-120-1570 (Claim Reconsideration);

(d) If preliminary review indicates that the matter should be handled as a Client contested case, the Administrator should refer the Provider or PHP Provider to the procedures established under OAR 410-120-1860 and 410-120-1865 and should dismiss the Provider appeal if the matter is addressed under those Client appeal procedures.

(3) If the Administrator decides that a meeting between the Provider, Provider Applicant or PHP Provider and DMAP staff will assist the review, the Administrator or designee will:

(a) Notify the Provider, Provider Applicant or PHP Provider requesting the review of the date, time, and place the meeting is scheduled;

(b) Notify the PHP (when Client is enrolled in a PHP) of the date, time, and place the meeting is scheduled. The PHP is not required to participate, but is invited to participate in the process.

(4) The review meeting will be conducted in the following manner:

(a) It will be conducted by the DMAP Administrator, or designee;

(b) No minutes or transcript of the review will be made;

(c) The Provider, Provider Applicant or PHP Provider requesting the review does not have to be represented by counsel during an administrative review meeting and will be given ample opportunity to present relevant information;

(d) DMAP staff will not be available for cross-examination, but DMAP staff may attend and participate in the review meeting;

(e) Failure to appear constitutes acceptance of DMAP's determination;

(f) The Administrator may combine similar administrative review proceedings, including the meeting, if the Administrator determines that joint proceedings may facilitate the review;

(g) The DMAP Administrator or designee may request the Provider, Provider Applicant or PHP Provider making the appeal to submit, in writing, new information that has been presented orally. In such an instance, a specific date for receiving such information will be established.

(5) The results of the administrative review will be sent to the Provider Provider Applicant or PHP Provider, involved in the review, and to the PHP when review involved a PHP Provider, in writing, within 30 calendar days of the conclusion of the administrative review proceeding. The result of the administrative review is final and binding on the parties to the administrative review.

(6) All administrative review decisions are subject to the procedures established in OAR 137-004-0080 to 137-004-0092 and judicial review under ORS 183.484 in the Circuit Court.

Stat. Auth.: ORS 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 461-013-0191 & 461-013-0220; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0800; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1600
Provider Appeals (Level 3) — Contested Case Hearings

(1) These rules apply to all contested case hearings of the Division of Medical Assistance Programs (DMAP) involving Providers or Prepaid Health Plan (PHP) Providers. The hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Division of Medical Assistance Programs for purposes of these rules. OAR 410-120-1560, Provider Appeals, to OAR 410-120-1700, Provider Hearings — Proposed and Final Orders, are the procedural rules applying to contested case hearings for Provider appeals conducted by the Division of Medical Assistance Programs (DMAP). The method described in OAR 137-003-0520(8) is used in computing any period of time applicable to timely filing of Provider requests for contested case hearings.

(2) A request for a contested case hearing is considered filed when the written request for review asking for a contested case hearing is received by the DMAP Administrator or by the person designated by the Administrator, within thirty (30) calendar days of the date of the decision affecting the Provider:

(a) If DMAP receives a request for contested case hearing from a Provider, Provider Applicant, or PHP Provider, DMAP will preliminarily review the request to determine whether it is properly reviewed as a contested case under OAR 410-120-1560. If the request for hearing was timely filed but should have been filed as claim reconsideration or administrative review, DMAP will refer the request to the proper appeal procedure and notify the Provider, Provider Applicant or PHP Provider;

(b) Client appeals that request a contested case hearing will be handled in accordance with OAR 410-120-1860 and 410-120-1865.

(3) In the event a request for contested case hearing is not timely, DMAP will determine whether to accept late filing in accordance with OAR 410-120-1560(5).

(4) In the event the Provider has no right to a contested case hearing on an issue, DMAP may enter an order accordingly. DMAP may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the Provider has a right to a contested case hearing.

(5) The party to a Provider hearing is the Provider. In the event that DMAP determines that a PHP Provider is entitled to a contested case hearing, the PHP Provider and the PHP are parties to the hearing. A Provider, PHP Provider or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(6) The burden of presenting evidence to support a fact or position rests on the proponent of the fact or position. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(7) Hearings will be held in Salem, unless otherwise stipulated to by all parties and agreed to by DMAP.

Stat. Auth.: ORS 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 461-013-0191 & 461-013-0225; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0820; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1680
Provider Appeals — Contested Case Pre-Hearing Conference

(1) After a request for review is timely filed and the Division of Medical Assistance Programs (DMAP) determines that the appeal should be conducted as a contested case hearing, DMAP shall notify the Provider(s) of the time and place of an informal conference, without the presence of the Administrative Law Judge (ALJ). The purposes of this informal conference are:

(a) To provide an opportunity to settle the matter;

(b) To make sure the parties and the Department understand the reason for the action that is the subject of the hearing request;

(c) To give the parties and the Department an opportunity to review the information which is the basis for that action;

(d) To give the parties and the Department the chance to correct any misunderstanding of the facts; and

(e) To determine if the parties wish to have any witness subpoenas issued when the contested case hearing is conducted; and

(f) To discuss any of the maters listed in OAR 137-003-0575.

(2) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(3) The parties must participate in the informal conference or provide to DMAP a statement of the issues being contested, including a detailed statement of the basis for the Provider's disagreement.

(4) DMAP may grant to the Provider or the PHP Provider the relief sought at any time.

(5) The Provider may, at any time prior to the hearing date, request an additional informal conference with the Department representative, which may be granted if the Department representative finds, in his or her sole discretion, that the additional informal conference will facilitate the hearing process or resolution of disputed issues.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 51-1985, f. 8-16-85; HR 2-1990, f.2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0205; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0900; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1700
Provider Appeals — Proposed and Final Orders

(1) The Administrative Law Judge (ALJ) will conduct the contested case hearing using the Attorney General's Model Rules at OAR 137-003-0501 and following.

(2) In a contested case hearing, the ALJ will serve a proposed order to all parties and the Division of Medical Assistance Programs (DMAP) unless prior to the hearing, DMAP notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (2), unless DMAP notifies the parties and the ALJ that DMAP will issue the final order.

(3) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file exceptions or written argument to the proposed order to be considered by DMAP. The exceptions must be in writing and reach DMAP not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may

be submitted without prior approval of DMAP. After receiving the exceptions or argument, if any, DMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, DMAP may issue an amended proposed order.

(4) A Provider may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by DMAP or the ALJ, whichever is first. The ALJ will send a final order confirming the withdrawal to the Provider. The Provider may cancel the withdrawal up to the 10th calendar day following the date such order is effective.

(5) If neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing, DMAP may elect one of the following options in its sole discretion:

(a) The hearing request may be dismissed by order, effective on the date scheduled for the hearing. DMAP may cancel the dismissal order on request of the party on a showing that the party was unable to attend the hearing and unable to request a postponement for reasons beyond his or her control; or

(b) DMAP may enter a final order by default, consistent with the procedures established in OAR 137-003-0670. Entry of a final order by default may be made when the agency determines that the issuance of a final order with findings is appropriate as a basis of sanction authority or to establish a basis for future Sanction authority or other reason consistent with the administration of the medical assistance programs. The designated record for purposes of a default order shall be the record as designated in the notice issued to the party or, if not so designated, shall consist of the files and records held by the Department in the hearing packet prepared by the Department in preparation for the hearing and such other information that may have been submitted by a party in advance of the hearing for use in the hearing.

(6) The final order is effective immediately upon being signed or as otherwise provided in the order. Final orders resulting from a Provider's withdrawal of a hearing request are effective the date the Provider withdraws. When the Provider fails to appear for the hearing, the effective date of the dismissal order or the final order by default is the date of the scheduled hearing.

(7) All contested case hearing decisions are subject to the procedures established in OAR 137-003-675 to 137-003-0700 and to judicial review under ORS 183.482 in the Court of Appeals.

Stat. Auth.: ORS 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 410-120-0920; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1855
Client's Rights and Responsibilities

(1) Division of Medical Assistance Programs (DMAP) Clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by Providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, chemical dependency or Family Planning services without getting a referral from a Primary Care Practitioner (PCP) or other Provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and Non-Covered Services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the DMAP Client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive DMAP covered services that meet generally accepted standards of practice and are Medically Appropriate;

(l) To obtain covered Preventive Services;

(m) To receive a referral to specialty Providers for Medically Appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and Referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another Provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, 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;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with DMAP and receive a response as defined in OAR 410-120-1860 and 410-120-1865;

(t) To request an Administrative Hearing with the Department of Human Services (DHS);

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of DHS privacy practices.

(2) DMAP Clients shall have the following responsibilities:

(a) To treat the Providers and clinic's staff with respect;

(b) To be on time for appointments made with Providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a Referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use Emergency Services appropriately;

(g) To give accurate information for inclusion in the Clinical Record;

(h) To help the Provider or clinic obtain Clinical Records from other Providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the Provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the Provider that his or her health care is covered with DMAP before services are received and, if requested, to show the Provider the DMAP Medical Care Identification form;

(n) To tell the DHS worker of a change of address or phone number;

(o) To tell the DHS worker if the DMAP Client becomes pregnant and to notify the DHS worker of the birth of the DMAP Client's child;

(p) To tell the DHS worker if any family members move in or out of the household;

(q) To tell the DHS worker and Provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(r) To pay for Non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist DMAP in pursuing any TPR available and to pay DMAP the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the DMAP; and

(v) To sign an authorization for release of medical information so that DHS can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1860
Client Contested Case Hearing Procedures

(1) These rules apply to all contested case hearings provided by the Division of Medical Assistance Programs (DMAP) involving a Client's medical or dental benefits, except as otherwise provided in OAR 410-141-0263. The hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to DMAP for purposes of this rule. The method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of Client requests for hearing.

(2) Medical Provider appeals and administrative reviews involving DMAP are governed by OAR 410-120-1560 through 410-120-1700.

(3) Complaints and appeals for Clients requesting or receiving medical assistance from a Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OAR 410-0141-0260. This rule describes the procedures applicable when those Clients request and are eligible for a DMAP contested case hearing.

(4) Contested Case Hearing Requests:

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

(A) The Department acts to deny Client services, payment of a claim, or to terminate, discontinue or reduce a course of treatment, or issues related to disenrollment in a Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), Dental Care Organization (DCO) or Chemical Dependency Organization (CDO); or

(B) The right of a Client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264(10) describing when a Client of a PHP may request a state hearing.

(b) To be timely, a request for a hearing is complete when DMAP receives the Department's Administrative Hearing request form (DHS 443) not later than the 45th day following the date of the decision notice;

(c) In the event a request for hearing is not timely, DMAP will determine whether the failure to timely file the hearing request was caused by circumstances beyond the control of the Client and enter an order accordingly. In determining whether to accept a late hearing request, DMAP requires the request to be supported by a written statement that explains why the request for hearing is late. DMAP may conduct such further inquiry as DMAP deems appropriate. In determining timeliness of filing a hearing request, the amount of time that DMAP determines accounts for circumstances beyond the control of the Client is not counted. DMAP may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness;

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

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

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

(5) Expedited Hearings:

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

(b) Expedited hearings are requested using **DHS Form 443**;

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

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

(6) Informal Conference:

(a) The DMAP hearing representative and the claimant, and their legal representative if any, may have an informal conference, without the presence of the Administrative law Judge (ALJ), to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for DMAP and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is subject of the hearing request;

(C) Give the claimant and DMAP an opportunity to review the information that is the basis for that action;

(D) Inform the claimant of the rules that serve as the basis for the contested action;

(E) Give the claimant and DMAP the chance to correct any misunderstanding of the facts;

(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and

(G) Give DMAP an opportunity to review its action.

(b) The claimant may, at any time prior to the hearing date, request an additional informal conference with the Department representative, which may be granted if the Department representative finds, in his or her sole discretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;

(c) DMAP may provide to the claimant the relief sought at any time before the Final Order is served;

(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by DMAP or the ALJ, whichever is first. The ALJ will send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth calendar day following the date such an order is effective.

(8) Contested case hearings are closed to non-participants in the hearing.

(9) Proposed and Final Orders:

(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings will serve a proposed order on all parties and DMAP, unless, prior to the hearing, DMAP notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (b) unless DMAP notifies the parties and the ALJ that DMAP will issue the final order;

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

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

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

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. DMAP will cancel the dismissal order on request of the party on a showing that the party was unable to attend the hearing and unable to request a postponement for reasons beyond his or her control.

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

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

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

Stat. Auth.: ORS 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 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0053; HR 19-1990, f. & cert. ef. 7-9-90; HR 35-1990(Temp), f. & cert. ef. 10-15-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1990, f. & cert. ef. 11-26-90; HR 11-1991(Temp), f. & cert. ef. 3-1-91; HR 34-1991, f. & cert. ef. 8-26-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0760; HR 7-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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

(1) The purpose of this rule is to describe the requirements governing the denial, reduction or termination of medical assistance, and access to the Division of Medical Assistance Programs (DMAP) administrative hearings process, for Clients requesting or receiving medical assistance services paid for by the Department on a fee-for-service basis. Complaint and appeal procedures for Clients receiving services from a Prepaid Health Plan shall be governed exclusively by the procedures in OAR 410-0141-0260.

(2) When the Department authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend or reduce the course of treatment or a covered service, the Department or its designee shall mail a written notice to the Client at least ten (10) calendar days before the date of the termination or reduction of the covered service unless there is documentation that the Client had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.

(3) The written Client notice must inform the Client of the action the Department has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the Client's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Department for additional information. The Department is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

(4) The Department shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the Client requests an administrative hearing before the effective date of the Client notice and requests that the services be continued, the Department shall continue the services. The service shall be continued until whichever of the following occurs first (but in no event should exceed ninety (90) days from the date of the Client's request for an administrative hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the case that is the subject of the administrative hearing; or

(C) The Client is no longer eligible for medical assistance benefits, or the health service, supply or item that is the subject of the administrative hearing is no longer a covered benefit in the Client's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy and the Department promptly informs the Client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the Client in writing that it is continuing the service. The notice shall inform the Client that if the hearing is resolved against the Client, the cost of any services continued after the effective date of the Client notice may be recovered from the Client pursuant to 42 CFR 431.230(b);

(c) The Department shall reinstate services if:

(A) The Department takes an action without providing the required notice and the Client requests a hearing;

(B) The Department does not provide the notice in the time required under section (2) of this rule and the Client requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the Client, but the Client's whereabouts become known during the time the Client is still eligible for services;

(D) The reinstated services must be continued until a hearing decision unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.

(d) The Department shall promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the Client, or the Department decides in the Client's favor before the hearing.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 30-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1870
Client Premium Payments

(1) All non-exempt Clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120.

(2) Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1875
Agency Hearing Representatives

(1) Subject to the approval of the Attorney General, an agency officer or employee is authorized to appear (but not make legal argument) on behalf of the Department in the following classes of hearings:

(a) Contested case hearings requested by Clients in accordance with OAR 410-120-1860 and 410-130-1865; and

(b) Contested case hearings involving Providers in accordance with OAR 410-120-1560 to 410-120-1700.

(2) Subject to the approval of the Attorney General, the Department of Human Services (DHS) Audit Manager responsible for the Division of Medical Assistance Programs (DMAP) audits is authorized to appear (but not make legal argument) on behalf of the Department in the following classes of hearings:

(a) DMAP Overpayment determinations made in an audit under OAR 410-120-1505 (Provider audit);

(b) DMAP Provider Sanction decisions made in conjunction with or in lieu of an overpayment determination in OAR 410-120-1505 (Provider audit).

(3) Legal argument as used in ORS 183.452 and this rule has the same meaning as defined in OAR 137-003-0008(1)(c) and (d) 137-003-0545.

(4) When a Department officer or employee, or the DHS Audit Manager, represents the Department, the presiding officer will advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer will provide reasonable opportunity for the Department officer or employee, or the DHS Audit Manager, to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after the conclusion of the hearing.

Stat. Auth.: ORS 409
Statutes Implemented: ORS 414.065
Hist.: HR 8-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 34-2003, f. & cert. ef. 5-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1880
Contracted Services

(1) Except as otherwise provided in OAR 410-120-1260 et seq. applicable to Provider enrollment or OAR 410-141-0000 et seq. governing Prepaid Health Plans (PHPs), insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 may be implemented for covered medical assistance services in any program area(s) of the Department of Human Services (DHS) in order to achieve one or more of the following purposes:

(a) To implement and maintain PHP services;

(b) To ensure access to appropriate Medical Services which would otherwise not be available;

(c) To more fully specify the scope, quantity, or quality of the services to be provided or to specify requirements of the Provider or to specify requirements of DHS in relation to the Provider;

(d) To obtain services more cost effectively, (e.g., to reduce the costs of program administration or to obtain comparable services at less cost than the fee-for-service rate).

(2) Contracts, interagency agreements, or intergovernmental agreements under OAR 410-120-1880, subsection (1) funded with federal funds will be subject to applicable federal procurement and contracting requirements, and this rule will be interpreted and applied to satisfy such requirements. To the extent required by the federal funding agency, DHS will seek prior federal approval of solicitations and/or contracts when DHS plans to acquire or enhance services or equipment that will be paid in whole or on part with federal funds.

(3) DHS is exempt from the Public Contracting Code for purposes of source selection pursuant to ORS 279A.025(2). DHS will use the following source selection procedures when entering into contracts under OAR 410-120-1880, subsection (1). Interagency agreements and intergovernmental agreements are not subject to competitive solicitation as the basis of source selection, and may be selected in accordance with

ORS 190.003 to 190.130 and other applicable law or authority. Competition must be used in obtaining contract services to the maximum extent practical, except as otherwise provided in subsection (4):

(a) Small Procurement Procedure may be used for the procurement of supplies and services less than or equal to $5,000. DHS may use any method reasonably appropriate to the nature of the supply or service and the business needs of the Department to identify potential contractors;

(b) Informal Solicitation Procedure may be used for the procurement of services if the estimated cost or contract price is $150,000 or less. Proposals will be solicited from at least three sources, except as otherwise provided in these rules;

(c) Formal Solicitation Procedure will be used for the procurement of services when the estimated cost or contract price is more than $150,000. Proposals must be solicited as outlined in these rules.

(4) Selection by Negotiation may be used in lieu of a competitive procurement under subsection (3) of this rule for the procurement of goods or services if:

(a) The good or service is available only from a single source or the sole source has special skills that are only available based upon his or her expertise or situation. If the DHS Director , or designee, determines that only a single contractor is available or practical for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the reasons for using a sole source contract must be placed in the contract file;

(b) Public need, significant risk of interruption of services, or emergency advises against a delay incident to competitive solicitation. If the DHS Director, or designee, determines that an emergency exists for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the nature of the emergency must be placed in the file;

(c) Compliance with federal requirements necessitated proceeding without competitive solicitation. Documentation of the applicable federal requirements must be placed in the contract file;

(d) Other authority including but not limited to statutory authority in ORS 414.115, 414.125, 414.135, and 414.145, or such other authority, exemptions and delegations of authority that may be applicable to the source selection for the procurement: Documentation of the authority must be placed in the contract file.

(5) A Request for Proposal (RFP) or similar solicitation mechanism must be prepared for contracts for which the Formal Solicitation Procedure will be used. The solicitation document should include at a minimum the following elements, when applicable:

(a) Statement of required work, including a clear description of the services to be provided, standards by which performance of the services will be measured and/or conditions affecting the delivery of services;

(b) Minimum standards and qualifications which contractors must meet to be eligible to provide the services;

(c) Information which the prospective contractors must submit in their proposals to support their capability, such as references and experience providing the same or similar services (when, where, for whom, type of service, etc.);

(d) Funding information and budget requirements;

(e) Information about ownership interests in software or hardware designed, acquired, developed or installed with federal funds, in compliance with federal requirements for ownership, management and disposition;

(f) The form and organization of proposals, when and where proposals are to be submitted, whether late proposals may be considered, and when an award of a contract is expected;

(g) The method and criteria to be used in evaluating proposals and the weighting assigned to each criterion;

(h) Provisions stating how and when the solicitation document must be contested, and how and when the final award must be contested;

(i) Notice that all costs incurred in the preparation of a proposal will be the responsibility of the proposer and will not be reimbursed by DHS; and

(j) Contract provisions, subject to subsection (8) of this rule.

(6) Proposals must be evaluated in a manner consistent with the evaluation criteria in the solicitation document. A written document stating why the selection was made will be placed in the contract file.

(7) Unless exempt under ORS 291.045 to 291.049 or rules adopted there under, DHS will obtain the review and approval of the solicitation document, contract or agreement by the Department of Justice.

(8) The terms and conditions of the contract to be awarded to a contractor selected using these source selection rules will be governed by the Public Contracting Code, except for interagency agreements or intergovernmental agreements exempt under ORS 279A.025(2), or contracts or agreements under other exemptions from the Public Contracting Code. The Public Contracting Code, if applicable, and such delegation of authority, if any, as may be made by the Department of Administrative Services to DHS determine contract approval authority.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 62-1986, f. 8-22-86, ef. 9-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0172; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0580; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1920
Institutional Reimbursement Changes

(1) The Division of Medical Assistance Programs (DMAP) is required under federal regulations, **42 CFR 447**, to submit specific assurances and related information to the Centers for Medicare and Medicaid Services (CMS) whenever it makes a significant change in its methods and standards for setting payment rates for Inpatient Hospital Services or long-term care facilities.

(2) A "significant change" is defined as a change in payment rates 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.

(3) Federal regulation specifies that a public notice will be published in one of the following:

(a) A state register similar to the Federal Register. For the Department of Human Services (DHS), the state register is the Oregon Bulletin published by the Secretary of State;

(b) The newspaper of widest circulation in each city with a population of 50,000 or more;

(c) The newspaper of widest circulation in the state, if there is no city with a population of 50,000 or more.

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 461-013-0006; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0380; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1940
Interest Payments on Overdue Claims

(1) Upon request by the provider, the Division Assistance Program (DMAP) will pay interest on an overdue claim:

(a) A claim is considered "overdue" if DMAP does not make payment within 45 days of receipt of a valid claim;

(b) The interest rate shall be the usual rate charged by the provider to the provider's clientele, but not more than 2/3 percent per month or eight percent per year.

(2) When billing DMAP for interest on an overdue valid claim the provider must furnish the following information in writing:

(a) Name of the service and the location the service was provided;

(b) The name of the client who received the service;

(c) Client ID Number;

(d) Date of service;

(e) Date of initial valid billing of DAMP;

(f) Amount of billing on initial valid claim;

(g) DMAP 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 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 461-013-0185; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0360; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

410-120-1960
Payment of Private Insurance Premiums

(1) 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.

(2) For purposes of this rule, an eligible applicant may be a non-Medicaid individual, for whom the Division of Medical Assistance

Programs (DMAP) would pay the premium if it is necessary in order to enroll the DMAP Client in the health plan in accordance with this rule. DMAP may pay health insurance policy premiums or otherwise enter into agreements with other health insurance plans that comply with ORS 414.115 to 414.145 on behalf of eligible individuals when:

(a) The policy is a major medical insurance policy; and

(b) The payment of premiums and/or co-insurance and deductibles is likely to be Cost Effective, as determined under section (4) of this rule, i.e., that the estimated net cost to DMAP will be less than the estimated cost of paying Providers on a Fee-for-Service (FFS) or other basis.

(c) An eligible applicant may be a non-Medicaid individual in the household if payment of the premium including that individual is cost effective, and if it is necessary to include that individual in order to enroll the DMAP Client in the health plan.

(3) DMAP will not pay private health insurance premiums for:

(a) Non-SSI institutionalized and waivered Clients whose income deduction is used for payment of health insurance premiums;

(b) Clients eligible for reimbursement of Cost-Effective, employer-sponsored health insurance (OAR 461-135-0990).

(4) DMAP will assure that all Medicaid covered services continue to be made available to Medicaid-eligible individuals for whom DMAP elects to purchase insurance.

(5) Assessment of Cost Effectiveness will include:

(a) The past utilization experience of the Client or eligible applicant as determined by past DMAP and third party insurance utilization and claims data; and

(b) The current and probable future health status of the Client or 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.

(6) DMAP may purchase documents or records necessary to establish or maintain the Client's eligibility for other insurance coverage.

(7) DMAP will not make payments for any benefits covered under the private health insurance plan, except as follows:

(a) DMAP will calculate DMAP's allowable payment for a service. The amount paid by the other insurer will be deducted from the DMAP allowable. If the DMAP allowable exceeds the third party payment, DMAP will pay the Provider of service the difference;

(b) The payment made by DMAP will not exceed any co-insurance, Copayment or deductible due;

(c) DMAP will make payment of co-insurance, Copayments or deductibles due only for covered services provided to Medicaid-eligible Clients.

(8) DMAP payment under this rule requires the Client to promptly inform the DHS worker, within 10 days, of any change of insurance coverage to minimize overpayment; the DHS worker, in turn, must promptly notify the PHI coordinator.

(9) As a condition of eligibility, Clients are required to pursue assets (OAR 461-120-0330), and required to obtain medical coverage (OAR 461-120-0345). Failure to notify the DHS worker of insurance coverage or changes in such coverage, and failure to provide periodic required documentation for PHI may impact continued eligibility.

(10) The effective date for starting reimbursement of cost-effective Private Health Insurance (PHI) premiums is one of the following:

(a) For new cases, the later of the following:

(A) The date of request; or

(B) If no member of the filing group is eligible for medical on the date of request, the date of initial medical eligibility.

(b) For ongoing cases, the later of the following:

(A) The first of the month in which the insurance becomes effective; or

(B) The first of the month in which the benefit group requests reimbursement.

(11) The Client or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment, or reimbursement of Client paid insurance premium.

Stat. Auth.: ORS 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 461-013-0170; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0500 & 410-120-0520; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07

410-120-1980
Requests for Information and Public Records

(1) The Division of Medical Assistance Programs (DMAP) will make non-exempt public records available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) DMAP may charge a fee for copies of non-exempt public records to cover actual costs per OAR 407-003-0010.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 192.410 - 192.500
Hist.: HR 32-1993, f. & cert. ef. 11-1-93; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 3-2007, f. & cert. ef. 6-1-07

DIVISION 121

PHARMACEUTICAL SERVICES

410-121-0000
Foreword

(1) The Pharmaceutical Services Oregon Administrative Rules are designed to assist providers in preparing claims for services provided to Division of Medical Assistance Programs (DMAP) fee-for-service clients. The Pharmaceutical OARs must be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120).

(2) Pharmaceutical services delivered through managed care plans contracted with DMAP, under the Oregon Health Plan, are subject to the policies and procedures established in the Oregon Health Plan Administrative Rules (OAR 410 division 141) and by the specific managed health care plans.

(3) DMAP endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

(4) Administrative rules and billing guidelines for Home Enteral/Parenteral Nutrition and IV services are included in OAR 410 division 148. Administrative rules and billing guidelines for Durable Medical Equipment are included in OAR 410 division 122.

(5) All DMAP rules are available on the Department of Human Services website.

[ED NOTE: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0021
Prior Authorization Required for Drugs and Products

(1) Pharmacies, and Medicare certified independent rural health clinics providing urgent medical services for clients as defined in ORS 414.324(6), may provide drug prescription services for fee-for-service Division of Medical Assistance Programs (DMAP) clients and receive reimbursement from DMAP by complying with all the following requirements:

(a) Comply with all applicable Federal and State statutes, regulations and rules;

(b) Meet all current licensing and regulatory requirements;

(c) Be enrolled as a pharmacy provider with DMAP;

(d) Pharmacies must have a current National Association of the Board of Pharmacy (NABP) number to bill DMAP;

(e) Medicare certified independent rural health clinics must have a pharmacist, physician, or nurse practitioner, licensed to dispense and bill drug prescriptions; and

(f) Comply with DMAP pharmacy billing requirements.

(2) Refer to OAR 410-120-1260 for enrollment details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 41-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05

410-121-0030
Practitioner-Managed Prescription Drug Plan (PMPDP)

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that fee for service clients of the Oregon Health Plan will have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners (informed by the latest peer reviewed research), make decisions concerning the clinical effectiveness of the prescription drugs;

(b) The licensed health care practitioners also consider the health condition of a client or characteristics of a client, including the client's gender, race or ethnicity.

(2) PMPDP Plan Drug List (PDL):

(a) The PDL is the primary tool that the Department of Human Services (DHS) has developed to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL consists of prescription drugs in selected classes that DHS, in consultation with the Health Resources Commission (HRC), has determined represent effective drug(s) available at the best possible price;

(c) For each selected drug class, the PDL will identify a drug(s) as the benchmark drug that DHS determines to be the most effective drug(s) available for the best possible price;

(d) The PDL will include other drugs in the class that are Medicaid reimbursable and which the Food and Drug Administration (FDA) has determined to be safe and effective if the relative cost is less than the benchmark drug(s). If pharmaceutical manufacturers enter into supplemental discount agreements with DHS that reduce the cost of their drug below that of the benchmark drug for the class, DHS will include their drug in the PDL;

(e) A copy of the current PDL is available on the web at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/.

(3) PMPDP PDL Selection Process:

(a) DHS will utilize the recommendations made by the HRC, which result from an evidence-based evaluation process, as the basis for identifying the most effective drug(s) within a selected drug class;

(b) DHS will determine the drug(s) identified in (3)(a) that is (are) available for the best possible price and will consider any input from the HRC about other FDA-approved drug(s) in the same class that are available for a lesser relative price. DHS will determine relative price using the methodology described in subsection (4);

(c) DHS will review drug classes and selected drug(s) for the drug classes periodically:

(A) Review will occur more frequently at the discretion of DHS if new safety information or the release of new drugs in a class or other information makes a review advisable;

(B) DHS will not add new drugs to the PDL until they have been reviewed by the HRC;

(C) DHS will make all changes or revisions to the PDL, using the rulemaking process and will publish the changes on DHS's Pharmaceutical Services provider rules Web page.

(4) Relative cost and best possible price determination:

(a) DHS will determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) DHS may also consider dosing issues, patterns of use and compliance issues. DHS will weigh these factors with any advice provided by the HRC in reaching a final decision;

(c) DHS will determine the benchmark drug based on (4)(b) and on the Estimated Acquisition Cost (EAC) on the first of the month (OAR 410-121-0155) in which DHS reviews that specific drug class;

(d) Once the cost of the benchmark drug is determined, DHS will recalculate the cost of the other FDA-approved drugs in the class using the EAC in effect for retail pharmacies on the first of the month in which DHS reviews that specific drug class less average available rebate. DHS will include drugs with prices under the benchmark drug cost on the PDL.

(5) Regardless of the PDL, pharmacy providers shall dispense prescriptions in the generic form, unless the practitioner requests otherwise, subject to the regulations outlined in OAR 410-121-0155. Table 121-0030-1, PMPDP PDL.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.06

Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04; OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 48-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07

410-121-0032
Supplemental Rebate Agreements

(1) Supplemental Rebate Agreements are negotiated for specific drug products between the Division of Medical Assistance Programs (DMAP) and pharmaceutical manufacturers. Manufacturers may submit Supplemental Rebate offers for consideration to include their drug(s) on the Practitioner's-Managed Prescription Drug Plan (PMPDP) Plan Drug List (PDL), OAR 410-121-0030:

(a) Manufacturers must submit Supplemental Rebate Agreements on the agreement template approved by the Centers for Medicare and Medicaid Services (CMS). This template is available on the Department of Human Services Web site;

(b) "Supplemental Rebates" are DMAP and CMS approved discounts paid by manufacturers per unit of drug. These rebates are authorized by the Social Security Act section 42 USC 1396r-8(a)(1) and are in addition to federal rebates mandated by the Omnibus Budget Rehabilitation Act (OBRA 90) and the federal rebate program;

(c) "Net Price" is the ingredient reimbursement amount minus the CMS Basic Rebate and CMS Consumer Price Index (CPI) Rebate minus the Supplemental Rebate;

(d) "CMS Basic Rebate" is the quarterly payment by a manufacturer pursuant to the manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with the Social Security Act, section 1927(c)(3), 42 USC 1396r-8(c)(1), and 42 USC1396r-8(c)(3);

(e) "CMS CPI Rebate" is the quarterly payment by the manufacturer pursuant to the manufacturer's CMS Medicaid Drug Rebate Agreement, made in accordance with 42 USC 1396r-8(c)(2).

(2) Manufacturers may offer Supplemental Rebates by submitting the completed template to DMAP:

(a) Manufacturers will be allowed to submit Supplemental Rebate offers for drugs recommended for inclusion on the PDL by the Health Resources Commission;

(b) Drugs will be considered for addition to the appropriate PDL class when the Net Price is equal to or less than the benchmark drug estimated acquisition cost as determined in OAR 410-121-0030(4).

(3) Manufacturers may submit a Supplemental Rebate Agreement offer by:

(a) Obtaining the CMS-approved template from the DHS website; and

(b) Submitting the completed Supplemental Rebate Agreement with attachment B listing the drugs offered to DMAP. The manufacturers may submit up to three separate attachment B drug lists with the Supplemental Rebate Agreement offer.

(4) Acceptance of the offer:

(a) DMAP will notify the manufacturer of the acceptance of the offer(s);

(b) Supplemental Agreements will be executed after signed by all parties, approved by CMS if required, and added to the PMPDP Plan Drug List by the Administrative rule process.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.965

Hist.: OMAP 97-2004, f. 12-30-04, cert. ef. 1-1-05

410-121-0033
Polypharmacy Profiling

(1) The Division of Medical Assistance Programs (DMAP) may impose prescription drug payment limitations on clients with more than 15 unique fee-for-service drug prescriptions in a six-month period.

(2) DMAP will review the client's drug therapy in coordination with the client's prescribing practitioner to evaluate for appropriate drug therapy.

(3) Appropriate drug therapy criteria will include, but is not limited to, the following:

(a) Overuse of selected drug classes;

(b) Under-use of generic drugs;

(c) Therapeutic drug duplication;

(d) Drug to disease interactions;

(e) Drug to drug interactions;

(f) Inappropriate drug dosage;

(g) Drug selection for age;

(h) Duration of treatment;

(i) Clinical abuse or misuse.

(4) The DMAP Medical Director in conjunction with the Drug Utilization Review (DUR) Board will make final determinations on imposed drug prescription payment limitations relating to this policy.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 1-2004, f. 1-23-04, cert. ef. 2-1-04

410-121-0040
Prior Authorization Required for Drugs and Products

(1) Prescribing practitioners are responsible for obtaining Prior Authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures required in OAR 410-121-0060.

(2) All drugs and categories of drugs, including but not limited to those drugs and categories of drugs that require PA as described in this rule, are subject to the following requirements for coverage:

(a) Each drug must be prescribed for conditions funded by OHP in a manner consistent with the Prioritized List of Health Services and its corresponding treatment guidelines, included within the client's benefit package of covered services, and not otherwise excluded or limited.

(b) Each drug must also meet other criteria applicable to the drug or category of drug in these Pharmacy Provider rules, including PA requirements imposed in this rule.

(3) The Department of Human Services (DHS) may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480). The drugs and categories of drugs for which DHS requires PA for this purpose are listed in **Table 410-121-0040-1**, with their approval criteria.

(4) DHS may require PA for individual drugs and categories of drugs to ensure medically appropriate use or to address potential client safety risk associated with the particular drug or category of drug, as recommended by the Drug Use Review (DUR) Board and adopted by the Department in this rule (see OAR 410-121-0100 for a description of the DUR program). The drugs and categories of drugs for which DHS requires PA for this purpose are included in **Table 410-121-0040-2**, with their approval criteria.

(5) PA is required for brand name drugs that have two or more generically equivalent products available. Criteria for approval are:

(a) If criteria established in subsection (3) or (4) of this rule applies, follow that criteria.

(b) If (5)(a) does not apply, the prescribing practitioner must document that the use of the generically equivalent drug is medically contraindicated, and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.

(6) PA will not be required:

(a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by DHS; or,

(b) For over-the-counter (OTC) covered rugs when prescribed for conditions covered under OHP.

(7) Psychotropic prescriptions for children under the age of six cannot be processed when a default 999999 provider number has been entered. If such a default provider number is used, the drug may not be dispensed until PA has been obtained. The PA process will include providing the correct provider number.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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 461-016-0170; HR 10-1991, f. & cert. ef. 2-19-91; HR 14-1993, f. & cert. ef. 7-2-93; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 18-1996(Temp), f. & cert. ef. 10-1-96; HR 8-1997, f. 3-13-97, cert. ef. 3-15-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2002, f. & cert. ef. 10-1-02; OMAP 66-2002, f. 10-31-02, cert. ef. 11-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 87-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 71-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 74-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 4-2006(Temp), f. & cert. ef. 3-15-06 thru 9-7-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 41-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07

410-121-0060
How to Get Prior Authorization for Drugs

(1) A prescriber electing to order a drug requiring PA may have any licensed medical personnel in their office call the Managed Access Program (MAP) Help Desk to request the PA. The PA request may also be transmitted to the MAP Help Desk by FAX using the request form shown in the Pharmaceutical Services Supplemental Information on the Department of Human Services website.

(2) PA approval:

(a) If the PA request is approved, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information will be available:

(A) PA approvals are given for a specific date of service and for specific NDC numbers or products:

(B) PA approvals do not guarantee eligibility or reimbursement.

(b) 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 PA;

(c) The pharmacy must also check whether the client's prescribed medications are covered by a managed care plan because an enrollment may have taken place after PA was received. If the client is enrolled in a managed care plan and the pharmacy receiving the PA is not a participating pharmacy provider in the managed care plan's network, the pharmacy must inform the client that it is not a participating provider in the managed care plan's network and must also recommend that the client contact his or her managed care plan for a list of pharmacies participating in its network;

(d) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy provider, if consistent with all other applicable administrative rules. There is no need for a PA number.

(3) If the PA request has been denied, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(4) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from First Health when the client is eligible for covered fee-for-service drug prescriptions:

(a) Clients who do not have a PA pending may receive an emergency dispensing for a 96-hour supply;

(b) Clients who do have a PA pending may receive an emergency dispensing up to a seven-day supply.

Stat. Auth.: ORS 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 461-016-0180; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0061
Durable Medical Equipment and Medical Supplies

Follow the guidelines in the Durable Medical Equipment and Medical Supplies (OAR 410 division 122) and Home Enteral/Parenteral Nutrition and IV Services (OAR 410 division 148) Administrative Rules and Supplemental Information for billing and prior authorization of these medical supplies and services. This information is available on the Department of Human Services website.

Stat. Auth.: ORS 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; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0100
Drug Use Review

(1) Drug Use Review (DUR) in Division Medical Assistance Programs (DMAP) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program shall include, but is not limited to, education in relation to overutilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse:

(a) Information collected in a DUR program that identifies an individual is confidential and may not be disclosed by the DMAP DUR Board or Retrospective DUR Council to any person other than health care providers appearing on a recipient's medication profile;

(b) Staff of the DUR Board and Retrospective DUR Council may have access to identifying information to carry out intervention activities approved by DMAP, after signing an agreement to keep the information confidential. The identifying information may not be released to anyone

other than staff members of the DUR Board or Retrospective DUR Council, or health care providers appearing on a recipient's medication profile. For purposes of DUR activities, identifying information is defined as the names of prescribing providers, pharmacy providers, and clients.

(2) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is performed at the point of sale by the dispensing pharmacist:

(a) Dispensing pharmacists must offer to counsel each DMAP client receiving benefits who presents a new prescription, unless the client refuses such counsel. Pharmacists must document these refusals:

(A) Dispensing pharmacists may offer to counsel the client's caregiver rather than the client presenting the new prescription if the dispensing pharmacist determines that it is appropriate in the particular instance;

(B) Counseling must be done in person whenever practicable;

(C) If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide access to toll-free services (for example, some mail order pharmacy services) and must provide access to toll-free service for long-distance client calls in relation to prescription counseling.

(b) Prospective DUR is not required for drugs dispensed by Fully Capitated Health Plans (FCHPs);

(c) Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening must be followed.

(3) Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. DMAP provides a professional drug therapy review for Medicaid clients through this program:

(a) The criteria used in retrospective DUR are compatible with those used in prospective DUR. The drug therapy review is carried out by a panel of physicians and pharmacists who are licensed in Oregon and appointed by the DMAP Director. Members of this panel are referred to as council members;

(b) If therapy problems are identified by the Retrospective DUR-Council, an educational letter is mailed to the prescribing provider, the dispensing provider, or both. Other forms of education are carried out under this program with DMAP approval.

(4) The DUR Board is a group of individuals who comprise an advisory committee to DMAP:

(a) The DUR Board is comprised of health care professionals with recognized knowledge and expertise in one or more of the following areas:

(A) Clinically appropriate prescribing of outpatient drugs covered by Medicaid;

(B) Clinically appropriate dispensing and monitoring of outpatient drugs covered by Medicaid;

(C) Drug use review, evaluation and intervention; or

(D) Medical quality assurance.

(b) The DUR Board's membership is made up of at least one-third, but not more than 51 percent, licensed and actively practicing physicians and at least one-third licensed and actively practicing pharmacists. The DUR Board is composed of the following:

(A) Four practicing pharmacists;

(B) Five practicing physicians;

(C) Two persons who represent people on Medical Assistance; and

(D) One person actively practicing dentistry.

(c) The Retrospective DUR Council coordinator will attend board meetings in an ex officio capacity;

(d) Appointments to the DUR Board are made by the DMAP Director:

(A) Nominations for DUR Board membership may be sought from various professional associations and each member may serve a two-year term;

(B) When a vacancy occurs, a new member is appointed to serve the remainder of the unexpired term;

(C) An individual appointed to the DUR Board may be reappointed upon the completion of the member's current term of service.

(e) Members of the DUR Board receive no compensation 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;

(f) Members of the DUR Board attend quarterly meetings, two of which must be attended in person.

(5) The DUR Board is designed to develop policy recommendations in the following areas in relation to Drug Use Review:

(a) Appropriateness of criteria and standards for prospective DUR and needs for modification of these areas. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medical appropriateness, and appropriateness of health care service may be compared. Criteria and standards will be consistent with the following compendia:

(A) American Hospital Formulary Services Drug Information;

(B) US Pharmacopeia-Drug Information;

(C) American Medical Association Drug Evaluations;

(D) Peer-reviewed medical literature; or

(E) Drug DEX.

(b) Recommendations for continued maintenance of patient confidentiality will be sought;

(c) The use of different types of education and interventions to be carried out or delegated by the DUR Board and the evaluation of the results of this portion of the program; and

(d) The preparation of an annual report on Oregon Medicaid DUR Program which describes:

(A) The nature and scope of the DUR Board and the activities carried out by the DUR Board, including:

(i) A description of how pharmacies without computers comply with prospective DUR;

(ii) Detailed information on new criteria and standards in use; and

(iii) Changes in state policy in relation to DUR requirements for residents in nursing homes.

(B) A summary of the education/intervention strategies developed; and

(C) An estimate of the cost savings in the pharmacy budget and indirect savings due to changes in levels of physician visits and hospitalizations.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 38-1992, f. 12-31-92, cert. ef. 1-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0135
Pharmacy Management Program Requirements

(1) The Pharmacy Management Program requires most fee-for-service clients to be enrolled in one pharmacy to receive their prescription drugs.

(2) The name and phone number of the pharmacy the client is required to use will be on the DMAP Medical Care ID. DMAP will only reimburse the pharmacy listed on the DMAP Medical Care ID.

(3) When no pharmacy is listed on the DMAP Medical Care ID, the client may have their prescriptions filled by any pharmacy that has Division of Medical Assistance Programs (DMAP) provider number.

(4) Enrollment of an Oregon Health Plan (OHP) Client in a Pharmacy Management Program pharmacy shall be mandatory unless the OHP Client:

(a) Is a Prepaid Health Plan (PHP) DMAP member;

(b) Has Medicare drug coverage in addition to OHP fee-for-service and no other third party pharmacy insurance coverage;

(c) Is an American Indian or Alaska Native with proof of Indian heritage;

(d) Is a child in the care and custody of the Department of Human Services;

(e) Is an inpatient or resident in a hospital, nursing facility, or other medical institution.

(5) Pharmacy Management Program clients may change their enrolled pharmacy if they:

(a) Move out of area;

(b) Are reapplying for OHP benefits; or

(c) Are denied access to pharmacy services by their selected pharmacy.

(6) Pharmacy Management Program clients may receive drugs from a different pharmacy if:

(a) The client has an urgent need to fill a prescription and the enrolled pharmacy is not available; or

(b) The enrolled pharmacy does not have the prescribed drug in stock; or

(c) The client is out of the area (more than 50 miles) of their enrolled pharmacy;

(d) The client is using mail order home delivery in addition to their enrolled pharmacy.

(7) Call the Pharmacy Benefits Administrator Point of Sale Technical Help Desk for authorization to fill a prescription in the situations described in (5)(a)–(c) above.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 26-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05

410-121-0140
Definition of Terms

(1) 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.

(2) Automated Information System (AIS): A computer system that provides on-line Medicaid eligibility information. AIS is accessed through the provider's touch-tone telephone by dialing 1-800-522-2508.

(3) Bulk Dispensing: Multiple doses of medication packaged in one container labeled as required by pertinent Federal and State laws and rules.

(4) Community Based Care Living Facility: For the purposes of the OMADivision of Medical Assistance Programs (DMAP) Pharmacy Program, "community based care living facilities" include:

(a) Supportive Living Facilities;

(b) 24-Hour Residential Services;

(c) Foster Care;

(d) Semi-independent Living Programs; and

(e) Assisted Living and Residential Care Facilities.

(5) Compounded Prescriptions: A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid ingredient that must be a reimbursable item or a legend drug in a therapeutic amount. Compounded prescription is further defined to include the Oregon Board of Pharmacy definition of Compounding.

(6) Dispensing: Issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist.

(7) Drug Order/Prescription:

(a) A medical practitioner's written or verbal instructions for a patient's medications; or

(b) A medical practitioner's written order on a medical chart for a client in a nursing facility.

(8) Durable Medical Equipment and supplies (DME): Equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. (9) Estimated Acquisition Cost (EAC): The estimated cost at which the pharmacy can obtain the product listed in OAR 410-121-0155.

(10) Managed Access Program (MAP): The Managed Access Program (MAP) is a system of determining, through a series of therapeutic and clinical protocols, which drugs require authorizations prior to dispensing:

(a) The drugs or categories of drugs requiring prior authorization (PA) are listed in OAR 410-121-0040;

(b) The practitioner, or practitioner's licensed medical personnel listed in OAR 410-121-0060, may request a PA.

(11) Nursing Facilities: The term "Nursing Facility" refers to an establishment that is licensed and certified by the DHS Seniors and People with Disabilities Division (SPD) cluster as a Nursing Facility.

(12) Point-of-Sale (POS): A computerized, claims submission process for retail pharmacies that provides on-line, real-time claims adjudication.

(13) Prescription Splitting: Any one or a combination of the following actions:

(a) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than a 34-day (See OAR 410-121-0146);

(b) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing for the quantity dispensed;

(c) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or

(d) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.

(14) Unit Dose: A sealed, single unit container of medication, so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for unit dose dispensing system established by the Oregon Board of Pharmacy.

(15) Unit Dose Delivery System: DMAP currently recognizes two types of unit dose dispensing systems in a nursing facility or community based living facility. Both the True and Modified Unit Dose delivery systems are described in OAR 410-121-0148.

Stat. Auth.: ORS 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 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 461-016-0010; 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 461-016-0190; 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; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 49-2001, f. 9-28-01, cert. ef. 10-1-01 thru 3-15-02; OMAP 59-2001, f. & cert. ef. 12-11-01; OMAP 37-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 9-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 18-2003(Temp), f. 3-14-03, cert. ef. 4-1-03 thru 9-1-03 (Suspended by OMAP 27-2003, f. 3-31-03, cert. ef. 4-1-03 thru 4-15-03); OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 42-2003(Temp), f. 5-30-03, cert. ef. 6-1-03 thru 11-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 72-2003(Temp), f. 9-23-03, cert. ef. 11-1-03 thru 4-15-04; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0143
Client Confidentiality

Pharmacists are responsible for maintaining the confidentiality of client information in compliance with HIPAA standards. Facilities shall provide adequate privacy for patient consultations.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 16-1992, f. & cert. ef. 7-1-92; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0144
Notation on Prescriptions

This rule applies to fee-for-service clients only.

(1) Prescribing practitioners must add a notation on pharmacy prescriptions indicating when there is a non-covered diagnosis.

(2) When the client 's diagnosis is excluded or below the current funding line on the Health Services Commission's Prioritized List of Health Services, use the following notations (or similar language):

(a) "Diagnosis not covered";

(b) "Excluded diagnosis"; or

(c) "Condition below the funding line."

(3) The Division of Medical Assistance Programs (DMAP) will not provide payment for prescriptions when a diagnosis is:

(a) Below the funding line;

(b) An excluded service; or

(c) On the excluded list.

(4) Payment for prescriptions with an excluded or not covered diagnosis is the responsibility of the client. These prescriptions will not be paid under the Oregon Health Plan. Pharmacies are not to bill DMAP for these prescriptions.

Stat.Auth.: ORS 409
Stats.Implemented: ORS 414.065
Hist.: OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0145
Prescription Requirements

(1) Division of Medical Assistance Programs (DMAP) will make payment for covered drugs supplied on drug order or prescription of a licensed practitioner and dispensed by a pharmacist. Dispensings include new prescriptions, refills of existing prescriptions, and over-the-counter (OTC) medications.

(a) Each drug order or prescription filled for a DMAP client must be retained in the pharmacy's file at the pharmacy's place of business; and,

(b) All drug orders or prescriptions must comply with the Oregon State Board of Pharmacy rules and regulations as listed in OAR 855 division 041.

(2) Notwithstanding subsection (1) of this rule, the following rules shall apply to over-the-counter Plan B emergency contraceptive drugs:

(a) DMAP may reimburse a pharmacy for distributing over-the-counter Plan B emergency contraceptive drug products to women who are 18 years old and older and who are Medicaid eligible; and,

(b) As a condition of reimbursement for over-the-counter Plan B emergency contraceptive drugs, DMAP may require that the pharmacy show proof that it has complied with Oregon Board of Pharmacy rules pertaining to the distribution of over-the-counter Plan B emergency contraceptive drugs.

Stat. Auth.: ORS 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 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82; AFS 53-85, f. 9-20-85, ef. 10-1-85 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0020; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0200; HR 25-1994, f. & cert. ef. 7-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07

410-121-0146
Dispensing Limitations

(1) The quantity indicated by the prescriber on the prescription may not be reduced except when in conflict with the limitations below. The Division of Medical Assistance Program (DMAP) 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 (OAR 410 division 120).

(2) The following dispensing limitations apply to DMAP reimbursement:

(a) Dispensing, except as otherwise noted in this rule, is limited to the amount prescribed but not to exceed a 34-day supply of the drug;

(b) Exceptions to the 34-day supply limitation includes mail order pharmacy dispensed through DMAP contracted Mail Order Pharmacy and prescription in the drug classes 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 Standard 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.

(c) After stabilization of a diabetic, a minimum of a one-month supply of Insulin should be provided per dispensing;

(d) For vaccines available in multiple dose packaging, a dispensing fee will be allowed for each multiple dose. When vaccines are administered at the pharmacy, refer to OAR 410-121-0185;

(e) For compounded prescriptions, components of the prescription shall be billed separately. A dispensing fee will be allowed for each component eligible for reimbursement. Any reimbursement received from a third party for compounded prescriptions must be split and applied equally to each component.

Stat. Auth.: ORS 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 461-016-0090; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0210; HR 16-1992, f. & cert. ef. 7-1-92; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1996(Temp), f. & cert. ef. 8-1-96; HR 27-1996, f. 12-11-96, cert. ef. 12-15-96; HR 20-1997, f. & cert. ef. 9-12-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 74-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04

410-121-0147
Exclusions and Limitations

The following items are not covered for payment by the Division of Medical Assistance Programs (DMAP):

(1) Drug Products for diagnoses below the funded line on the Health Services Commission Prioritized List;

(2) Home pregnancy kits;

(3) Fluoride for individuals over 18 years of age;

(4) Expired drug products;

(5) Drug Products from Non-Rebatable Manufacturers;

(6) Drug products that are not assigned a National Drug Code (NDC) number;

(7) Drug products that are not approved by the Federal Drug Administration (FDA);

(8) Drug products dispensed for Citizen/Alien-Waived Emergency Medical client benefit type;

(9) DESI drugs (see OAR 410-121-0420);

(10) Medicare Part D covered drugs or classes of drugs for fully dual eligible clients;

Stat. Auth.: ORS 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; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0148
Dispensing in a Nursing Facility or Community Based Care Living Facility

(1) A pharmacy serving Division of Medical Assistance Programs (DMAP) clients in a nursing facility or a Community Based Care Living 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. (16) Unit Dose Delivery System:

(a) DMAP currently recognizes two types of unit dose dispensing systems:

(A) A True Unit Dose delivery system in a nursing facility or community-base care facility requires that:

(i) A pharmacy must deliver each client's medication a minimum of five days weekly, or delivery of medical carts every other day with service available seven days a week;

(ii) Resumption of the same medication after a "stop order" or discontinuance ("DC") order constitutes a new prescription;

(iii) The monthly billing period shall remain the same for all clients;

(iv) Small quantity prescriptions are allowed only when the monthly billing period is interrupted, e.g., hospitalization, new patient admit.

(B) A Modified Unit Dose delivery system in a nursing facility or community-based care facility requires that:

(i) A pharmacy must deliver each client's medication in a sealed single-or multi-dose package;

(ii) A pharmacy must dispense the greater of the quantity prescribed or a 30-day supply, except when short-term therapy is specified by the prescriber;

(iii) A pharmacy must bill DMAP for the date of dispensing within the timely filing limit;

(iv) Manufacturer's Unit Dose packaging of drugs is not reimbursable.

(b) Unit Dose dispensing is a 30-day blister pack, bingo or punch card containing multiple sealed single doses of medication:

(A) The pharmacy must have a system for dispensing and recovery of unused doses that has been approved by the State Board of Pharmacy;

(B) A 30-day card system that does not meet the requirements of the State Board of Pharmacy for recovery of unused doses, or for other reasons does not qualify for payment is not considered a True or Modified Unit Dose Delivery System.

(c) True and Modified Unit Dose providers must:

(A) Supply DMAP with a list of the nursing and community based care living facilities it will serve under this system;

(B) Sign an agreement to abide by the requirements of the program;

(C) Keep a separate, detailed Medication Administration Record (MAR) of all medications dispensed for each facility client served.

(2) Pharmacies that do not dispense through a unit dose or 30-day card system may bill DMAP for a dispensing fee for each dispensing of legend drugs to eligible clients on a DMAP fee-for-service basis.

(3) The pharmacy must submit a written notification to DMAP of the agreement between the pharmacy and the nursing or community based care living facility. The notice must be received in DMAP 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 Facility Dispensing Statement (DMAP 3063) signed by the pharmacist in charge, stating the dispensing method to be used for each qualified 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 DMAP only for the medications actually dispensed. 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 DMAP through a completed Facility Dispensing Statement (DMAP 3063) signed by the pharmacist in charge if at least one of the following situations arise:

(a) The percentage level of true or modified unit dose dispensings falls below the percentage level defined in OAR 410-121-0160;

(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 facility already on record as being served by the pharmacy.

(6) Pharmacies shall not bill DMAP for repackaging/handling fees. There may only be one billing for each dispensing.

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

Stat. Auth.: ORS 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 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 83-1982 (Temp), f. & ef. 9-2-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 58-1983, f. 11-30-83, ef. 1-1-84; AFS 16-1985, f. 3-26-85, ef. 5-1-85; AFS 52-1986, f. & ef. 7-2-86; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0070; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0230; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0149
Medicaid Temporary Prescription Drug Assistance for Fully Dual Eligible Medicare Part D Clients

(1) This rule is a temporary solution implemented because many pharmacies are not able to verify that the fully dual eligible client is enrolled in one of the federal Medicare Prescription Drug Plans or that the client is eligible for low-income subsidy assistance. DMAP will continue to work with the federal Medicare program to resolve these implementation issues with Part D coverage.

(2) Effective January 14, 2006, for the purposes described in Subsection (1), enrolled pharmacies may send the Division of Medical Assistance Programs (DMAP) claims for Part D drugs and cost-sharing obligations of clients who have both Medicare and Medicaid coverage (fully dual eligible clients) if:

(a) The drug(s) was covered by DMAP for fully dual eligible clients prior to January 1, 2006; and

(b) The pharmacy has attempted to bill Medicare's Part D system but cannot resolve the claim by:

(A) Continuing to bill the Medicare Part D plan as the primary payer identified through an E-1 query;

(B) Trying to resolve the issue with the Medicare Part D plan directly;

(C) Billing Wellpoint/Anthem, Medicare's Point of Sale Solution.

(3) If all the criteria in Subsection (2) are met, then DMAP will consider paying the claim or a portion of the claim, as follows:

(a) The pharmacy must contact the DHS Medicare hotline at 1-877-585-0007 to obtain authorization for claim submission;

(b) The fully dual eligible client is responsible for paying the appropriate Medicare copayment;

(c) DMAP payment authorization will be limited to not greater than a one-month supply; and

(d) DMAP's reimbursement amount will be limited to the amount the Part D drug plan would have paid, had the Part D drug plan adjudicated the claim first, or the amount DMAP would pay for Medicaid clients who are not also Medicare beneficiaries.

(4) This rule supersedes all other rules relating to the limitations and exclusions of drug coverage for clients with Medicare Part D.

Stat. Auth. ORS 409.010, 409.050, 2005 OL, Ch. 754 (SB 1088)

Statutes Implemented: ORS 414.065

Hist.: OMAP 1-2006(Temp), f. & cert. ef. 1-18-06 thru 6-29-06; OMAP 29-2006, f. 6-22-06, cert. ef. 6-29-06; OMAP 41-2006, f. 12-15-06, cert. ef. 1-1-07

410-121-0150
Billing Requirements

(1) When billing the Division of Medical Assistance Programs (DMAP) for drug products, the provider must not bill in excess of the usual and customary charge to the general public.

(2) The National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed, must be indicated.

(3) Actual metric decimal quantity dispensed, must be billed.

(4) The provider must accurately furnish all information required on the 5.1 Universal Claims Form if submitting a paper claim.

(5) The prescribing provider's Medicaid Provider Identification (ID) Number is mandatory on all fee-for-service client drug prescription claims. Claims will deny for a missing or invalid prescriber Medicaid Provider ID Number. Exceptions to this include, but are not limited to, the following:

(a) A miscellaneous Medicaid provider number of 999999 may be used for:

(A) Out-of-state prescribing providers; and

(B) Inactive Oregon Medicaid Providers;

(b) Prescribing providers who do not have a Medicaid Provider ID Number for billing, but who prescribe for fee-for-service prescriptions for clients under prepaid health plans (PHP), long-term care, or other capitated contracts are to be identified with the:

(A) Non-billing Provider ID Number assigned for prescription writing only;

(B) Clinic or facility Medicaid Provider ID Number until an individual Non-billing Provider ID Number is obtained; or

(C) Supervising physician's Provider ID Number when billing for prescriptions written by the physician assistant, physician students, physician interns, or medical professionals who have prescription writing authority.

(c) A miscellaneous Medicaid Provider ID Number of 999999 may not be used for psychotropic prescriptions for children under the age of six.

(d) A Medicaid Provider ID number of BBBBBB must be used in order for a pharmacy to be reimbursed for distributing the emergency contraceptive drug product Plan B over-the-counter to women who are 18 years old or older and who are Medicaid eligible.

(6) When clients have private insurance, providers are required to bill the private insurance as primary and DMAP as secondary.

(7) When clients have Medicare prescription drug coverage, providers are required to bill Medicare as primary and DMAP as secondary.

(8) Billing for Death With Dignity services – Death With Dignity:

(a) Claims for Death With Dignity services cannot be billed through the Point-of-Sale system.

(b) Services must be billed directly to DMAP, even if the client is in a PHP.

(c) Prescriptions must be billed on a 5.1 Universal Claims Form paper claim form using an NDC number.

(d) Claims must be submitted on paper billing forms to DMAP at PO Box 14165, Salem, Oregon 97308-0992.

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

Stat. Auth.: ORS 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 461-016-0093; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0240; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 44-1998(Temp), f. 12-1-98, cert. ef. 12-1-98 thru 5-1-99; OMAP 11-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 25-1999, f. & cert. ef. 6-4-99; OMAP 5-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07

410-121-0155
Reimbursement

Payment for covered fee-for-service drug products will be the lesser of the usual and customary amount billed or the Estimated Acquisition Cost (EAC) of the generic form, minus any applicable copayments, plus a professional dispensing fee. Refer to OAR 410-120-1230 for client copayment details.

(1) EAC is the lesser of:

(a) The Centers for Medicare and Medicaid Services' (CMS) federal upper limits (FUL) for payment;

(b) The Oregon Maximum Allowable Cost (OMAC);

(c) Retail pharmacies: eighty-five percent of Average Wholesale Price (AWP) of the drug; or

(d) Unit dose or modified unit dose pharmacies: eighty-nine percent of AWP for long-term care clients in a nursing facility or community based living facility; or

(e) Contracted mail order pharmacy: seventy-nine percent of AWP for brand (trade) name drugs, forty percent of AWP for generic drugs and eighty-two percent of AWP for injectable drugs.

(2) The Division of Medical Assistance Programs (DMAP) shall revise its estimated acquisition cost file weekly.

(3) Pharmacies must make available to DMAP any information necessary to determine the pharmacy's actual acquisition cost of drug products dispensed to DMAP clients.

(4) Payment for trade name forms of multisource products will be the lesser of the amount billed or the EAC of the trade name form of the product, minus applicable copayments, plus a professional dispensing fee only if the prescribing practitioner has received a prior authorization for a trade name drug.

(5) 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 DMAP.

(6) No professional dispensing fee is allowed for dispensing:

(a) Condoms, contraceptive foams, suppositories, inserts, jellies, and creams;

(b) Pill splitters/cutters;

(c) Medical supplies and equipment; and

(d) Oral nutritional supplements.

(7) Over-the-counter contraceptive drugs and devices will be reimbursed at the lesser of billed amount or EAC, plus fifty percent of EAC.

(8) Oral nutritional supplements will be reimbursed at the lesser of billed amount or EAC, plus one third of EAC.

(9) Pill splitters/cutters with a National Drug Code (NDC) number will be reimbursed at the lesser of billed amount, or EAC. A practitioner prescription is not required. The limit is one per client in a twelve-month period.

Stat. Auth.: ORS 184.750, 184.770, 409, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 846(Temp), f. & ef. 7-1-77; PWC 858, f. 10-14-77, ef. 11-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 15-1979(Temp), f. 6-29-79, ef. 7-1-79; AFS 41-1979, f. & ef. 11-1-79; AFS 15-1981, f. 3-5-81, ef. 4-1-81; AFS 35-1981(Temp), f. 6-26-81, ef. 7-1-81; AFS 53-1981(Temp), f. & ef. 8-14-81; AFS 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices. AFS 74-1982 (Temp), f. 7-22-81, ef. 8-1-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 113-1982(Temp), f. 12-28-82, ef. 1-1-83; AFS 13-1983, f. & ef. 3-21-83; AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 18-1984, f. 4-23-84, ef. 5-1-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0100; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0250; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 32-2002, f. & cert. ef. 8-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0157
Participation in the Medicaid Drug Rebate Program

(1) The Oregon Medicaid Pharmaceutical Services Program is a participant in the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). Pharmaceutical companies participating in this program have signed agreements with CMS to provide rebates to the Division of Medical Assistance Programs (DMAP) on all their drug products. DMAP will reimburse providers only for outpatient drug products manufactured or labeled by companies participating in this program.

(2) Documents in rule by reference: Names and Labeler Code numbers for participants in the Medicaid Drug Rebate Program are the responsibility of and maintained by CMS. DMAP receives this information from CMS in the form of numbered and dated Releases. Subsequently, DMAP produces and updates Master Pharmaceutical Manufacturer's Rebate Lists (Lists), alphabetical and numeric, by manufacturer. These lists are used by DMAP providers to bill for services. DMAP includes in rule by reference, the following CMS Releases and subsequent DMAP Master Pharmaceutical Manufacturer's Rebate Lists: Release #136, dated February 17, 2005 — Lists updated March 30, 2005; Release #137, dated May 13, 2005 and Lists updated June 23, 2005; Release #138, dated August 5, 2005, and Lists updated August 19, 2005, and Release #139, dated December 1, 2005 — Lists updated December 8, 2005; Release #140, dated March 15, 2006, and Lists updated March 17, 2006, Release # 142, dated July 3, 2006, and Lists updated July 12, 2006; Release # 143, dated August 23, 2006, and Lists updated August 29, 2006. All CMS Releases are available on the Department of Human Services' website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html, and on the CMS website: www.cms.hhs.gov/medicaid/drugs/drughmpg.asp, and the subsequent DMAP Master Pharmaceutical Manufacturer's Rebate Lists, are available on the Department of Human Services' website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html.

(3) Retroactive effective dates: The CMS Medicaid Drug Rebate Program experiences frequent changes in participation and often this information is submitted to DMAP after the effective date(s) of some changes. Therefore, certain participant additions and deletions may be effective retroactively. See specific instructions in the CMS Releases for appropriate effective date(s) of changes.

(4) DMAP 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.

(5) The actual National Drug Code (NDC) dispensed and the actual metric decimal quantity dispensed, must be billed.

Stat. Auth.: ORS 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; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2000(Temp), f. 12-29-00, cert. ef. 1-1-01 thru 5-1-01; OMAP 3-2001, f. & cert. ef. 3-16-01; OMAP 24-2001(Temp) f. 5-9-01, cert. ef. 5-10-01 thru 11-1-01; OMAP 25-2001(Temp) f. 6-28-01, cert. ef. 7-1-01 thru 12-1-01; OMAP 27-2001(Temp) f. 7-30-01, cert. ef. 8-1-01 thru 1-26-02; OMAP 48-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 56-2001(Temp), f. & cert. ef. 11-1-01 thru 4-15-02; OMAP 57-2001(Temp), f. 11-28-01, cert. ef. 12-1-01 thru 4-15-02; OMAP 66-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 4-2002(Temp), f. & cert. ef. 3-5-02 thru 8-1-02; OMAP 16-2002(Temp) f. & cert. ef. 4-12-02 thru 9-1-02; OMAP 20-2002(Temp), f. & cert. ef. 5-15-02 thru 10-1-02; OMAP 34-2002(Temp), f. & cert. ef. 8-14-02 thru 1-15-03; OMAP 67-2002(Temp), f. & cert. ef. 11-1-02 thru 3-15-03; OMAP 6-2003(Temp), f. & cert. ef. 2-14-03 thru 7-1-03; OMAP 38-2003, f. & cert. ef. 5-9-03; OMAP 39-2003(Temp), f. & cert. ef. 5-15-03; OMAP 48-2003, f. & cert. ef. 7-7-03; OMAP 74-2003, f. & cert. ef. 10-1-03; OMAP 5-2004(Temp), f. & cert. ef. 2-4-04 thru 6-15-04; OMAP 24-2004, f. & cert. ef. 3-30-04; OMAP 31-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 42-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 53-2004(Temp), f. & cert. ef. 9-10-04 thru 2-15-05; OMAP 82-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 1-2005(Temp), f. & cert. ef. 1-14-05 thru 6-1-05; OMAP 6-2005, f. 3-1-05, cert. ef. 3-31-05; OMAP 7-2005(Temp), f. 3-1-05, cert. ef. 4-1-05 thru 8-1-05; OMAP 30-2005, f. & cert. ef. 6-6-05; OMAP 55-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 5-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 7-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 12-2006, f. 5-26-06, cert. ef. 6-1-06; OMAP 49-2006, f. 12-28-06, cert. ef. 1-1-07

410-121-0160
Dispensing Fees

(1) Pharmacy providers must apply for an Division of Medical Assistance Programs (DMAP) review of their pharmacy dispensing fee level by completing a Pharmacy Prescription Survey (DMAP 3062) when one of the following situations occurs:

(a) The pharmacy initiates dispensing medications to clients in facilities and the most recent two months worth of dispensing data is available. DMAP will only accept the most recent two months worth of data;

(b) The pharmacy discontinues dispensing medications to clients in facilities. The pharmacy provider is required to notify DMAP within 60 days and complete a new Pharmacy Prescription Survey with the most

recent two-months worth of dispensing data available. DMAP will only accept the most recent two months worth of data; or

(c) A completed Pharmacy Prescription Survey signed by the pharmacist in charge must be submitted to DMAP to initiate a review of dispensing fees.

(2) Unless otherwise provided, the professional dispensing fee allowable for services is as follows:

(a) $3.50 — Retail Pharmacies;

(b) $3.91 — Institutional Pharmacies operating with a True or Modified Unit Dose Delivery System as defined by DMAP and that are enrolled with DMAP as an institutional pharmacy by sending a copy of its institutional pharmacy license with its provider application:

(A) This dispensing fee applies to prescriptions dispensed to clients identified on DHS case files as residing in a Long Term Care Nursing Facility or for clients covered by the Centers for Medicare and Medicaid Services community based waiver;

(B) All other dispensing fees for institutional pharmacies will be at the retail rate.

(c) $7.50 — Compound prescriptions with two or more ingredients.

(3) The True or Modified Unit Dose Delivery System applies to those providers who give this service to over fifty percent of their patient population base associated with a particular Medicaid provider number.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 461-016-0101; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 20-1990, f. & cert. ef. 7-9-90, Renumbered from 461-016-0260; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 21-1993(Temp), f. & cert. ef. 9-1-93; HR 12-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 5-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 22-1998, f. & cert. ef. 7-15-98; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 50-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 60-2001, f. & cert. ef. 12-11-01; OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04; OMAP 21-2004, f. 3-15-04, cert. ef. 4-15-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0185
Pharmacy Based Immunization Delivery

(1) A pharmacist may administer vaccines to persons who are over the age of eighteen as provided by ORS 689.205 and The Board of Pharmacy Administrative rule 855-041-0500.

(2) When billing for vaccines administration, use either the CMS-1500 or the Point Of Sale claims processing system:

(a) When using the CMS-1500 billing form:

(A) Use the appropriate CPT-code (90471 and 90472) for the administration plus the appropriate vaccine code(s) 90476-90749;

(B) An ICD-9 diagnosis must be shown in field 21 of the CMS-1500; and

(C) The diagnosis code must be shown to the highest degree of specificity.

(b) When using the Point-of-Sale system, use the National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed. The administration fee for this service will be equivalent to those under 90471–90472.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05

410-121-0190
Clozapine Therapy

(1) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications. Clozapine Supervision is the management and record keeping of clozapine dispensings as required by the manufacturer of clozapine.

(2) Clozapine supervision:

(a) Pharmacists are to bill for Clozapine Supervision by using code 90862, adding TC modifier;

(b) Providers billing for clozapine supervision must document all of the following:

(A) Exact date and results of White Blood Counts (WBCs), upon initiation of therapy and at recommended intervals per the drug labeling;

(B) Notations of current dosage and change in dosage;

(C) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;

(D) Dates provider sent required information to manufacturer;

(E) Only one provider, either pharmacist or physician, may bill per week per client;

(F) Limited to five units per 30 days per client;

(G) An ICD-9 diagnosis must be shown on the CMS-1500 or 837P. The diagnosis code must be shown to the 5th digit on the CMS-1500, DMAP 505, or the 837P.

(3) Drug Products — The information required on the 5.1 Universal Claim Form must be included in the billing. The actual drug product may be billed electronically or submitted on the 5.1 Universal Claim Form.

(4) Venipuncture — If the pharmacy performs venipuncture, bill for that procedure on a CMS-1500 or 837P. Use Procedure Code 36415.

Stat. Auth.: ORS 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; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 17-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 45-2002, f. & cert. ef. 10-1-02; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05

410-121-0200
Billing Forms

(1) Prescription Drug Invoice 5.1 Universal Claim Form:

(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 codes in the Home Enteral/Parenteral Nutrition and IV Services Administrative Rules (OAR 410 division 148);

(b) The provider may bill on the form when a valid DMAP 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) All completed 5.1 Universal Claim Forms should be mailed to the Division of Medical Assistance Programs (DMAP); A paper claim must be used when the billed amount exceeds $99,999.

(2) All durable medical equipment and certain enteral/parenteral nutrition and IV services must be billed on the CMS-1500, using the billing instructions found in the DMAP Durable Medical Equipment and Medical Supplies Administrative Rules and Supplemental Information, and the DMAP Home Enteral/Parenteral Nutrition and IV Services Administrative Rules and Supplemental Information.

[ED NOTE: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0220
Instructions for Completion of the Prescription Drug Invoice

(1) The 5.1 Universal Claim Form is the required billing form for pharmacies billing on a paper claim. Use the standard Instructions for completion of the 5.1 Universal Claim Form.

(2) Enter all applicable information for billing of prescription drug claims for clients on the Oregon Health Plan.

Stat. Auth.: ORS 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 461-016-0280; HR 14-1993, f. & cert. ef. 7-2-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03

410-121-0280
Billing Quantities, Metric Quantities and Package Sizes

(1) Use the actual metric quantity dispensed when billing (up to four decimal places).

(2) Use the following units when billing products:

(a) Solid substances (e.g., powders, creams, ointments, etc.), bill per Gram;

(b) Solid substances that are reconstituted with a liquid (e.g., dry powder ampules and vials) such as antibiotic vials or piggybacks must be billed in metric quantity of one each;

(c) Tablets, capsules, suppositories, lozenges, packets; bill per each unit. Oral contraceptives are to be billed per each tablet;

(d) Injectables that are prepackaged syringe — (e.g., tubex, carpujects), bill per ml.;

(e) Prepackaged medications and unit doses must be billed per unit (tablet or capsule). Unit dose liquids are to be billed by ml.;

(f) Fractional units: Bill exact metric decimal quantities dispensed.

Stat. Auth.: ORS 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 461-016-0320; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99

410-121-0300
CMS Federal Upper Limits for Drug Payments

(1) The Centers for Medicare and Medicaid Services (CMS) Federal Upper Limits for Drug Payments listing of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and 1927(e) of the Act as amended by OBRA 1993.

(2) Payments for multiple source drugs must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the State and specified in the State Plan), plus an amount based on the limit per unit. CMS has determined the amount based on the limit per unit to be equal to 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.

(3) The FUL drug listing is published in the State Medicaid Manual, Part 6, Payment for Services, Addendum A. The most current Transmittals and subsequent changes are posted to the CMS website (contact DMAP for most current website address). The FUL price listing will be updated approximately every six months.

(4) Retroactive effective dates: The CMS FUL Drug Listing experiences occasional changes and often this information is submitted to DMAP after the effective date(s) of some changes. Therefore, certain participant additions and deletions may be effective retroactively. See specific instructions in the CMS Releases for appropriate effective date(s) of changes.

(6) The most current CMS Federal Upper Limits for Drug Payments Listing includes changes to Transmittal #37, included in the January 20, 2005 Title XIX State Agency Letter, effective for February 14, 2005; the March 10, 2006 Title XIX State Agency Letter, effective for services rendered on or after April 10, 2006; the June 23, 2006 Title XIX State Agency Letter, effective for services rendered on or after July 23, 2006 and are available for downloading on DMAP's Website (contact DMAP for most current website address). To request a hard copy, call DMAP.

Stat. Auth.: ORS 409.010, 409.110, 409.050

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 3-1990(Temp), f. & cert. ef. 2-23-90; HR 13-1990, f. & cert. ef. 4-20-90, Renumbered from 461-016-0330; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 45-1990, f. & cert. ef. 12-28-90; HR 10-1991, f. & cert. ef. 2-19-91; HR 37-1991, f. & cert. ef. 9-16-91; HR 13-1992, f. & cert. ef. 6-1-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 35-1992(Temp), f. & cert. ef. 12-1-92; HR 1-1993(Temp), f. & cert. ef. 1-25-93; HR 3-1993, f. & cert. ef. 2-22-93; HR 5-1993(Temp), f. 3-10-93, cert. ef. 3-22-93; HR 8-1993(Temp), f. & cert. ef. 4-1-93; HR 11-1993, f. 4-22-93, cert. ef. 4-26-93; HR 15-1993(Temp), f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 25-1993(Temp), f. & cert. ef. 10-1-93; HR 14-1994, f. & cert. ef. 3-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 43-1998(Temp), f. & cert. ef. 11-20-98 thru 5-1-99; OMAP 5-1999, f. & cert. ef. 2-26-99; OMAP 42-2000(Temp), f. & cert. ef. 12-15-00 thru 5-1-01; OMAP 1-2001(Temp), f. & cert. ef. 2-1-01 thru 6-1-01; OMAP 2-2001(Temp), f. 2-14-01, cert. ef. 2-15-01 thru 7-1-01; OMAP 18-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 23-2001(Temp), f. & cert. ef. 4-16-01 thru 8-1-01; OMAP 26-2001(Temp), f. & cert. ef. 6-6-01 thru 1-2-02; OMAP 51-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-15-01; OMAP 58-2001, f. 11-30-01, cert. ef. 12-1-01; OMAP 67-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 3-2002(Temp), f. & cert. ef. 2-15-02 thru 6-15-02; OMAP 5-2002(Temp) f. & cert. ef. 3-5-02 thru 6-15-02; OMAP 19-2002(Temp), f. & cert. ef. 4-22-02 thru 9-15-02; OMAP 29-2002(Temp), f. 7-15-02, cert. ef. 8-1-02 thru 1-1-03; OMAP 71-2002(Temp), f. & cert. ef. 12-1-02 thru 5-15-03; OMAP 10-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 11-2003(Temp), f. 2-28-03, cert. ef. 3-1-03 thru 8-15-03; OMAP 41-2003, f. & cert. ef. 5-29-03; OMAP 51-2003, f. & cert. ef. 8-5-03; OMAP 54-2003(Temp), f. & cert. ef. 8-15-03 thru 1-15-03; OMAP 75-2003, f. & cert. ef. 10-1-03; OMAP 83-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 4-15-04; OMAP 2-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 32-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 43-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 93-2004(Temp), f. & cert. ef. 12-10-04 thru 5-15-05; OMAP 2-2005, f. 1-31-05, cert. ef. 2-1-05; OMAP 23-2005(Temp), f. & cert. ef. 4-1-05 thru 9-1-05; OMAP 29-2005, f. & cert. ef. 6-6-05; OMAP 56-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 59-2005(Temp), f. 11-8-05, cert. ef. 11-12-05 thru 5-1-06; OMAP 68-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 8-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 13-2006, f. 5-26-06, cert. ef. 6-1-06; OMAP 50-2006, f. 12-28-06, cert. ef. 1-1-07

410-121-0320
Oregon Maximum Allowable Cost (OMAC)

(1) The Oregon maximum allowable cost, or the maximum amount that the Division of Medical Assistance Programs (DMAPDMAP) will reimburse for prescribed drugs, is determined by DMAP's claims processing company, First Health Services. First Health Services determines the maximum allowable cost on selected multiple-source drug designation when a bioequivalent drug product is available from at least two wholesalers serving the State of Oregon.

(2) First Health Services generates and maintains all official OMAC lists and provides a copy of each list to DMAP. OMAC lists are generated monthly and each list indicates the amount, per product, that DMAP will reimburse to providers for products provided to DMAP clients during that particular month. For example: The OMAC list, January 1, 2003, includes the amounts DMAP will reimburse for products provided during the month of January 2003; the list, February 1, 2003, covers the month of February 2003, etc.

(3) DMAP includes in rule by reference the OMAC lists for January 1, 2005, February 1, 2005, March 1, 2005, April 1, 2005, May 1, 2005, June 1, 2005, July 1, 2005, August 1, 2005, September 1, 2005, October 1, 2005, November 1, 2005 and December 1, 2005.

(4) DMAP includes in rule by reference the OMAC lists for January 1, 2006, February 1, 2006, March 1, 2006, April 1, 2006, May 1, 2006, June 1, 2006, July 1, 2006, August 1, 2006, September 1, 2006, October 1, 2006, November 1, 2006, and December 1, 2006.

(5) DMAP includes in rule by reference the OMAC lists for January 1, 2007, February 1, 2007, March 1, 2007, April 1, 2007, May 1, 2007, June 1, 2007, July 1,2007, August 1, 2007, September 1, 2007, October 1, 2007, November 1, 2007 and December 1, 2007.

(6) Current OMAC lists are available for review and/or downloading on DMAP's website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/. Future lists, referenced in this rule, will be available and posted to DMAP's website upon receipt from First Health Services.

(7) The OMAC list does not apply if a prescriber certifies that a singlesource (brand) drug is medically necessary.

Stat. Auth.: ORS 184.750, 184.770, 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 461-016-0340; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 6-2002(Temp), f. & cert. ef. 3-5-02 thru 8-1-02; OMAP 17-2002(Temp), f. & cert. ef. 4-12-02 thru 9-1-02; OMAP 28-2002(Temp), f. 6-28-02, cert. ef. 7-1-02 thru 12-1-02; OMAP 35-2002(Temp), f. & cert. ef. 8-14-02 thru 1-1-03; OMAP 38-2002(Temp), f. & cert. ef. 8-30-02 thru 1-15-03; OMAP 40-2002(Temp), f. & cert. ef. 10-1-02 thru 2-15-03; OMAP 68-2002(Temp), f. & cert. ef. 11-15-02 thru 4-1-03; OMAP 7-2003, f. & cert. ef. 2-14-03 thru 7-1-03; OMAP 52-2003, f. & cert. ef. 8-5-03; OMAP 3-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 96-2004, f.12-30-04, cert. ef. 1-1-05; OMAP 69-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 51-2006, f. 12-28-06, cert. ef. 1-1-07

410-121-0420
DESI Less-Than-Effective Drug List

(1) An October 23, 1981 ruling by District of Columbia Federal Court directed the Department of Health and Human Services to stop reimbursement, effective October 30, 1981, under Medicaid and Medicare Part B for all DESI less-than-effective drugs which have reached the Federal Drug Administration Notice-of-Opportunity-for-Hearing stage.

(2) Since this ruling means the Federal funding for these drugs will be terminated, payment for drugs will not be made by DMAP. The "Active Ingredient" and "Route" of administration columns are the major controlling factors regarding the FDA's less-than-effective drug determinations and CMS'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, 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, DMAP will not reimburse for DESI drugs or dispensings of products that are identical, related, or similar.

(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.

(5) DESI Less Than Effective Drug List is available for download on the Department of Human Services website. If you would like to request a hard copy of this list, please call DMAP.

Stat. Auth.: ORS 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 461-016-0390; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0580
Oregon Medicaid and Pharmaceutical Manufacturers' Dispute Resolution Procedures

(1) Within 60 days after the end of each calendar quarter, the Division of Medical Assistance Programs (DMAP) shall report the number of units dispensed for each drug National Drug Code (NDC) for which payment was made to the manufacturer of said product. Utilization reports to manufacturers shall follow this schedule:

(a) The period from January 1 through March 31 will be Quarter 1. Quarter 1 invoices shall be due by May 30 of that same year;

(b) The period from April 1 through June 30 will be Quarter 2. Quarter 2 invoices shall be due by August 29 of that same year;

(c) The period from July 1 through September 30 will be Quarter 3. Quarter 3 invoices shall be due by November 29 of that same year;

(d) The period from October 1 through December 31 will be Quarter 4. Quarter 4 invoices shall be due by February 29 of the following year.

(2) A manufacturer must make payment within 30 days of receipt of utilization reports, i.e., rebate invoice. Using eight days as reasonable time for reports to reach the manufacturer, payment of the invoiced amount is due per the following schedule:

(a) Rebate payment for Quarter 1 shall be due by July 7 of that same year;

(b) Rebate payment for Quarter 2 shall be due by October 7 of that same year;

(c) Rebate payment for Quarter 3 shall be due by January 6 of the following year;

(d) Rebate payment for Quarter 4 shall be due by April 6 of the following year.

(3) DMAP considers any failure to make timely payment in full of the amount due to be a dispute. Timely is defined by DMAP as 38 days after the postmarked date of the invoice.

(4) If a manufacturer does not indicate in writing, by specific NDC number(s), the reason(s) for non-payment in full, a letter asking for clarification will be sent and interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution, beginning 38 days after the postmarked date of each invoice.

(5) Utilization/unit disputes shall be handled by a careful examination of paid claims data to determine the reasonableness of the reported units of products provided to Oregon recipients. If it is determined that the manufacturer is in error a letter notifying the manufacturer of the completed review and findings will be mailed to the manufacturer and interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution.

(6) If a manufacturer determines that incorrect information was sent to the Centers for Medicare and Medicaid Services (CMS), the manufacturer must still make payment in full to Oregon Medicaid for the invoiced rebate amount. Oregon Medicaid will credit the manufacturer's account through CMS's prior period adjustment process.

(7) Interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution, on the 31st day after a manufacturer receives information from DMAP 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 DMAP in letter form. Each letter will include a DMAP Audit Request Form and instructions to the manufacturer on how to complete the form. The letter will also include a standard explanation of the audit process.

(9) Days referred to in this process shall be considered calendar days.

(10) Efforts should be made through an informal rebate resolution process as outlined in this rule before a hearing will be scheduled. Hearings will follow OAR 410-120-0760 through 410-120-1060 and be held in Marion County, OR.

(11) Oregon Medicaid will notify CMS of all disputing manufacturers in writing.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 21-1992, f. 7-31-92, cert. ef. 8-1-92; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0625
Items Covered in the All-Inclusive Rate for Nursing Facilities

(1) The all-inclusive rate for nursing facilities includes but is not limited to various drug products and OTC items. Please bill the nursing facility for these items.

(2) The all-inclusive list is available for downloading in the Office of Medcical Assistance Programs Web page on the Department of Human Services website.

Stat. Auth.: ORS 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; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0920; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

DIVISION 122

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

410-122-0010
Definitions

(1) Activities of daily living (ADL's) — Activities related to personal care. Personal care services include activities such as bathing, dressing, grooming, hygiene, eating, elimination, etc. that are necessary to maintain or improve the client's health, when possible.

(2) Buy up — "Buy-up" refers to a situation in which a client wants to upgrade to a higher level of service than he or she is eligible for; e.g., a heavy duty walker instead of a regular walker.

(3) Consecutive Months — Any period of continuous use where no more than a 60-day break occurs.

(4) Durable Medical Equipment — Equipment, furnished by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or a home health agency that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a client in the absence of an illness or injury and is appropriate for use in the home. Some examples include wheelchairs, crutches and hospital beds. Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment.

(5) Home — For purposes of purchase, rental and repair of durable medical equipment that is used primarily as a supportive measure to support a client's basic daily living activities, home is a place of permanent residence, such as an assisted living facility (includes the common dining area), a 24-hour residential care facility, an adult foster home, a child foster home or a private home. This does not include hospitals or nursing facilities or any other setting that exists primarily for the purpose of providing medical/nursing care.

(6) Lifetime need — 99 months or more.

(7) Manufacturer Part Number (MPN):

(a) Each manufacturer provides an MPN to identify that manufacturer's part. It is a specification used by the manufacturer to store a part in an illustrated part catalog (graphics and text);

(b) An MPN uniquely identifies a part when used together with manufacturer code (external manufacturer), which is the own name used by the manufacturer and not the manufacturer name provided by other.

(8) Medical Records — Include the physician's office records, hospital records, nursing facility records, home health agency records, records from other healthcare professionals, diagnostic and test reports. This documentation must be made available to the Division of Medical Assistance Programs (DMAP) on request.

(9) Medical Supplies — Generally nonreusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing. Some medical supplies may also be used on a repeated, limited duration basis.

(10) Mobility-related activities of daily living (MRADL's) — Include toileting, eating, dressing, grooming and bathing.

(11) Morbidity — A diseased state, often used in the context of a "morbidity rate" (i.e. The rate of disease or proportion of diseased people

in a population). In common clinical usage, any disease state, including diagnosis and complications is referred to as morbidity.

(12) Morbidity Rate — The rate of illness in a population. The number of people ill during a time period divided by the number of people in the total population.

(13) The DMAP Maximum Allowable Rate — The maximum amount paid by DMAP for a service.

(14) Practitioner — A person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitioner's license and certification.

(15) Prosthetic and Orthotic Devices — Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies. Prosthetic and orthotic devices also include leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the client's physical condition.

(16) Purchase price — Includes:

(a) Delivery;

(b) Assembly;

(c) Adjustments, if needed; and

(d) Training in the use of the equipment or supply.

(17) Rental fees — Include:

(a) Delivery;

(b) Training in the use of the equipment;

(c) Pick-up;

(d) Routine service, maintenance and repair; and

(e) Moving equipment to new residence, if coverage is to continue.

(18) Technician — A DMEPOS provider staff professionally trained through product or vendor-based training, technical school training (e.g., electronics) or through apprenticeship programs with on-the-job training.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 54-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0020
Orders

(1) The purchase, rental or modifications of durable medical equipment, and the purchase of supplies must have an order prior to dispensing items to a client.

(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the treating practitioner prior to submitting a claim to the Division of Medical Assistance Programs (DMAP).

(3) A provider may dispense some items based on a verbal order from the treating practitioner, except those items requiring a written order prior to delivery (see below) or as specified in a particular rule:

(a) A provider must maintain documentation of the verbal order and this documentation must be available to DMAP upon request;

(b)The verbal order must include all the following elements:

(A) Client's name; and,

(B) Name of the practitioner; and

(C) Description of the item; and

(D) Start date of the order; and

(E) Primary ICD-9 diagnosis code for the equipment/supplies requested.

(c) For items that are dispensed based on a verbal order, the provider must obtain a written order that meets the requirements outlined below for written orders.

(4) For an item requiring a written order prior to delivery, Medicare criteria must be met.

(5) The DMEPOS provider must have on file a written order, information from the treating practitioner concerning the client's diagnosis and medical condition, and any additional information required in a specific rule.

(6) DMAP accepts any of the following forms of orders and Certificates of Medical Necessity (CMN): a photocopy, facsimile image, electronically maintained or original "pen and ink" document.

(a) An electronically maintained document is one which has been created, modified, and stored via electronic means such as commercially available software packages and servers;

(b) It is the provider's responsibility to ensure the authenticity/validity of a facsimile image, electronically maintained or photocopied order;

(c) A provider must also ensure the security and integrity of all electronically maintained orders and/or certificates of medical necessity;

(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed;

(7) A written order must be legible and contain the following elements:

(a) Client's name; and

(b) Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features; and

(c) The detailed description of the item may be completed by someone other than the practitioner. However, the treating practitioner must review the detailed description and personally indicate agreement by his signature and the date that the order is signed;

(A) DMAP requires practitioners to sign for services they order;

(B) This signature may be handwritten, electronic, or stamped, and it must be in the client's medical record;

(C) The ordering practitioner is responsible for the authenticity of the signature;

(D) If a practitioner allows a signature stamp, the provider performing the service must retain a signed statement in their records that this practitioner is the only person who has and uses the stamp;

(d) Primary ICD-9 diagnosis code for the equipment/supplies requested;

(8) A provider is responsible to obtain as much documentation from the client's medical record as necessary for assurance that DMAP coverage criteria for an item(s) is met.

(9) Certain items require one or more of the following additional elements in the written order:

(a) For accessories or supplies that will be provided on a periodic basis:

(A) Quantity used;

(B) Specific frequency of change or use — "as needed" or "prn" orders are not acceptable;

(C) Number of units;

(D) Length of need: Example: An order for surgical dressings might specify one 4" x 4" hydrocolloid dressing which is changed one to two times per week for one month or until the ulcer heals;

(b) For orthoses: If a custom-fabricated orthosis is ordered by the physician, this must be clearly indicated on the written order;

(c) Length of need:

(A) If the coverage criteria in a rule specifies length of need; or,

(B) If the order is for a rental item;

(d) Any other medical documentation required by rule.

(10) For repairs: Labor for repairs, parts for DME repairs and replacement parts for DME (e.g., batteries) do not require a written order.

(11) A new order is required:

(a) When required by Medicare (for a Medicare covered service) (www.cignamedicare.com); or

(b) When there is a change in the original order for an item; or,

(c) When an item is permanently replaced; or

(d) When indicated by the treating practitioner;

(A) A new order is required when an item is being replaced because the item is worn or the client's condition has changed; and,

(B) The provider's records should also include client-specific information regarding the need for the replacement item; and,

(C)This information should be maintained in the provider's files and be available to DMAP on request; and,

(D) A new order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical appropriateness of the item;

(e) When there is a change of DMEPOS provider: In cases where two or more providers merge, the resultant provider should make all reasonable attempts to secure copies of all active CMN's and written orders from the provider(s) purchased. This document should be kept on file by the resultant provider for future presentation to DMAP, if requested;

(f) On a regular or specific basis (even if there is no change in the order) only if it is so specified in a particular rule.

(12) A provider is required to maintain and provide (when required by a particular rule) legible copies of facsimile image and electronic transmissions of orders.

Stat. Auth.: ORS 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 461-024-0004; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert.

ef. 8-1-96; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 72-2002(Temp), f. & cert. ef. 12-24-02 thru 5-15-03; OMAP 36-2003, f. & cert. ef. 5-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0040
Prior Authorization Authority

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers must obtain prior authorization (PA) for HCPCS Level II codes when indicated, unless otherwise noted in a specific rule.

(2) Providers must request PA as follows (see the DMEPOS Supplemental Information for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (DMAP).

(3) For clients with Medicare coverage, PA is only required for DMEPOS not covered by Medicare.

(4) For DMEPOS provided after normal working hours, providers must submit PA requests within five working days from the initiation of service.

(5) See OAR 410-120-1320 for more information about PA.

Stat. Auth.: ORS 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 461-024-0010; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 6-2004, f. 2-10-04 cert. ef. 3-15-04; OMAP 20-2004(Temp), f. & cert. ef. 3-15-04 thru 4-30-04; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 26-2004, f. 4-15-04 cert. ef. 5-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0055
OHP Standard Benefit Package Limitations

(1) The Division of Medical Assistance Programs (DMAP) limits coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the Oregon Health Plan (OHP) Standard benefit package to the codes referenced in **Table 122-0055**. Coverage requirements and limitations, as specified in chapter 410, division 122, apply. For more information about the OHP Standard benefit package, see DMAP General Rules (chapter 410, division 120).

(2) **Table 122-0055**

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0080
Conditions of Coverage, Limitations, Restrictions and Exclusions

(1) The Division of Medical Assistance Programs (DMAP) may pay for durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) when the item meets all the criteria in this rule, including all of the following conditions. The item:

(a) Has been approved for marketing by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended;

(b) Is reasonable and medically appropriate for the individual client;

(c) Is primarily and customarily used to serve a medical purpose;

(d) Is generally not useful to a person in the absence of illness or injury;

(e) Is appropriate for use in a client's home;

(f) Specifically, for durable medical equipment, can withstand repeated use; i.e., could normally be rented, and used by successive clients;

(g) Meets the coverage criteria as specified in this division and subject to service limitations of DMAP rules;

(h) Is requested in relation to a diagnosis and treatment pair that is above the funding line on the Prioritized List of Health Services, OAR 410-141-0520, consistent with treatment guidelines for the Prioritized List of Health Services, and not otherwise excluded under OAR 410-141-0500; and

(i) Is included in the OHP Client's benefit package of covered services.

(2) Conditions for Medicare-Medicaid Services:

(a) When Medicare is the primary payer for a covered service and when DMAP DMEPOS coverage criteria differs from Medicare coverage criteria, DMAP DMEPOS coverage criteria are waived, except as provided in subsection (b) of this section, and only if the item is requested in relation to a diagnosis and treatment pair that is above the funding line on the Prioritized List of Health Services, OAR 410-141-0520, consistent with treatment guidelines for the Prioritized List of Health Services, and not otherwise excluded under OAR 410-141-0500; and included in the OHP Client's benefit package of covered services;

(b) If Medicare is the primary payer and Medicare denies payment, an appeal to Medicare must be filed timely prior to submitting the claim to DMAP for payment. If Medicare denies payment based on failure to submit a timely appeal, DMAP may reduce any amount DMAP determines could have been paid by Medicare;

(c) If Medicare denies payment on appeal, DMAP will apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the Oregon Health Plan.

(3) DMAP will not cover DMEPOS items when the item or the use of the item is:

(a) Not primarily medical in nature;

(b) For personal comfort or convenience of client or caregiver;

(c) A self-help device;

(d) Not therapeutic or diagnostic in nature;

(e) Used for precautionary reasons (e.g., pressure-reducing support surface for prevention of decubitus ulcers);

(f) Inappropriate for client use in the home (e.g., institutional equipment like an oscillating bed);

(g) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or

(h) Reimbursed as part of the all-inclusive rate in a nursing facility, or as part of a home and community based care waiver service, or by any other public, community or third party resource.

(4) In addition to the particular requirements in this rule, particular coverage criteria, limitations and restrictions for durable medical equipment, prosthetics, orthotics and supplies are specified in the appropriate rule. To the extent that codes are identified in these rules or in fee schedules, the codes are provided as a mechanism to facilitate payment for covered items and supplies consistent with OAR 410-122-0186, but codes do not determine coverage. If prior authorization is required, the request must document that prior authorization was obtained in compliance with the rules in this division.

(5) DMEPOS providers must have documentation on file that supports coverage criteria are met.

(6) Billing records must demonstrate that the provider has not exceeded any limitations and restrictions in rule. DMAP may require additional claim information from the provider consistent with program integrity review processes.

(7) Documentation described in (4), (5) and (6) above must be made available to DMAP on request.

(8) To identify non-covered items at a code level, providers can refer to the DMAP fee schedule, subject to the limitation that fee schedules and codes do not determine coverage, and are solely provided as a mechanism to facilitate payment for covered services and supplies consistent with OAR 410-122-0186. If an item or supply is not covered for an OHP Client in accordance with these rules, there is no basis for payment regardless of whether there is a code for the item or supply on the fee schedule.

(9) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System).

(10) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitute a buy-up and are prohibited. Refer to the DMAP General Rules (chapter 410 division 120) for specific language on buy-ups.

(11) Equipment purchased by DMAP for a client is the property of the client.

(12) Rental charges, starting with the initial date of service, regardless of payer, apply to the purchase price.

(13) A provider who supplies rented equipment is to continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances.

(14) Before renting, providers should consider purchase for long-term requirements.

(15) DMAP will not pay DMEPOS providers for medical supplies separately while a client with Medicare Part A coverage is under a home health plan of care and covered home health care services.

(16) DMAP will not pay DMEPOS providers for medical supplies separately while a client is under a hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, DMAP or other carrier.

(17) The items listed in **Table 122-0080** generally do not meet the requirements under DMEPOS rules for purchase, rent or repair of equipment or items. A request for equipment or an item on this list will not be granted until all criteria in this rule are met.

(18) See General Rules, OAR 410-120-1200 Excluded Services and Limitations for more information on general scope of coverage and limitations.

(19) **Table 122-0080**

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

Stat. Auth.: ORS 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 461-024-0020; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 26-1994, f. & cert. ef. 7-1-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 46-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0180
Healthcare Common Procedure Coding System (HCPCS) Level II Coding

(1) The Healthcare Common Procedure Coding System (HCPCS) level II is a comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. The Centers for Medicare and Medicaid Services (CMS) maintain and distribute HCPCS Level II Codes.

(2) HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independently of the process for making coverage and payment determinations for medical services.

(3) The Division of Medical Assistance Programs (DMAP) uses the HCPCS Level II Code Set to ensure that claims are processed in an orderly and consistent manner.

(4) When requesting authorization and submitting claims, DMEPOS providers must use these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code.

(5) This rule division may not contain all code updates needed to report medical services and supplies.

(6) For the most up-to-date information on code additions, changes, or deletions, refer to the fee schedule posted on the DMAP Web site.

(7) The DMAP fee schedule lists all of the current HCPCS codes in an alphanumeric index.

(8) Newly established temporary codes and effective dates for their use are also posted on the DMAP Web site at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml.

(9) CMS updates permanent national codes annually on January 1st.

(10) CMS may add, change, or delete temporary national codes on a quarterly basis.

(11) The statistical analysis durable medical equipment carrier (SADMERC) is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code should be used to describe DMEPOS items. SADMERC assistance is available by calling 1-877-735-1326 between 9 AM to 4 PM (EST). In addition, the SADMERC has a product classification list on its Web site www.palmettogba.com that lists individual items to code categories.

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

Stat. Auth.: ORS 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 461-024-0200; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 410-122-0100; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 12-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 26-1999, f. & cert. ef. 6-4-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 54-2001(Temp), f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02; OMAP 63-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0182
Legend

(1) The Division of Medical Assistance Programs (DMAP) uses abbreviations in the tables within this division.

(2) This rule explains the meaning of these abbreviations.

(3) PA — Prior authorization (PA): "PA" indicates that PA is required, even if the client has private insurance. See OAR 410-122-0040 for more information about PA requirements.

(4) PC — Purchase: "PC" indicates that purchase of this item is covered for payment by DMAP.

(5) RT — Rent: "RT" indicates that the rental of this item is covered for payment by DMAP.

(6) MR — Months Rented:

(a) "13" — Indicates that after 13 months of continuous rental or when the usual purchase price is reached (whichever is lesser), the equipment is considered paid for and owned by the client. After 13 months of rental payments, the provider must transfer title of the equipment to the client.

(b) "36" — Beginning with the first rental month on or after January 1, 2006, indicates that after 36 months of continuous rental or when the usual purchase price is reached (whichever is lesser), the equipment is considered paid for and owned by the client. After 36 months of rental payments, the provider must transfer title of the equipment to the client.

(7) RP — Repair: "RP" indicates that repair of this item is covered for payment by DMAP.

(8) NF — Nursing Facility: "NF" indicates that this procedure code is covered for payment by DMAP when the client is a resident of a nursing facility.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0184
Repairs, Maintenance, Replacement, Delivery and Dispensing

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: The Division of Medical Assistance Programs (DMAP) may cover repairs, maintenance, and replacement of medically appropriate, covered durable medical equipment, prosthetics and orthotics, including those items purchased or in use before the client enrolled with DMAP.

(a) Repairs:

(A) To repair means to fix or mend and to put the equipment back in good condition after damage or wear to make the equipment serviceable;

(B) If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment will be made for the amount of the excess;

(C) Payment for repairs is not covered when:

(i) The skill of a technician is not required; or

(ii) The equipment has been previously denied; or

(iii) Equipment is being rented, including separately itemized charges for repair; or

(iv) Parts and labor are covered under a manufacturer's or supplier's warranty;

(D) Code E1340 must not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate;

(b) Maintenance:

(A) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking of the client's equipment is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, may be covered as repairs for medically appropriate client-owned equipment. For example, this might include, breaking down

sealed components and performing tests that require specialized testing equipment not available to the client;

(B) Payment for maintenance/service is not covered for rented equipment, unless it is a capped rental item. DMAP may authorize payment for covered maintenance and servicing of capped rental items after six months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the provider's or manufacturer's warranty, whichever is later. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of maintenance and servicing at no more than the rental fee schedule allowable amount;

(C) Up to one month's rental will be reimbursed at the level of either the equipment provided; or, the equipment being repaired, whichever is less costly;

(D) Maintenance that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered;

(c) Replacement — Replacement refers to the provision of an identical or nearly identical item:

(A) Temporary Replacement: One month's rental of temporary replacement for client-owned equipment being repaired, any type (K0462) may be reimbursed when covered client-owned equipment such as a wheelchair is in need of repair. The equipment in need of repair must be unavailable for use for more than one day. For example, the repair takes more than one day or a part has to be ordered and the wheelchair is non-functional;

(B) Permanent Replacement: Situations involving the provision of a different item because of a change in medical condition must meet the specific coverage criteria identified in chapter 410, division 122;

(C) Equipment which the client owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment;

(i) Reasonable useful lifetime of durable medical equipment (DME) is no less than five years;

(ii) Computation of the useful lifetime is based on when the equipment is delivered to the client, not the age of the equipment;

(iii) Replacement due to wear is not covered during the reasonable useful lifetime of the equipment;

(iv) During the reasonable useful lifetime, repair up to the cost of replacement (but not actual replacement for medically appropriate equipment owned by the client) may be covered;

(D) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered;

(d) Delivery: (A) Providers may deliver directly to the client or the designee (person authorized to sign and accept delivery of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) on behalf of the client);

(B) Providers, their employees, or anyone else having a financial interest in the delivery of an item are prohibited from signing and accepting an item on behalf of a client;

(C) A provider may deliver DMEPOS to a client in a hospital or nursing facility for the purpose of fitting or training the client in its proper use. This may be done up to two days prior to the client's anticipated discharge to home. On the claim bill the date of service as the date of discharge and specify the place of service (POS) as the client's home. The item must be for subsequent use in the client's home;

(D) A provider may deliver DMEPOS to a client's home in anticipation of a discharge from a hospital or nursing facility. The provider may arrange for actual delivery approximately two days prior to the client's anticipated discharge to home. On the claim bill the date of service as the date of discharge and specify the POS as the client's home;

(E) No payment is made on dates of service the client receives training or fitting in the hospital or nursing facility for a particular DMEPOS item;

(e) For Dispensing Refills:

(A) For DMEPOS products that are supplied as refills to the original order, providers must contact the client or designee prior to dispensing the refill to check the quantity on hand and continued need for the product;

(B) Contact with the client or designee regarding refills may only take place no sooner than approximately seven days prior to the delivery/shipping date;

(C) For subsequent deliveries of refills, the provider may deliver the DMEPOS product no sooner than approximately fifteen days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DMAP will allow for the processing of claims for refills delivered/shipped prior to the client exhausting their supply, but the provider must not dispense supplies that exceed a client's expected utilization;

(D) Supplies dispensed are based on the practitioner's order. Regardless of utilization, a provider must not dispense more than a three-month quantity of supplies at a time. This three-month dispensing restriction for supplies may be further limited by rule limitations of coverage;

(E) The provider must not automatically ship, dispense or deliver a quantity of supplies on a predetermined regular basis, even if the client or designee has "authorized" this in advance.

(F) Shipping and handling charges are not covered;

(f) The following services are not covered:

(A) Pick-up, delivery, shipping and handling charges for DMEPOS, whether rented or purchased including travel time:

(i) These costs are included in the calculations for allowable rates;

(ii)These charges are not billable to the client;

(B) Supplies used with DME or a prosthetic device prior to discharge from a hospital or nursing facility;

(C) Surgical dressings, urological supplies, or ostomy supplies applied in the hospital or nursing facility, including items worn home by the client.

(2) Documentation Requirements:

(a) For Repairs, Maintenance and Temporary Replacement: A new Certificate of Medical Necessity (CMN) and/or physician's order is not required;

(b) Submit the following documentation with the prior authorization request:

(A) For Repairs/Maintenance:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and estimated labor time; and

(iii) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair;

(B) For Temporary Replacement:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Narrative description, manufacturer and brand name/model name and number of the replacement equipment; and

(iii) Itemized statement of parts needed for repair including the estimated date of service, manufacturer's name (if billing for parts, include manufacturer's name and part number for each part), product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and estimated labor time; and

(iv) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair; and

(v) Description of why repair takes more than one day to complete;

(C) For Permanent Replacement: See specific coverage criteria in chapter 410, division 122 for more information;

(D) For Proof of Delivery: DMEPOS providers are required to:

(I) Maintain proof of delivery documentation to the client in their records for seven years;

(II) Maintain documentation that supports that conditions of coverage in this rule are met;

(III) Make proof of delivery documentation available to DMAP upon request;

(c) Proof of delivery requirements are based on the method of delivery;

(d) A signed and dated delivery slip is required for items delivered directly by the provider to the client or designee. The delivery slip must include the following:

(A) When a designee signs the delivery slip, their relationship to the client must be noted and the signature legible;

(B) The client or designee's signature with the date the items were received; and

(C) Client's name; and

(D) Quantity, brand name, serial number and a detailed description of the items being delivered; and

(E) The date of signature on the delivery slip must be the date the DMEPOS item is received by the client or designee; and

(F) The date the client receives the item is the date of service;

(e) If the provider uses a delivery/shipping service or mail order, an example of proof of delivery would include the service's tracking slip and the provider's own shipping invoice:

(A) The provider's shipping invoice must include the:

(i) Client's name, and

(ii) Quantity, brand name, serial number and a detailed description of the items being delivered; and

(iii) Delivery service's package identification number associated with each individual client's package with a unique identification number and delivery address, including the actual date of delivery, if possible; and

(iv) The shipping date must be used as the date of service, unless the actual date of delivery is available, then use this date as the date of service;

(B) The delivery service's tracking slip must reference:

(i) Each client's packages; and

(ii) The delivery address and corresponding package identification number given by the delivery service;

(f) Providers may utilize a signed/dated return postage-paid delivery/shipping invoice from the client or designee as a form of proof of delivery that must contain the following information:

(A) Client's name;

(B) Quantity, brand name, serial number and a detailed description of items being delivered;

(C) Required signatures from either the client or the designee;

(g) Delivery to Nursing Facilities or Hospitals:

(A) The date of service is the date the DMEPOS item(s) is received by the nursing facility if delivered by the DMEPOS provider;

(B) The date of service is the shipping date (unless the actual delivery date is known and documented) if the DMEPOS provider uses a delivery/shipping service;

(h) For those clients who are residents of an assisted living facility, a twenty-four hour residential facility, an adult foster home, a child foster home, a private home or other similar living environment, providers must ensure supplies are identified and labeled for use only by the specific client for whom the supplies/items are intended.

(3) Procedure Codes:

(a) Replacement parts for wheelchair repair are billed using the specific Healthcare Common Procedure Coding System (HCPCS) code, if one exists, or code K0108 (other accessories);

(b) E1340:

(A) Repair or non-routine service requiring the skill of a technician, labor component, per 15 minutes;

(B) This code is used for services not covered by other codes or combination of codes in reference to the repairs of DMEPOS;

(c) K0108 — Other wheelchair accessories — PA;

(d) K0462 — Temporary replacement for client-owned equipment being repaired, any type — Prior authorization (PA) required – PA.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0186
Payment Methodology

(1) The Division of Medical Assistance Programs (DMAP) utilizes a payment methodology for covered durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which is generally based on Medicare's fee schedule.

(2) Payment is calculated using the DMAP fee schedule amount, the manufacturer's suggested retail price (MSRP) or the actual charge submitted, whichever is lowest.

(3) DMAP reimburses for the lowest level of service, which meets medical appropriateness. See OAR 410-120-1280 Billing and 410-120-1340 Payment.

(4) Reimbursement for durable medical equipment, miscellaneous (E1399) and other wheelchair accessories (K0108) is capped as follows:

(a) E1399 — $6,000.00;

(b) K0108 — $12,000.00.

(5) Reimbursement for codes E1399 and K0108 is determined as either:

(a) 80% of the Manufacturer's Suggested Retail Price (MSRP); or,

(b) If the MSRP is not available, the lowest amount of the following, plus 20 percent:

(A) Manufacturer's invoice; or

(B) Manufacturer's wholesale price; or

(C) Acquisition cost; or

(D) Manufacturer's bill to provider;

(c) If (5)(a) or (b) are not available, reimbursement will be the "estimated price" plus 20 percent. An "estimated price" is the price the provider expects the manufacturer to charge.

(6) When requesting prior authorization (PA) for items billed at or above $100, the DMEPOS provider:

(a) Must submit a copy of:

(A) The items from (5)(a)–(c) that will be used to bill; and,

(B) Name of the manufacturer, description of the item, including product name/model name and number and technical specifications;

(b) May be required to submit a picture of the item.

(7) The DMEPOS provider must submit verification for items billed under code E1399 and K0108 when no specific Healthcare Common Procedure Coding System (HCPCS) code is available and an item category is not specified in chapter 410, division 122 rules. Verification can come from an organization such as the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

(8) DMAP may review items that exceed the maximum allowable/cap on a case-by-case basis. For these situations, the provider must submit the following documentation:

(a) Documentation that supports the client meets all of the coverage criteria for the less costly alternative; and,

(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) which clearly explains why the less costly alternative is not sufficient to meet the client's medical needs, and;

(c) The expected hours of usage per day, and;

(d) The expected outcome or change in client's condition.

(9) For codes A4649 (surgical supplies; miscellaneous) and E1399 when $50.00 or less per each unit:

(a)The DMEPOS provider must have documentation on file which supports the correct Healthcare Common Procedure Coding System (HCPCS) code was used for billing according to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(b) Subject to service limitations of DMAP rules;

(c) PA is not required.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0200
Pulse Oximeter for Home Use

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a tamper-proof pulse oximeter rental for home use when all of the following criteria are met:

(A) The client has frequently fluctuating oxygen saturation levels that are clinically significant;

(B) Measurements are integral in dictating acute therapeutic intervention;

(C) The absence of readily available saturation measurements represents an immediate and demonstrated health risk;

(D) The client has a caregiver trained to provide whatever care is needed to reverse the low oxygen saturation level ordered by the physician.

(b) Some examples of when home pulse oximetry may be covered include the following:

(A) When weaning a client from home oxygen or a ventilator; or

(B) When a change in the client's physical condition requires an adjustment in the liter flow of their home oxygen needs; or

(C) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep; or

(D) To monitor a client on a ventilator at home; or

(E) To periodically re-assess the need for long-term oxygen in the home; or

(F) In conjunction with infant home apnea monitoring; or

(G) When a client exhibits a certain unstable illness and has compromised or potentially compromised respiratory status; or

(H) When evidence-based clinical practice guidelines support the need.

(c) Home pulse oximetry for indications other than those listed above may be considered medically appropriate upon medical review;

(d) The use of home pulse oximetry for indications considered experimental and investigational, including the following, are not covered:

(A) Asthma management;

(B) When used alone as a screening/testing technique for suspected obstructive sleep apnea;

(C) Routine use (e.g., client with chronic, stable cardiopulmonary condition).

(e) The durable medical equipment prosthetics, orthotics and supplies (DMEPOS) provider is responsible to ensure the following services for home pulse oximetry rental are provided:

(A) Training regarding the use and care of the equipment and care of the client as it relates to the equipment, including progressive intervention and cardiopulmonary resuscitation (CPR) training prior to use of the equipment by the client; and

(B) A follow-up home visit within the first 30 days of equipment setup to ensure a CPR/emergency area has been designated; and

(C) Monthly telephone follow-up and support to ensure caregivers are using the equipment as ordered by the physician; and

(D) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.

(f) DMAP may cover probes for a client-owned covered oximeter:

(A) DMAP will consider the least costly alternative for payment of probes, whether disposable or reusable, which meets the medical need of the client;

(B) Disposable probes (oxisensors) may be used on the same client as long as the adhesive attaches without slippage; or

(C) Probes must be used and replaced based on the manufacturer's recommendations.

(2) Documentation Requirements:

(a) Submit the following documentation for prior authorization (PA) review:

(A) An order from the treating physician that clearly specifies the medical appropriateness for home pulse oximetry testing;

(B) Documentation of signs/symptoms/medical condition exhibited by the client, that require continuous pulse oximetry monitoring as identified by the need for oxygen titration, frequent suctioning or ventilator adjustments, etc.;

(C) Plan of treatment that identifies a trained caregiver available to perform the testing, document the frequency and the results and implement the appropriate therapeutic intervention, when necessary;

(D) For probes for a client-owned oximeter, documentation that probes requested are the least costly alternative;

(E) Other medical records that corroborate conditions for coverage are met as specified in this rule.

(b) An appropriate history and physical exam and progress notes must be available for review by DMAP, upon request;

(c) For an initial request, approval may be given for no longer than the first three months of rental;

(d) Continued approval beyond the initial authorization, is based on ongoing review of above documentation including appropriate and medical oversight as indicated and direction to support the need, including an identified intervention plan by the treating physician.

(3) Procedure Codes:

(a) A4606 — Oxygen probe for use with client-owned oximeter device, replacement:

(A) PA required;

(B) DMAP will purchase.

(b) E0445 — Oximeter device for measuring blood oxygen levels non-invasively, per month:

(A) PA required;

(B) DMAP will rent;

(C) DMAP will repair;

(D) Item considered purchased after seven months of rent;

(E) Quantity (units) is one on a given date of service;

(F) The allowable rental fee includes all equipment, supplies. services, including all probes, routine maintenance and necessary training for the effective use of the pulse oximeter.

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 32-1999, f. & cert. ef. 10-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06

410-122-0202

Continuous Positive Airway Pressure (CPAP) System

(1) Indications and Limitations of Coverage and/or Medical Appropriateness

(a) Initial Coverage:

(A) A single-level continuous positive airway pressure (CPAP) device (E0601) may be covered by the Division of Medical Assistance Programs (DMAP) when the client has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (i or ii):

(i) The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour; or

(ii) The AHI is from 5 to 14 events per hour with documented symptoms of:

(I) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or

(II) Hypertension, ischemic heart disease, or history of stroke;

(B) A three-month rental period is required for CPAP prior to purchase;

(b) Continued coverage of an E0601 beyond the first three months of therapy: Ongoing rental beyond the first three months is an option in lieu of purchase if medically appropriate and cost effective;

(c) For a client using a CPAP prior to Medicaid enrollment, and, with recent, supportive documentation from the treating practitioner indicative of effective treatment with a CPAP device, coverage criteria in this rule may be waived;

(d) Payment Authorization: From the initial date of service through the second date of service, CPAP rental and only related accessories necessary for the effective use of the CPAP during this time period and subject to rule limitations may be dispensed without prior authorization. The provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting claims and will be given once all required documentation has been received and any other applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040. All subsequent services starting with the third date of service require prior authorization;

(e) An order refill does not have to be approved by the ordering physician; however, a client or their caregiver must specifically request ongoing CPAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider must not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance.

(2) Guidelines:

(a) A continuous positive airway pressure (CPAP) device delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs;

(b) A respiratory cycle is defined as an inspiration, followed by an expiration;

(c) Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). It must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment;

(d) For the purpose of this rule, polysomnographic studies must be performed in an attended, facility-based sleep study laboratory, and not in the home or in a mobile facility. These labs must be qualified providers

of Medicare services and comply with all applicable state regulatory requirements;

(e) The diagnostic portion of the polysomnogram recording must be a minimum of two hours;

(f) Polysomnographic studies must not be performed by a durable medical equipment (DME) provider;

(g) The apnea-hypopnea index (AHI) is defined as the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected;

(h) Apnea is defined as the cessation of airflow for at least 10 seconds documented on a polysomnogram;

(i) Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation;

(j) The AHI calculation must be based on the sleep time (in hours) within the two hours (or more) of recorded time.

(3) Documentation Requirements:

(a) Initial Coverage: Prior to the third date of service, submit the following documentation:

(A) A facility-based polysomnogram report that supports a diagnosis of obstructive sleep apnea (OSA); and, if applicable;

(B) Any other medical documentation that supports indications of coverage;

(b) Continued coverage beyond the first three months of therapy: No sooner than the 61st day after initiating therapy and prior to the fourth date of service, submit documentation from the treating physician that indicates the client is continuing to effectively comply (time spent at the effective pressure) with CPAP treatment. This means that the client is continuing to use the CPAP at the effective pressure for at least four hours in a 24-hour continuous period at least 80 percent of the time.

(4) Accessories:

(a) Accessories used with an E0601 device are covered when the coverage criteria for the device are met;

(b) Accessories are separately reimbursable at the time of initial issue and when replaced;

(c) Either a non-heated (E0561) or heated (E0562) humidifier is covered when ordered by the treating physician for use with a covered E0601 device;

(d) The following represents the usual maximum amount of accessories expected to be medically appropriate:

(A) A4604 — 1 per 3 months;
(B) A7030 — 1 per 3 months;
(C) A7031 — 1 per 6 months;
(C) A7032 — 2 per month;
(D) A7033 — 2 per month;
(E) A7034 — 1 per 3 months;
(F) A7035 — 1 per 6 months;
(G) A7036 — 1 per 6 months;
(H) A7037 — 1 per 1 month;
(I) A7038 — 2 per 1 month;
(J) A7039 — 1 per 6 months;
(K) A7046 — 1 per 6 months.

(5) Miscellaneous:

(a) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating physician. When the equipment is not being used as prescribed, the provider must stop billing for the equipment and related accessories and supplies;

(b) For auto-titrating CPAP devices, use HCPCS code E0601;

(c) Products must be coded as published by SADMERC's Product Classification List for CPAP Systems and Respiratory Assist Devices.

(6) **Table 122-0202**.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 46-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0203
Oxygen and Oxygen Equipment

(1) Indications and limitations:

(a) For all the sleep oximetry criteria described in (b) (c) and (d) below, the five minutes do not have to be continuous:

(A) When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria are met;

(B) If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result will determine coverage;

(b) The Division of Medical Assistance Programs (MAP) may cover home oxygen therapy services for clients who are:

(A) Children under age 19 when the treating practitioner has determined it to be medically appropriate;

(B) Adults 19 years of age and older if the following conditions are met:

(i) The treating practitioner has determined that the client has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy; and

(ii) The client's blood gas study meets the criteria stated below; and

(iii) A physician or qualified provider or supplier of laboratory services performed the qualifying blood gas study; and

(iv) The qualifying blood gas study was obtained under the following conditions:

(I) If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date; or

(II) If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the client is in a chronic stable state, that is, not during a period of acute illness or an exacerbation of their underlying disease;

(v) Alternative treatment measures have been tried or considered and deemed clinically ineffective;

(C) Clients residing in a nursing facility only when continuous oxygen is required that exceeds 1000 liters in a 24-hour period. See OAR 410-120-1340 and 411-070-0085;

(c) Group I coverage duration and indications:

(A) DMAP limits initial Group I coverage to 12 months or the practitioner-specified length of need, whichever is shorter. See documentation requirements for information on recertification;

(B) Criteria for Group I include any of the following:

(i) An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake); or

(ii) An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least five minutes taken during sleep for a client who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake; or

(iii) A decrease in arterial PO 2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis); or

(iv) An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a client who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air;

(d) Group II coverage duration and indications:

(A) Initial coverage limited to three months or the practitioner-specified length of need, whichever is shorter. See documentation requirements for information on recertification;

(B) Criteria include presence of PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least five minutes, or during exercise (as described under Group I criteria); and any of the following:

(i) Dependent edema suggesting congestive heart failure; or

(ii) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or

(iii) Erythrocythemia with a hematocrit greater than 56 percent.

(e) Group III indications include a presumption of non-coverage and are considered precautionary, not therapeutic, in nature. Criteria

include arterial PO2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent;

(f) DMAP does not cover oxygen therapy and related services, equipment or supplies for any of the following:

(A) Angina pectoris in the absence of hypoxemia;

(B) Dyspnea without cor pulmonale or evidence of hypoxemia;

(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia;

(D) Terminal illnesses that do not affect the respiratory system;

(E) Humidifiers (E0550, E0555 and E0560) with rented oxygen equipment. All accessories, such as humidifiers necessary for the effective use of oxygen equipment, are included in the monthly rental payment;

(F) Group III clients;

(G) Emergency or stand-by oxygen systems, including oxygen as needed (i.e., PRN), since they are precautionary and not therapeutic in nature;

(H) Topical hyperbaric oxygen chambers (A4575);

(I) Oxygen for topical use;

(J) Back-up equipment, since it is part of the all-inclusive rate;

(K) Travel oxygen:

(i) Clients traveling outside the DMEPOS provider's service area must make their own arrangements for oxygen;

(ii) DMAP will only pay one DMEPOS provider for oxygen during any one rental month;

(iii) The traveling client is responsible to pay for oxygen furnished by an airline, not the DMEPOS provider.

(2) Guidelines for testing and certification:

(a) Testing specifications:

(A) The term blood gas study in this policy refers to either an arterial blood gas (ABG) test or an oximetry test:

(i) An ABG is the direct measurement of the partial pressure of oxygen (PO2) on a sample of arterial blood;

(ii) The PO2 is reported as mm Hg;

(iii) An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger;

(iv) The saturation is reported as a percent;

(B) The qualifying blood gas study must be performed by a qualified provider (a laboratory, physician, etc.);

(i) DMAP does not consider a DMEPOS provider a qualified provider or a qualified laboratory for purposes of this policy;

(ii) DMAP will not accept blood gas studies either performed by, or paid for, by a DMEPOS provider;

(iii) This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests;

(C) For sleep oximetry studies, the tester must provide the client a tamper-proof oximeter that has the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value;

(D) When oxygen services are based on an oxygen study obtained during exercise, DMAP requires documentation of three oxygen studies in the client's medical record:

(i) Testing at rest without oxygen; and

(ii) Testing during exercise without oxygen; and

(iii) Testing during exercise with oxygen applied, to demonstrate the improvement of the hypoxemia.

(E) The qualifying test value (i.e., testing during exercise without oxygen) on the Certificate of Medical Necessity (CMN). The other results do not have to be routinely submitted but must be available to DMAP on request;

(F) The qualifying blood gas study may be performed while the client is on oxygen, as long as the reported blood gas values meet the Group I or Group II criteria.

(b) Certification:

(A) On the CMN, the blood gas study obtained must be the most recent study prior to the initial date, indicated in Section A of the CMN, and this study must be obtained within 30 days prior to that initial date;

(B)There is an exception for clients who were on oxygen prior to enrollment with DMAP. For those clients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent test obtained prior to enrollment with DMAP;

(C) For clients initially meeting Group I criteria:

(i) The tester must report the most recent blood gas study prior to the 13th month of therapy on the recertification CMN;

(ii) If the estimated length of need on the initial CMN is less than lifetime and the practitioner wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the revised certification;

(D) For clients initially meeting Group II criteria:

(i) On the recertification CMN, the tester must report the most recent blood gas study that was performed between the 61st and 90th day following the date of the initial certification CMN;

(ii) If a tester does not obtain a qualifying test between the 61st and 90th day of home oxygen therapy, but the client continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, DMAP will resume coverage beginning with the date of that test;

(iii) If the estimated length of need on the initial CMN is less than lifetime and the practitioner wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the revised certification;

(E) On any revised CMN, the tester must report the most recent blood gas study performed prior to the revision date;

(F) DMAP may request a repeat blood gas study at any time;

(G) The treating practitioner must see and evaluate the client:

(i) Within 30 days prior to the date of initial certification;

(ii) Within 90 days prior to the date of any recertification;

(iii) If the treating practitioner fails to see and reevaluate the client within 90 days prior to recertification, but subsequently evaluates and determines the client meets the blood gas study criteria, DMAP will cover the dates of service between the scheduled recertification date and the practitioner visit date.

(3) Portable oxygen system coverage:

(a) A portable oxygen system may be covered if the client is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;

(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. (See the exception in Section (4) of this rule);

(c) If a portable oxygen system is covered, the DMEPOS provider must provide whatever quantity of oxygen the client uses;

(d) DMAP's reimbursement is the same, regardless of the quantity of oxygen dispensed;

(e) Code K0738 (portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flow meter, humidifier, cannula or mask, and tubing) is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.

(4) Liter flow greater than 4 liters per minute (LPM):

(a) DMAP will pay for a higher allowance of a flow rate of greater than 4 LPM only if:

(A) Basic oxygen coverage criteria have been met; and

(B) The client meets Group I or II criteria; and

(C) A blood gas study is performed while client is on 4 LPM oxygen;

(b) DMAP will limit payment to the standard fee schedule allowance if the provider requests a flow rate greater than 4 LPM when the coverage criterion for the higher allowance is not met;

(c) If a client qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen:

(A) DMAP will pay for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both;

(B) In this situation, if both a stationary system and a portable system are requested for the same rental month, DMAP will not cover the portable oxygen system.

(5) Oxygen contents:

(a) The DMAP allowance for rented oxygen systems includes oxygen contents;

(b) Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a client-owned stationary gaseous or liquid system respectively;

(c) Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

(A) The client owns a concentrator and rents or owns a portable system; or

(B) The client rents or owns a portable system and has no stationary system (concentrator, gaseous, or liquid);

(C) If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased.

(6) Oxygen accessory items:

(a) The DMAP allowance for rented systems includes, but is not limited to, the following accessories:

(A) Transtracheal catheters (A4608);

(B) Cannulas (A4615);

(C) Tubing (A4616);

(D) Mouthpieces (A4617);

(E) Face tent (A4619);

(F) Masks (A4620, A7525);

(G) Oxygen tent (E0455);

(H) Humidifiers (E0550, E0555, E0560);

(I) Nebulizer for humidification (E0580);

(J) Regulators (E1353);

(K) Stand/rack (E1355);

(b) The DMEPOS provider must provide any accessory ordered by the practitioner;

(c) Accessories are separately payable only when they are used with a client-owned system that was purchased prior to June 1, 1989. DMAP does not cover accessories used with a client-owned system that was purchased on or after June 1, 1989;

(7) Billing for miscellaneous oxygen items:

(a) DMAP only covers rented oxygen systems (E0424, E0431, E0434, E0439, E1390RR, E1405 RR, E1406RR, E1392RR);

(b) For gaseous or liquid oxygen systems or contents, report one unit of service for one month rental. Do not report in cubic feet or pounds;

(c) Use the appropriate modifier if the prescribed flow rate is less than 1 LPM (QE) or greater than 4 LPM (QF or QG). DMAP only accepts these modifiers with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). Do not use these modifiers with codes for portable systems or oxygen contents;

(d) Use Code E1391 (oxygen concentrator, dual delivery port) in situations in which two clients are both using the same concentrator. In this situation, this code must only be requested for one of the clients;

(e) Use Codes E1405 and E1406 (oxygen and water vapor enriching systems) only for products for which a written coding verification has been received from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(f) Code E1392 describes a portable oxygen concentrator system. Use E1392 when billing DMAP for the portable equipment add-on fee for clients using lightweight oxygen concentrators that can function as both the client's stationary equipment and portable equipment. A portable concentrator:

(A) Weighs less than 10 pounds;

(B) Is capable of delivering 85% or greater oxygen concentration; and

(C) Is capable of providing at least two hours of remote portability at a 2 LPM order equivalency;

(g) Contact the SADMERC for guidance on the correct coding of these items.

(8) Documentation Requirements: The DMEPOS provider must have the following documentation on file which supports conditions of coverage as specified in this rule are met:

(a) Medical records that reflect the need for the oxygen care provided include records from:

(A) Physician's or practitioner's office;

(B) Hospital;

(C) Nursing home;

(D) Home health agency;

(E) Other health care professionals;

(F) Test reports;

(b) The treating practitioner's signed and dated orders for each item billed. When the DMEPOS provider bills DMAP before the provider receives a signed and dated order, the provider must submit the claim with an EY modifier added to each affected HCPCS code;

(A) In the following situations, a new order must be obtained and kept on file by the DMEPOS provider, but neither a new CMN nor a repeat blood gas study are required:

(i) Prescribed maximum flow rate changes but remains within one of the following categories:

(I) Less than 1 LPM;

(II) 1-4 LPM;

(III) Greater than 4 LPM;

(ii) Change from one type of system to another (i.e., concentrator, liquid, gaseous);

(c) A completed, signed, dated CMN from the treating practitioner;

(A) The CMN may substitute for a written order if it is sufficiently detailed;

(B) The CMN for home oxygen is CMS form 484. Section B (order information) of the CMN must be completed by the physician or the practitioner, not the DMEPOS provider. The DMEPOS provider may use Section C to record written confirmation of other details of the oxygen order, or the practitioner can enter other details directly, such as means of deliver (e.g., cannula, mask, etc.) and the specifics of varying oxygen flow rates or non-continuous use of oxygen;

(C) The ABG PO2 must be reported on the CMN if both an ABG and oximetry test were performed the same day under the condition reported on the CMN (that is, at rest, awake, during exercise, or during sleep);

(D) A completed sleep study documenting the qualifying desaturation for clients who qualify for oxygen coverage based only on a sleep oximetry study. The saturation value reported in Question 1(b) of the Oxygen CMN must be the lowest value (not related to artifact) during the five-minute qualifying period reported on the sleep study;

(E) The blood gas study reported on the initial CMN must be the most recent study obtained prior to the initial date and this study must be obtained within 30 days prior to that initial date;

(i) There is an exception for clients who were on oxygen in a Medicare Health Maintenance Organization (HMO) and who transition to fee-for-service Medicare;

(ii) For those clients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent test obtained while in the HMO;

(F) The DMEPOS provider must submit to DMAP an initial CMN in the situations described below. The initial date refers to the dates reported in Section A of the CMN;

(i) With the first claim to DMAP for home oxygen, even if the client was on oxygen prior to becoming eligible for DMAP coverage, or oxygen was initially covered by a Medicare HMO;

(ii) When the first CMN did not meet coverage criteria and the client was subsequently retested and meets coverage criteria, the initial date on the new CMN is the date of the subsequent, qualifying blood gas study;

(iii) When a change occurs in the client's condition that caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. This indication does not apply if there was just a break in billing because the client was in a hospital, nursing facility, hospice or Medicare HMO, but the client continued to need oxygen during that time;

(iv) When a Group I client with length of need less than or equal to 12 months was not retested prior to Revised Certification/ Recertification, but a qualifying study was subsequently performed. The initial date on this new CMN is the date of the subsequent, qualifying blood gas study;

(v) When a Group II client did not have a qualifying, repeat blood gas study between the 61st and 90th days of coverage, but a qualifying study was subsequently performed. The initial date on the new CMN is the date of the subsequent, qualifying blood gas study;

(vi) When a change of provider occurs due to an acquisition and the previous provider did not file a recertification when it was due or the requirements for recertification were not met when it was due. The initial date on this new CMN is the date of the subsequent qualifying blood gas study;

(G) The DMEPOS provider must submit to DMAP a recertification CMN in the following circumstances. The initial date refers to the dates reported in Section A of the CMN:

(i) For Group I oxygen test results, 12 months after the initial certification (i.e., with the 13th month's claim). The blood gas reported study must be the most recent study performed prior to the 13th month of therapy;

(ii) If a Group I client with a lifetime length of need was not seen and evaluated by the practitioner within 90 days prior to the 12-month recertification, but was subsequently seen, the date on the recertification CMN must be the date of the practitioner visit;

(iii) For Group II oxygen test results, three months after the initial certification (i.e., with the fourth month's claim). The reported blood gas

study must be the most recent study performed between the 61st and 90th day following the initial date;

(iv) If there was a change of provider due to an acquisition and the previous DMEPOS provider did not file a recertification when it was due, but all the requirements for the recertification were met when it was due, the provider would file a recertification CMN with the recertification date being 12 months (for a Group I initial CMN) or three months (for a Group II initial CMN) after the initial date;

(v) In other situations at the discretion of DMAP. The blood gas study must be the most recent study that was performed within 30 days prior to the recertification date;

(H) The DMEPOS provider must submit to DMAP a revised CMN in the following circumstances. Submission of a revised CMN does not change the recertification schedule specified elsewhere. The initial date refers to the dates reported in Section A of the CMN:

(i) When the prescribed maximum flow rate changes from one of the following categories to another:

(I) Less than 1 LPM;

(II) 1-4 LPM;

(III) Greater than 4 LPM;

(IV) If the change is from category (a) or (b) to category (c), a repeat blood gas study with the client on 4 LPM must be performed within 30 days prior to the start of the greater than 4 LPM flow;

(ii) When a portable oxygen system is added subsequent to initial certification of a stationary system. In this situation, DMAP does not require a repeat blood gas study, unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the client is at rest (awake) or during exercise within 30 days prior to the revised date;

(iii) When a stationary system is added subsequent to initial certification of a portable system. In this situation, DMAP does not require a repeat blood gas study;

(iv) When the length of need expires, if the practitioner specified less than lifetime length of need on the most recent CMN. In this situation, a blood gas study must be performed within 30 days prior to the revised date;

(v) When there is a new treating practitioner, but the oxygen order is the same. In this situation, DMAP does not require a repeat blood gas study.

NOTE: In this situation, the revised CMN does not have to be submitted with the claim but must be kept on file by the provider;

(vi) If there is a new provider, that provider must be able to provide DMAP with a CMN on request. That CMN would not necessarily be an initial CMN or the first CMN for that client. If the provider obtains a new CMN, it would be considered a revised CMN;

(vii) If the indications for a revised CMN are met at the same time that a recertification CMN is due, file the CMN as a recertification CMN.

(9) **Table 122-0203**.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0204
Nebulizer

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Equipment:

(A) Small Volume Nebulizer:

(i) A small volume nebulizer and related compressor may be covered to administer inhalation drugs based on evidence-based clinical practice guidelines;

(ii) The physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, the MDI was not sufficient for the administration of needed inhalation drugs.

(B) Large Volume Nebulizer:

(i) A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is medically appropriate to deliver humidity to a client with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;

(ii) Combination code E0585 will be covered for the same indications as in (1)(a)(B)(i);

(C) The Division of Medical Assistance Programs (DMAP) will consider other uses of compressors/generators individually on a case by case basis, to determine their medical appropriateness, such as a battery powered compressor (E0571);

(b) Accessories:

(A) A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and should not be separately billed when used for clients with rented home oxygen equipment;

(B) DMAP does not cover use of a large volume nebulizer, related compressor/generator, and water or saline when used predominately to provide room humidification;

(C) A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the client/caregiver is an acceptable alternative to the large volume nebulizer when used as indicated in (1)(a)(B)(i) of this rule;

(D) Kits and concentrates for use in cleaning respiratory equipment are not covered;

(E) Accessories are separately payable if the related aerosol compressor and the individual accessories are medically appropriate. The following table lists each covered compressor/ generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;

(F) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7017, A7525, E1372); E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0571 (A7003, A7004, A7005, A7006, A7013, A7015, A7525) ; E0572 (A7006, A7014); E0585 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7525);

(G) This array of accessories represents all possible combinations but it may not be appropriate to bill any or all of them for one device;

(H) **Table 122-0204-1** lists the usual maximum frequency of replacement for accessories. DMAP will not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by DMAP before dispensing. The provider must submit requests for more than the usual maximum replacement amount to DMAP for review.

(2) Coding Guidelines:

(a) Accessories:

(A) Code A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece and mouthpiece. In addition, code A7006 includes a filter;

(B) Code A7004 includes only the lid, jar and baffles;

(C) Code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer;

(D) Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing;

(E) Code A7017 is billed for a durable, bottle type nebulizer when it is used with a E0572 compressor or a separately billed E0565 compressor;

(F) Code A7017 would not be separately billed when an E0585 system was also being billed. Code E0580 (Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as A7017, but should only be billed when this type of nebulizer is used with a client-owned oxygen system.

(b) Equipment:

(A) In this policy, the actual equipment (i.e., electrical device) will generally be referred to as a compressor (when nebulization of liquid is achieved by means of air flow). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor in order to achieve a functioning delivery system for aerosol therapy;

(B) Code E0565 describes an aerosol compressor, which can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation;

(C) A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered;

(D) A portable compressor (E0571) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option;

(E) A light duty adjustable pressure compressor (E0572) is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow of 6-8 L/m, but is capable only of intermittent operation.

(3) Documentation Requirements:

(a) When billing and dispensing for an item in **Table 122-0204**, medical records must corroborate that all criteria in this rule are met;

(b) When a battery powered compressor (E0571) is dispensed, supporting documentation which justifies the medical appropriateness must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(c) The DMEPOS provider must maintain these medical records and make them available to DMAP on request.

(4) **Table 122-0204-1**.

(5) **Table 122-0204-2.**

[ED. NOTE: Table referenced is available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0205
Respiratory Assist Devices

(1) As referenced in this policy, non-invasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy).

(2) Indications and Coverage — General:

(a) The "treating prescribing practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD);

(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state regulatory requirements;

(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider. For purposes of this policy's coverage and payment guidelines, a DMEPOS provider is not considered a qualified provider or supplier of these tests;

(d) If there is discontinuation of usage of E0470 or E0471 device at any time, the provider is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

(3) Coverage criteria for E0470 and E0471 devices — **Table 122-0205-1**.

(4) Documentation:

(a) The following documentation must be submitted with the request for prior authorization (PA) and the original kept on file by the provider:

(A) An order for all equipment and accessories including the client's diagnosis, an ICD-9-CM code signed and dated by the treating prescribing practitioner;

(B) Summary of events from the polysomnogram, if required in this rule under the indications and coverage section or **Table 122-0205-1**;

(C) Arterial blood gas results, if required under the indications and coverage section or **Table 122-0205-1**;

(D) Sleep oximetry results, if required under the indications and coverage section or **Table 122-0205-1**;

(E) Treating prescribing practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea;

(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth month review.

(b) A copy of the Evaluation of Respiratory Assist Device (DMAP 2461) completed and signed by the client, family member or caregiver;

(c) Clients currently using BiPapS and BiPap ST are not subject to the new criteria.

(5) Procedure Codes — **Table 122-0205-2**.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0206
Intermittent Positive Pressure Breathing (IPPB)

E0500, IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source the Division of Medical Assistance Programs (DMAP) will rent. Covered if medically appropriate for the following indications:

(1) Clients at risk of respiratory failure because of decreased respiratory function secondary to kyphoscoliosis or neuromuscular disorders.

(2) Clients with severe bronchospasm or exacerbated chronic obstructive pulmonary disease (COPD) who fail to respond to standard therapy.

(3) The management of atelectasis that has not improved with simple therapy.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0207
Respiratory Supplies

Table 122-0207.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0208
Suction Pumps

(1) Indications and Limitations of Coverage:

(a) Use of a home model respiratory suction pump may be covered for a client who has difficulty raising and clearing secretions secondary to:

(A) Cancer or surgery of the throat or mouth; or

(B) Dysfunction of the swallowing muscles; or

(C) Unconsciousness or obtunded state; or

(D) Tracheostomy; or

(E) Neuromuscular conditions.

(b) When a respiratory suction pump (E0600) is covered, tracheal suction catheters are separately payable supplies. In most cases, in the home setting, sterile catheters are medically appropriate only for tracheostomy suctioning. Three suction catheters per day are covered for medically appropriate tracheostomy suctioning, unless additional documentation is provided. When a tracheal suction catheter is used in the oropharynx, which is not sterile, the catheter can be reused if properly cleansed and/or disinfected. In this situation, the medical appropriateness for more than three catheters per week requires additional documentation;

(c) Sterile saline solution (A4216, A4217) may be covered and separately payable when used to clear a suction catheter after tracheostomy suctioning. It is not usually medically appropriate for oropharyngeal suctioning. Saline used for tracheal lavage is not covered;

(d) Supplies (A4628) are covered and are separately payable when they are medically appropriate and used with a medically appropriate suction pump (E0600) in a covered setting;

(e) When a suction pump (E0600) is used for tracheal suctioning, other supplies (e.g., cups, basins, gloves, solutions, etc.) are included in the tracheal care kit code, A4625 — (see OAR 410-122-0209 for details). When a suction pump is used for oropharyngeal suctioning, these other supplies are not medically appropriate;

(f) The suction device must be appropriate for home use without technical or professional supervision. Those using the suction apparatus

must be sufficiently trained to adequately, appropriately and safely use the device.

(2) A client's medical record must reflect the need for the supplies dispensed and billed. The medical record must be kept on file by the DME provider and made available to the Division of Medical Assistance Programs (DMAP) upon request.

(3) A portable or stationary home model respiratory suction pump (E0600) is an electric aspirator designed for oropharyngeal and tracheal suction.

(4) A portable or stationary home model gastric suction pump (E2000) is an electric aspirator designed to remove gastrointestinal secretions.

(5) A tracheal suction catheter is a long, flexible catheter.

(6) An oropharyngeal catheter is a short, rigid (usually) plastic catheter of durable construction.

(7) Code E0600 must not be used for a suction pump used with gastrointestinal tubes.

(8) Code E2000 must be used for a suction pump used with gastrointestinal tubes.

(9) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(10) When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be clear documentation in the client's medical records corroborating the medical appropriateness for the higher utilization. DMAP may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities billed.

(3) Table 122-0208.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0209
Tracheostomy Care Supplies

(1) Indications and Coverage: For a client following an open surgical tracheostomy which has been open or is expected to remain open for at least three months.

(2) Documentation: A prescription for tracheal equipment which is signed by the prescribing practitioner must be kept on file by the DME-POS provider. The prescribing practitioner's records must contain information which supports the medical appropriateness of the item ordered.

(3) Procedure Codes — Table 122-0209.

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

Stat. Auth.: ORS 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; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0210
Ventilators

(1) Indications and limitations of coverage:

(a) Mechanical ventilatory support may be provided to a client for the purpose of life support during therapeutic support of suboptimal cardiopulmonary function, or therapeutic support of chronic ventilatory failure;

(b) A ventilator may be covered by the Division of Medical Assistance Programs (DMAP) for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. This includes both positive and negative pressure types.

(2) Primary Ventilators:

(a) A primary ventilator may be covered if supporting documentation indicates:

(A) A client is unable to be weaned from the ventilator or is unable to be weaned from use at night; or

(B) Alternate means of ventilation were used without success; or

(C) A client is ready for discharge and has been on a ventilator more than 10 days.

(b) E0450, E0460, E0461 or E0472 may be covered if:

(A) A client has no respiratory drive either due to paralysis of the diaphragm or a central brain dysfunction; or

(B) A client has a stable, chronic condition with no orders to wean from the ventilator; or

(C) A client has had a trial with blood gases and has no signs or symptoms of shortness of breath or increased work of breathing; or

(D) A client has uncompromised lung disease;

(c) E0463 or E0464 may be covered if supporting documentation indicates:

(A) A client has chronic lung disease where volume ventilation may further damage lung tissue; or

(B) A client has a compromised airway or musculature and has respiratory drive and a desire to breathe; or

(C) A client will eventually be weaned from the ventilator; or

(D) A client has compromised respiratory muscles from muscular dystrophies or increased resistance from airway anomalies or scoliosis conditions.

(3) Backup Ventilators — A backup ventilator may be covered if supporting documentation indicates:

(a) The client is more than 60 minutes from the nearest hospital or a backup ventilator and has no documented spontaneous respirations; or

(b) Documentation supports medical appropriateness; or

(c) The client is transported frequently with a portable ventilator, and the ventilator is not a portable model; or

(d) The primary ventilator is used at maximum performance with high pressure and rate.

(4) Rental fee:

(a) The rental fee for the ventilator is all-inclusive of any equipment, supplies, services, including respiratory therapy (respiratory care) services, routine maintenance and training necessary for the effective use of the ventilator; and

(b) The ventilator provider must provide 24-hour emergency coverage, including an emergency telephone number; and

(c) The client must have a telephone or reasonable access to one.

(5) Payment authorization: Prior authorization (PA) is not required when E0450, E0460, E0461 or E0472 is dispensed as the primary ventilator. The provider is responsible to ensure all rule requirements are met. Payment authorization is required prior to the second date of service and before submitting claims. Payment authorization will be given once all required documentation has been received and any other applicable rules and criteria have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040.

(6) PA:

(a) PA is required for a backup ventilator; and

(b) Reimbursement for a backup ventilator is paid at 50% of the fee schedule amount, 50% of the manufacturer's suggested retail price (MSRP) or 50% of the actual charge, whichever is lowest.

(7) Documentation: For services requiring payment authorization or PA, submit documentation that supports requirements found in this rule. **Table 122-0210**.

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

Stat. Auth.: ORS 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; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0220
Pacemaker Monitor

(1) E0610 — Pacemaker monitor, self-contained, checks battery depletion, includes audible and visible check systems:

(a) The Division of Medical Assistance Programs (DMAP) will purchase;

(b) Also covered for payment by DMAP when client is a resident of a nursing facility.

(2) E0615 — Pacemaker monitor, self-contained, checks battery depletion and other pacemaker components, includes digital/visible check systems:

(a) DMAP will purchase;

(b) Also covered for payment by DMAP when client is a resident of a nursing facility.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 9-1993 f. & cert. ef. 4-1-93; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0240
Apnea Monitors for Infants

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) For infants less than 12 months of age with documented apnea, or who have known risk factors for life-threatening apnea, the Division of Medical Assistance Programs (DMAP) may cover home apnea monitors and related supplies for any of the following indications:

(A) Up to three months for:

(i) Apnea of prematurity: Sudden cessation of breathing that lasts for at least 20 seconds, is accompanied by bradycardia (heart rate less than 80 beats per minute), or is accompanied by oxygen desaturation (O2 saturation less than 90 % or cyanosis) in an infant younger than 37 weeks gestational age;

(ii) Apparent life-threatening event (ALTE): An episode that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging;

(iii) Documented gastroesophageal reflux disease (GERD) that results in apnea, bradycardia, or oxygen desaturation;

(iv) Documented prolonged apnea of greater than 20 seconds in duration;

(v) Documented apnea accompanied by bradycardia to less than 80 beats per minute;

(vi) Documented apnea accompanied by oxygen desaturation (below 90 %), cyanosis or pallor;

(vii) Documented apnea accompanied by marked hypotonia;

(viii) When off medication for bradycardia previously treated with caffeine, theophylline, or similar agents;

(B) Upon discharge from an acute care facility for up to one month post-diagnosis for diagnosis of pertussis, with positive cultures;

(C) As the later sibling of an infant who died of Sudden Infant Death Syndrome (SIDS), until the later sibling is one month older than the age at which the earlier sibling died and remains event-free;

(D) On a case by case basis for:

(i) Infants with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise;

(ii) Infants with neurologic or metabolic disorders affecting respiratory control;

(iii) Infants with chronic lung disease (bronchopulmonary dysplasia), especially those requiring supplemental oxygen, continuous positive airway pressure, or mechanical ventilation;

(b) Infant apnea monitors are usually considered medically appropriate for no longer than approximately three months except for specific conditions listed above;

(c) The rental fee includes all training, instruction, assistance, 24-hour on-call support and any other needed services for effective use of the apnea monitor, including cardiopulmonary resuscitation training. The durable medical equipment prosthetics orthotics and supplies (DMEPOS) provider is responsible for ensuring delivery of these services;

(d) DMAP may cover related supplies necessary for the effective functioning of the apnea monitorfor a three-month period, based on the following limitations:

(A) Electrodes, per pair (A4556) — 3 units;

(B) Lead wires, per pair (A4557) — 2 units;

(C) Conductive paste or gel (A4558) — 1 unit;

(D) Belts (A4649) — 2 units;

(e) The cost of apnea monitor rental includes the cost of cables;

(f) DMAP does not cover apnea monitors with memory recording (E0619) when the attending physician is monitoring the infant with ongoing sleep studies and pneumograms.

(2) Coding Guidelines: For billing purposes, use diagnosis code 798.0, Sudden Infant Death Syndrome (SIDS), for later siblings of infants who died of SIDS.

(3) Documentation Requirements: Submit the following information with the prior authorization request:

(a) Documentation (medical records including hospital records, sleep studies, physician's progress notes, physician-interpreted report from an apnea monitor with memory recording, etc.) of the episode or episodes that led to the diagnosis;

(b) An order from the physician who has diagnosed the infant as having clinically significant apnea or known risk factors for life-threatening apnea. The physician's order must indicate the specific type of apnea monitor (with or without recording feature) and detailed information about the type and quantity of related supplies needed;

(c) For an apnea monitor with recording feature (E0619), submit documentation that supports why an apnea monitor without recording feature (E0618) is not adequate to meet the medical need;

(d) When dispensing and billing for an item in Table 122-0240, the provider must ensure that documentation corroborates that all criteria in this rule are met;

(e) The DMEPOS provider must maintain documentation and make it available to DMAP on request.

(4) Table 122-0240.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0250
Breast Pumps

(1) Electric breast pumps will only be rented if documentation supports:

(a) Local resources were explored, e.g., Health Department, Hospital, etc.;

(b) Medical appropriateness for infant:

(A) Pre-term; or

(B) Term and hospitalized beyond five days; or

(C) Cleft palate or cleft lip; or

(D) Cranial-facial abnormalities; or

(E) Unable to suck adequately; or

(F) Re-hospitalized for longer than five days; or

(G) Failure to thrive.

(c) Medical appropriateness for mother:

(A) Has breast abscess; or

(B) Mastitis; or

(C) Hospitalized due to illness or surgery (for short-term use to maintain lactation); or

(D) Taking contraindicated medications (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) Electric pump is not for the comfort and convenience of the mother;

(b) Documentation that transition to breast feeding started as soon as the infant was stable enough to begin breast feeding;

(c) Use E1399 for an electric breast pump starter kit for single or double pumping;

(d) A starter kit will be reimbursed separately from the pump rental;

(e) Rental will not exceed 60 days;

(f) Supplemental Nutrition System (SNS), is not covered.

(3) Procedure Codes:

(a) E0602 — Breast pump, manual, any type — the Division of Medical Assistance Programs (DMAP) will purchase;

(b) E0603 — Breast pump, electric (AC and/or DC), any type, per day:

(A) DMAP will rent;

(B) Prior authorization required by DMAP.

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0255 [Renumbered to **410-122-0655**]

410-122-0260
Home Uterine Monitoring

(1) The following criteria will be used to determine payment. Monitors will be approved for:

(a) Pre-term labor — this 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.

(2) Uterine monitoring will only be approved for the above conditions between the 24th and through the completion of the 36th week of pregnancy.

(3) The allowable rental fee for the uterine monitor includes all equipment, supplies, services and nursing visits necessary for the effective use of the monitor. This does not include medications or prescribing practitioner's professional services.

(4) The client must have a telephone or reasonable access to one. The Division of Medical Assistance Programs (DMAP) will not be responsible for providing the telephone.

(5) S9001 — Uterine home monitoring, with or without associated nursing services:

(a) Prior Authorization (PA) required;

(b) DMAP will rent.

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0280
Heating/Cooling Accessories

Procedure Codes for Heating/Cooling Accessories: Table 122-0280.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0300
Light Therapy

(1) Phototherapy (bilirubin light therapy):

(a)The Division of Medical Assistance Programs (DMAP) may cover home phototherapy for a term or near-term infant whose elevated bilirubin is not due to a primary hepatic disorder or other hemolytic disorder that requires inpatient care;

(b) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instruction and 24 hour on-call service necessary for the effective use of the equipment;

(c) Documentation by the treating physician must indicate home phototherapy is an appropriate treatment modality;

(d) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must make supporting documentation available to DMAP on request.

(2) Table 122-0300

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0320
Manual Wheelchair Base

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a manual wheelchair when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADL) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010, Definitions, for complete definition of MRADL;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the manual wheelchair that is being requested;

(D) Use of a manual wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

(E) The client is willing to use the requested manual wheelchair in the home, and will use it on a regular basis in the home;

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested manual wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

(b) Only when conditions of coverage as specified in (1)(a) of this rule are met, may DMAP authorize a manual wheelchair for any of the following situations:

(A) When the wheelchair can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a manual wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a manual wheelchair may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of a manual wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a manual wheelchair;

(B) For a purchase request, when a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement cost;

(C) When a covered, client-owned wheelchair is in need of repair, DMAP may pay for one month's rental of a wheelchair. See OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing).

(c) DMAP does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

(d) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. DMAP does not reimburse for adapting living quarters;

(e) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(f) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(g) DMAP may cover an adult tilt-in-space wheelchair (E1161) when a client meets all of the following conditions:

(A) Is dependent for transfers;

(B) Spends a minimum of four hours a day continuously in a wheelchair;

(C) The client's plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(D) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting.

(h) DMAP may cover a standard hemi (low seat) wheelchair (K0002) when a client requires a lower seat height (17" to 18") because of short stature or needing assistance to place his/her feet on the ground for propulsion;

(i) DMAP may cover a lightweight wheelchair (K0003) when a client:

(A) Cannot self-propel in a standard wheelchair using arms and/or legs; and

(B) Can and does self-propel in a lightweight wheelchair.

(j) High-strength lightweight wheelchair (K0004):

(A) DMAP may cover a high-strength lightweight wheelchair (K0004) when a client:

(i) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or

(ii) Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

(B) If the expected duration of need is less than three months (e.g., post-operative recovery), a high-strength lightweight wheelchair is rarely medically appropriate;

(k) DMAP may cover an ultralightweight wheelchair (K0005) when a client has medical needs that require determination on a case by case basis;

(l) DMAP may cover a heavy-duty wheelchair (K0006) when a client weighs more than 250 pounds or has severe spasticity;

(m) DMAP may cover an extra heavy-duty wheelchair (K0007) when a client weighs more than 300 pounds;

(n) For a client residing in a nursing facility, an extra heavy-duty wheelchair (K0007) may only be covered when a client weighs more than 350 pounds;

(o) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement and Delivery;

(p) A manual wheelchair for use only outside the home is not covered.

(2) Coding Guidelines:

(a) Adult manual wheelchairs (K0001-K0007, K0009, E1161) have a seat width and a seat depth of 15" or greater;

(b) For codes K0001-K0007 and K0009, the wheels must be large enough and positioned so that the user can self-propel the wheelchair;

(c) In addition, specific codes are defined by the following characteristics:

(A) Adult tilt-in-space wheelchair (E1161):

(i) Ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining the same back-to-seat angle; and

(ii) Lifetime warranty on side frames and crossbraces.

(B) Standard wheelchair (K0001):

(i) Weight: Greater than 36 pounds; and

(ii) Seat height: 19" or greater; and

(iii) Weight capacity: 250 pounds or less.

(C) Standard hemi (low seat) wheelchair (K0002):

(i) Weight: Greater than 36 pounds; and

(ii) Seat height: Less than 19"; and

(iii) Weight capacity: 250 pounds or less.

(D) Lightweight wheelchair (K0003):

(i) Weight: 34-36 pounds; and

(ii) Weight capacity: 250 pounds or less.

(E) High strength, lightweight wheelchair (K0004):

(i) Weight: Less than 34 pounds; and

(ii) Lifetime warranty on side frames and crossbraces.

(F) Ultralightweight wheelchair (K0005):

(i) Weight: Less than 30 pounds;

(ii) Adjustable rear axle position; and

(iii) Lifetime warranty on side frames and crossbraces.

(G) Heavy duty wheelchair (K0006) has a weight capacity greater than 250 pounds;

(H) Extra heavy duty wheelchair (K0007) has a weight capacity greater than 300 pounds.

(d) Coverage of all adult manual wheelchairs includes the following features:

(A) Seat width: 15"–19";

(B) Seat depth: 15"–19";

(C) Arm style: Fixed, swingaway, or detachable, fixed height;

(D) Footrests: Fixed, swingaway, or detachable.

(e) Codes K0003-K0007 and E1161 include any seat height;

(f) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(g) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(h) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings;

(i) A manual wheelchair with a seat width and/or depth of 14" or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229 (see 410-122-0720 Pediatric Wheelchairs);

(j) For more information on other features included in the allowance for the wheelchair base, see 410-122-0340 Wheelchair Options/Accessories;

(k) Contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements:

(a) Functional Mobility Evaluation Form (DMAP 3125):

(A) Providers must submit this form or other medical documentation that supports conditions of coverage in this rule are met for purchase and modifications of all covered, client-owned manual wheelchairs except for K0001, K0002, or K0003 (unless modifications are required).

(B) Information must include, but is not limited to:

(i) Medical justification, needs assessment, order, and specifications for the wheelchair, completed by a physical therapist, occupational therapist or treating physician. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; and

(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and physical or occupational therapist.

(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order;

(b) Additional Documentation:

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a manual wheelchair; only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs, or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since DMAP determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(E) Detailed information about client-owned equipment (including serial numbers), as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it can't be grown or modified, if applicable;

(F) For the home assessment, prior to delivery of the wheelchair, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters. This assessment must support that the client's home can accommodate and allow for the effective use of a wheelchair. This assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc.;

(G) All Healthcare Common Procedure Coding System (HCPCS) codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that will be separately billed;

(c) A written order by the treating physician, identifying the specific type of manual wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority; and

(d) For purchase of K0001, K0002 or K0003 (without modifications):

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a manual wheelchair;only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Neck, trunk, and pelvic posture and flexibility;

(IV) Sitting and standing balance;

(v) Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance.

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since DMAP's coverage of a wheelchair is determined solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options; and

(E) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(F) The DMAP 3125 Functional Mobility Evaluation Form is not required;

(e) For an ultralight wheelchair (K0005), documentation from a physical therapist, occupational therapist or treating physician that includes a description of the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home. This may include what types of activities the client frequently encounters and whether the client is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base; and

(f) When code K0009 requested, all information from a physical therapist, occupational therapist or treating physician that justifies the medical appropriateness for the item; and

(g) Any additional documentation that supports indications of coverage are met as specified in this policy; and

(h) For a manual wheelchair rental, submit all of the following:

(A) A written order from the treating physician, identifying the specific type of manual wheelchair needed:

(i) If the order does not specify the type of wheelchair requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested;

(ii) The DMEPOS provider may enter the items on this order;

(iii) This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority;

(B) HCPCS codes;

(C) Documentation from the DMEPOS provider which supports that the client's home can accommodate and allow for the effective use of the requested wheelchair;

(i) The above documentation must be kept on file by the DMEPOS provider; and

(j) Documentation that the coverage criteria have been met must be present in the client's medical records and this documentation must be made available to DMAP on request.

(4) **Table 122-0320**.

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

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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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0325

Motorized/Power Wheelchair Base

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a power wheelchair (PWC) (K0815-K0816, K0822-K0829, K0835-K0843, K0848-K0864, K0898) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) entirely; places the client at reasonably determined height-

ened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day;

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the PWC that is being requested;

(E) Use of a PWC will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(F) The client is willing to use the requested PWC in the home, and the client will use it on a regular basis in the home;

(G) The client has either:

(i) Strength, postural stability, or other physical or mental capabilities insufficient to safely operate a power-operated vehicle (POV) in the home; or

(ii) Living quarters that do not provide adequate access between rooms, maneuvering space, and surfaces for the operation of a POV with a small turning radius;

(H) The client has either:

(i) Sufficient mental and physical capabilities to safely operate the PWC that is being requested; or

(ii) A caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the PWC that is being requested;

(I) The client's weight is less than or equal to the weight capacity of the PWC that is being requested;

(b) Only when conditions of coverage as specified in (1)(a) of this rule are met, may DMAP authorize a PWC for any of the following situations:

(A) When the PWC can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a PWC will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a PWC may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of a PWC coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a PWC;

(B) When a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement costs;

(C) When a covered client-owned wheelchair is in need of repair, DMAP may pay for one month's rental of a wheelchair (see OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing);

(c) For a PWC to be covered, the treating physician must conduct a face-to-face examination of the client before writing the order and the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device;

(A) When this examination is performed during a hospital or nursing home stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(B) The physician may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination;

(i) If the client was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the client and perform any additional examination that is needed. The report of the physician's visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the DMEPOS provider with a copy of both examinations within 45 days after the face-to-face examination with the physician;

(ii) If the physician saw the client to begin the examination before referring the client to a PT/OT, then if the physician sees the client again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician signs and dates the PT/OT examination;

(iii) If the PWC is a replacement of a similar item that was previously covered by DMAP or when only PWC accessories are being ordered and all other coverage criteria in this rule are met, a face to face examination is not required;

(d) DMAP does not reimburse for another chair if a client has a medically appropriate wheelchair, regardless of payer;

(e) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. DMAP does not reimburse for adapting the living quarters;

(f) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, head lights, and tail lights;

(g) Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the wheelchair;

(h) The delivery of the PWC must be within 120 days following completion of the face-to-face examination;

(i) A PWC may not be ordered by a podiatrist;

(j) The following are not covered:

(i) A PWC with a captain's chair for a client who needs a separate wheelchair seat and/or back cushion;

(ii) Portable PWCs (K0813, K0814, K0820, K0821);

(iii) Seat elevator PWC's (K0830, K0831);

(iv) A PWC for use only outside the home.

(2) Coding Guidelines:

(a) Specific types of PWC's:

(A) A Group 1 PWC (K0813-K0816) or a Group 2 Heavy Duty (HD), Very Heavy Duty (VHD), or Extra Heavy Duty (EHD) wheelchair (K0824-K0829) may be covered when the coverage criteria for a PWC are met;

(B) A Group 2 Standard PWC with a sling/solid seat (K0820, K0822) may be covered when:

(i) The coverage criteria for a PWC are met; and

(ii) The client is using a skin protection and/or positioning seat and/or back cushion that meets the coverage criteria defined in Wheelchair Options/Accessories, 410-122-0340;

(C) A Group 2 Single Power Option PWC (K0835 – K0840) may be covered when the coverage criteria for a PWC are met; and

(i) The client either:

(I) Requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or

(II) Meets the coverage criteria for a power tilt or recline seating system (see Wheelchair Options/Accessories, 410-122-0340) and the system is being used on the wheelchair; and

(ii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the DMEPOS provider;

(D) A Group 2 Multiple Power Option PWC (K0841-K0843) may be covered when the coverage criteria for a PWC are met; and

(i) The client either:

(I) Meets the coverage criteria for a power tilt or recline seating system with three or more actuators (see Wheelchair Options/Accessories, 410-122-0340); or

(II) Uses a ventilator which is mounted on the wheelchair; and

(ii)The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical appropriateness for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the DMEPOS provider;

(E) A Group 3 PWC with no power options (K0848-K0855) may be covered when:

(i) The coverage criteria) for a PWC are met; and

(ii) The client is unable to stand and pivot to transfer due to a neurological condition or myopathy; and

(iii) The client has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the DMEPOS provider;

(F) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) may be covered when:

(i) The Group 3 criteria (2)(a)(E) (i) and (2)(a) (E) (ii) are met; and

(ii) The Group 2 Single Power Option (2)(a)(C)(i)(I) and (2)(a)(C)(i)(II) or Multiple Power Options (criteria (2)(a)(D)(i)(I) and (2)(a)(D)(i)(II) are met

(b) PWC Basic Equipment Package: Each PWC code is required to include the following items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted):

(i) Lap belt or safety belt (E0978);

(ii) Battery charger single mode (E2366);

(iii) Complete set of tires and casters any type (K0090, K0091, K0092, K0093, K0094, K0095, K0096, K0097, K0099);

(iv) Legrests. There is no separate billing/payment if fixed or swingaway detachable non-elevating legrests with/without calf pad (K0051, K0052, E0995) are provided. Elevating legrests may be billed separately;

(v) Fixed/swingaway detachable footrests with/without angle adjustment footplate/platform (K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0052);

(vi) Armrests. There is no separate billing/ payment if fixed/swingaway detachable non-adjustable armrests with arm pad (K0015, K0019, K0020) are provided. Adjustable height armrests may be billed separately;

(vii) Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair (E0981, E0982);

(viii) Weight specific components per patient weight capacity;

(ix) Controller and Input Device. There is no separate billing/payment if a non-expandable controller and proportional input device (integrated or remote) is provided. If a code specifies an expandable controller as on option (but not a requirement) at the time of initial issue, it may be separately billed;

(c) If a client needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it may be appropriate to request a captain's chair seat rather than a sling/solid seat/back and a separate general use seat and/or back cushion;

(d) A PWC with a seat width or depth of 14" or less is considered a pediatric PWC base and is coded E1239,PWC, pediatric size, not otherwise specified (see OAR 410-122-0720 Pediatric Wheelchairs);

(e) Contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician:

(A) This report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) Why a power-operated vehicle (POV/scooter) can't meet this client's mobility needs in the home;

(v) This client's physical and mental abilities to operate a PWC safely in the home;

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in activities of daily living (ADLs), how these conditions will be ameliorated or compensated by use of the wheelchair;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Each element does not have to be addressed in every evaluation:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or PWC and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a PWC may use that device outside the home, because DMAP's coverage of a wheelchair is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's written order, received by the DMEPOS provider within 45 days (date stamp or equivalent must be used to document receipt date) after the physician's face-to-face examination. The order must include all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "power wheelchair" or "power mobility device"– or may be more specific;

(i) If this order does not identify the specific type of PWC that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific PWC that is being ordered and any options and accessories requested.

(ii) The items on this clarifying order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the

treating physician, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination;

(C) Date of the face-to-face examination;

(D) Pertinent diagnoses/conditions and diagnosis codes that relate specifically to the need for the PWC;

(E) Length of need;

(F) Physician's signature;

(G) Date of physician signature;

(c) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it can't be grown or modified, if applicable;

(e) For the home assessment, prior to or at the time of delivery of a PWC, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters.This assessment must support that the client's home can accommodate and allow for the effective use of a PWC. Assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) A written document (termed a detailed product description) prepared by the DMEPOS provider and signed and dated by the physician that includes:

(i) The specific base (Healthcare Common Procedure Coding System (HCPCS) code and manufacturer name/model) and all options and accessories (including HCPCS codes), whether PA is required or not, that will be separately billed;

(ii) The DMEPOS provider's charge and the DMAP fee schedule allowance for each separately billed item;

(iii) If there is no DMAP fee schedule allowance, the DMEPOS provider must enter "not applicable";

(iv)The DMEPOS provider must receive the signed and dated detailed product description from the physician prior to delivery of the PWC;

(v) A date stamp or equivalent must be used to document receipt date of the detailed product description; and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The DMEPOS provider must keep the above documentation on file;

(i) Documentation that the coverage criteria have been met must be present in the client's medical records and made available to DMAP on request.

(4) Prior Authorization:

(a) All codes in this rule required PA and may be purchased, rented and repaired;

(b) See DMAP's fee schedule for more information;

(c) Codes specified in this rule are not covered for clients residing in nursing facilities;

(d) Rented equipment is considered purchased when the client has used the equipment for 13 months, when the provider's actual charge for purchase is met, when the manufacturer's suggested retail price (MSRP) is met or when DMAP's fee schedule allowable for purchase is met, whichever is the lowest;

(e) For PWC's furnished on a rental basis with dates of services prior to November 15, 2006, use codes K0010, K0011, K0012 and K0014 as appropriate.

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

Stat. Auth.: ORS 409

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Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0330
Power-Operated Vehicle

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a power-operated vehicle (POV) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day:

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;

(E) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the POV being requested;

(F) Use of a POV will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(G) The client is willing to use the requested POV in the home, and the client will use it on a regular basis in the home;

(H) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup POVs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if the POV meets the same need, custom colors, and wheelchair gloves;

(b) For a POV to be covered, the treating physician must conduct a face-to-face examination of the client before writing the order:

(A)The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device.

(B) When this examination is performed during a hospital or nursing home stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(C) The physician may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination:

(i) If the client was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the client and perform any additional examination that is needed. The report of the physician's visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the DMEPOS provider with a copy of both examinations within 45 days after the face-to-face examination with the physician;

(ii) If the physician saw the client to begin the examination before referring the client to a PT/OT, then if the physician sees the client again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician signs and dates the PT/OT examination;

(iii) If the POV is a replacement of a similar item that was previously covered by DMAP or when only POV accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(c) DMAP may authorize a new POV when a client's existing POV is no longer medically appropriate; or repair and/or modifications to the POV exceed replacement costs;

(d) If a client has a medically appropriate POV regardless of payer, DMAP will not reimburse for another POV;

(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.;

(f) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the POV;

(g) If a patient-owned POV meets coverage criteria, medically appropriate replacement items, including but not limited to batteries, may be covered;

(h) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically appropriate;

(i) DMAP will cover one month's rental of a POV if a client-owned POV is being repaired;

(j) The following services are not covered:

(A) POV for use only outside the home; and

(B) POV for a nursing facility client.

(2) Coding Guidelines:

(a) Code E1230 is used only for POVs that can be operated inside the home;

(b) CodesK0800 — K0802 are not used for a manual wheelchair with an add-on tiller control power pack;

(c) A replacement item, including but not limited to replacement batteries, should be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified);

(d) For guidance on correct coding, DMEPOS providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician:

(A) The report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) This client's physical and mental abilities to operate a POV (scooter) safely in the home:

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions will be ameliorated or compensated;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Each element does not have to be addressed in every evaluation:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a POV may use that device outside the home, because DMAP's coverage of a POV is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's written order, received by the DMEPOS provider within 30 days after the physician's face-to-face examination, which includes all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "POV" or "power mobility device" — or may be more specific:

(i) If this order does not identify the specific type of POV that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific POV that is being ordered and any options and accessories requested;

(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination.

(C) Date of the face-to-face examination;

(D) Most significant ICD-9 diagnosis code that relates specifically to the need for the POV;

(E) Length of need;

(F) Physician's signature;

(G) Date of physician signature;

(c) For all requested equipment and accessories, include the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) All Healthcare Common Procedure Coding System codes (HCPCS) to be billed on this claim (both codes that require authorization and those that do not require authorization); and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The above documentation must be kept on file by the DMEPOS provider;

(i) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to DMAP on request.

(4) Billing:

(a) Procedure Codes:

(A) K0800 Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds — PA;

(B) K0801 Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds — PA;

(C) K0802 Power operated vehicle, group 1 very heavy duty, patient weight capacity, 451 to 600 pounds — PA;

(b) DMAP will purchase, rent and repair;

(c) Item considered purchased after 13 months of rent.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0340
Wheelchair Options/Accessories

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover options and accessories for covered wheelchairs when the following criteria are met:

(A) The client has a wheelchair that meets DMAP coverage criteria; and

(B) The client requires the options/accessories to accomplish their mobility-related activities of daily living (MRADLs) in the home. See 410-122-0010 Definitions for definition of MRADLs;

(b) DMAP does not cover options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities;

(c) Arm of Chair:

(A) Adjustable arm height option (E0973, K0017, K0018, K0020) may be covered when the client:

(i) Requires an arm height that is different than what is available using nonadjustable arms; and

(ii) Spends at least two hours per day in the wheelchair;

(B) An arm trough (K0106) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements;

(d) Foot rest/Leg rest:

(A) Elevating leg rests (E0990, K0046, K0047, K0053, K0195) may be covered when:

(i) The client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or

(ii) The client has significant edema of the lower extremities that requires having an elevating leg rest; or

(iii) The client meets the criteria for and has a reclining back on the wheelchair;

(B) Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per leg rest;

(C) Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests;

(e) Nonstandard Seat Frame Dimensions:

(A) For all adult wheelchairs, DMAP includes payment for seat widths and/or seat depths of 15-19 inches in the payment for the base code. These seat dimensions must not be separately billed;

(B) Codes E2201-E2204 and E2340-E2343 describe seat widths and/or depths of 20 inches or more for manual or power wheelchairs;

(C) A nonstandard seat width and/or depth (E2201-E2204 and E2340-E2343) is covered only if the patient's dimensions justify the need;

(f) Rear Wheels for Manual Wheelchairs: Code K0064 (flat free insert) is used to describe either:

(A) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or

(B) Non-removable foam material in a foam filled rubber tire;

(C) K0064 is not used for a solid self-skinning polyurethane tire;

(g) Batteries/Chargers:

(A) Up to two batteries (E2360-E2365) at any one time are allowed if required for a power wheelchair;

(B) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base;

(h) Seating:

(A) DMAP may cover a general use seat cushion and a general-use wheelchair back-cushion for a client whose wheelchair that meets DMAP coverage criteria;

(B) A skin protection seat cushion may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets DMAP coverage criteria; and

(ii) The client has either of the following:

(I) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or

(II) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis), post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease;

(C) A positioning seat cushion, positioning back cushion, and positioning accessory (E0955-E0957, E0960) may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets DMAP coverage criteria; and

(ii) The client has any significant postural asymmetries due to one of the diagnoses listed in criterion (h)(A)(ii)(II) or to one of the following diagnoses: monoplegia of the lower limb; hemiplegia due to stroke, traumatic brain injury, or other etiology; muscular dystrophy; torsion dystonias; spinocerebellar disease;

(D) A combination skin protection and positioning seat cushion may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion;

(E) Separate payment is allowed for a seat cushion solid support base (E2618) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161) or lightweight power wheelchair. There is no separate payment when this is used with other types of power wheelchairs because those wheelchairs include a solid support base;

(F) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion;

(G) There is no separate payment for mounting hardware for a seat or back cushion;

(H) There is no separate payment for a headrest (E0955, E0966) on a captain's seat on a power wheelchair;

(I) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient:

(i) Basic materials include liquid foam or a block of foam and sheets of fabric or liquid coating material:

(I) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately;

(II) The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface;

(ii) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, CAD-CAM technology, or detailed measurements of the patient used to create a configured cushion:

(I) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated;

(II) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion;

(iii) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617;

(J) A custom fabricated seat cushion may be covered if criteria (i) and (iii) are met. A custom fabricated back cushion may be covered if criteria (ii) and (iii) are met:

(i) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;

(ii) Client meets all of the criteria for a prefabricated positioning back cushion;

(iii) There is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs;

(K) A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the Statistical Analysis DME Regional Carrier SADMERC or which does not meet the criteria stated in this rule is not covered;

(L) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest;

(M) The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion;

(N) A solid insert (E0992) is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support and is included in the allowance for a seat cushion;

(O) A solid support base for a seat cushion is a rigid piece of plastic or other material that is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2618 for this solid support base;

(i) DMAP will only cover accessories billed under the following codes when SADMERC has made written confirmation of use of the code for the specific product(s) being billed: E2601-E2608, E2611-

E2616, E2620, E2621; E2609 and E2617 (brand-name products), K0108 (for wheelchair cushions):

(A) Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC Web site or by contacting the SADMERC;

(B) A Product Classification List with products that have received a coding verification can be found on the SADMERC Web site;

(j) Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(k) Power seating systems:

(A) A power-tilt seating system (E1002):

(i) Includes all the following:

(I) A solid seat platform and a solid back; any frame width and depth;

(II) Detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests;

(IV) Fixed or flip-up footplates;

(V) Motor and related electronics with or without variable speed programmability;

(VI) Switch control that is independent of the power wheelchair drive control interface;

(VII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability for the supplier to adjust the seat to back angle;

(IV) Ability to support patient weight of at least 250 pounds.

(B) A power recline seating system (E1003-E1005):

(i) Includes all the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth;

(III) Detachable or flip-up fixed height or adjustable height arm rests;

(IV) Fixed or swingaway detachable leg rests;

(V) Fixed or flip-up footplates;

(VI) A motor and related electronics with or without variable speed programmability;

(VII) A switch control that is independent of the power wheelchair drive control interface;

(VIII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to recline to greater than or equal to 150 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability to support patient weight of at least 250 pounds.

(C) A power tilt and recline seating system (E1006-E1008):

(i) Includes the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests; fixed or flip-up footplates;

(IV) Two motors and related electronics with or without variable speed programmability;

(V) Switch control that is independent of the power wheelchair drive control interface;

(VI) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Ability to recline to greater than or equal to 150 degrees from horizontal;

(III) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

(D) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises, a mechanical linkage between the two panels allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(E) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises, a separate motor controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(F) A power leg elevation feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s);

(l) Codes E2310 and E2311 (Power Wheelchair Accessory):

(A) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or non-proportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing;

(B) Include a function selection switch that allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected;

(C) When the wheelchair drive function is selected the indicator feature may also show the direction that is selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface;

(D) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present);

(E) When a switch is medically appropriate and a client has adequate hand motor skills, a switch would be considered the least costly alternative;

(F) E2310 or E2311 may be considered for coverage when a client does not have hand motor skills or presents with cognitive deficits, contractures or limitation of movement patterns that prevents operation of a switch;

(G) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick);

(H) If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it is not covered.

(m) Power Wheelchair Drive Control Systems:

(A) The term interface in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc.;

(B) A proportional interface is one in which the direction and amount of movement by the client controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick;

(C) A non-proportional interface is one that involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a non-proportional interface is a sip-and-puff mechanism;

(D) The term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface) and convert that input into power output to the motor and gears in the power wheelchair base;

(E) A switch is an electronic device that turns power to a particular function either "on" or "off". The external component of a switch may be either mechanical or non-mechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of non-mechanical switches include, but are not limited to, proximity, infrared, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component;

(F) A stop switch allows for an emergency stop when a wheelchair with a non-proportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch is sometimes referred to as a kill switch;

(G) A direction change switch allows the client to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time;

(H) A function selection switch allows the client to determine what operation is being controlled by the interface at any particular time. Operations may include, but are not limited to, drive forward, drive backward, tilt forward, recline backward, etc.;

(I) An integrated proportional joystick and controller is an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair;

(J) The interfaces described by codes E2320-E2322, E2325, and E2327-E2330 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking;

(K) A remote joystick (E2320, E2321) is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. These codes include remote joysticks that are used for hand control as well as joysticks that are used for chin control. Code E2320 includes any type of proportional remote joystick stick including, but not limited to standard, mini-proportional, compact, and short throw remote joysticks;

(L) When code E2320 or E2321 is used for a chin control interface, the chin cup is billed separately with code E2324;

(M) Code E2320 also describes a touchpad that is an interface similar to the pad-type mouse found on portable computers;

(N) Code E2322 describes a system of 3-5 mechanical switches that are activated by the client touching the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch, if provided, are included in the allowance for the code;

(O) Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick — e.g., U shape or T shape — or that have some other nonstandard feature — e.g., flexible shaft;

(P) A sip and puff interface (E2325) is a non-proportional interface in which the client holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit that is described by code E2326;

(Q) A proportional, mechanical head control interface (E2327) is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the client's head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code;

(R) A proportional, electronic head control interface (E2328) is one in which a client's head movements are sensed by a box placed behind the client's head. The direction and amount of movement of the client's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the client's arm or leg control the direction and speed of the wheelchair;

(S) A non-proportional, contact switch head control interface (E2329) is one in which a client activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(T) A non-proportional, proximity switch head control interface (E2330) is one in which a client activates one of three switches placed around the back and sides of their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(U) Code E2399 (not otherwise classified interface) is appropriately used in the following situations:

(i) An integrated proportional joystick and controller box are being replaced due to damage; or

(ii) The item being replaced is a remote joystick box only (without the controller); or

(iii) The item being replaced is another type of interface, e.g. sip and puff, head control without the controller); or

(iv) The item being replaced is the controller box only (without the remote joystick or other type of interface); or

(v) There is no specific E code that describes the type of drive control interface system that is provided. In this situation, E2399 would be used at the time of initial issue or if the item was being provided as a replacement;

(V) The KC modifier (replacement of special power wheelchair interface):

(i) Is used in the following situations:

(I) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface — e.g., remote joystick, head control, sip and puff, etc.; or

(II) The client has a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage;

(ii) The KC modifier is never used at the time of initial issue of a wheelchair;

(iii) The KC modifier specifically states replacement, therefore, the RP modifier is not required. The KC modifier is not used when billing code E2399;

(n) Other Power Wheelchair Accessories: An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface may be covered if the client has a covered speech generating device. (See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services.);

(o) Miscellaneous Accessories:

(A) Anti-rollback device (E0974) is covered if the client propels himself/herself and needs the device because of ramps;

(B) A safety belt/pelvic strap (E0978) is covered if the client has weak upper body muscles, upper body instability or muscle spasticity that requires use of this item for proper positioning;

(C) A shoulder harness/straps or chest strap (E0960) and a safety belt/pelvic strap (E0978) are covered only to treat a client's medical symptoms:

(i) A medical symptom is defined as an indication or characteristic of a physical or psychological condition;

(ii) E0960 and E0978 are not covered when intended for use as a physical restraint or for purposes intended for discipline or convenience of others;

(D) One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028) would be to move the component out of the way so that a client could perform a slide transfer to a chair or bed;

(E) A fully reclining back option (E1226) is covered if the client spends at least 2 hours per day in the wheelchair and has one or more of the following conditions/needs:

(i) Quadriplegia;

(ii) Fixed hip angle;

(iii) Trunk or lower extremity casts/braces that require the reclining back feature for positioning;

(iv) Excess extensor tone of the trunk muscles; and/or

(v) The need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(2) Documentation Requirements: Submit documentation that supports coverage criteria in this rule are met and the specified information as follows with the prior authorization (PA) request:

(a) A Certificate of Medical Necessity (CMN) for E0973, E0990, K0017, K0018, K0020, E1226, K0046, K0047, K0053, and K0195. For these items, the CMN may act as a substitute for a written order if it contains all of the required elements of an order. Depending on the type of wheelchair, the CMN for these options/accessories is either CMS Form 843 (power wheelchairs) or CMS Form 844 (manual wheelchairs);

(b) When code K0108 is billed, a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical appropriateness for the item;

(c) Options/accessories for individual consideration might include documentation on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment;

(d) For a custom-fabricated seat cushion:

(A) A comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a DMEPOS provider)

which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs, and;

(B) Diagnostic reports that support the medical condition;

(C) Dated and clear photographs;

(D) Body contour measurements;

(e) Documentation that the coverage criteria in this rule have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to DMAP on request.

(3) **Table 122-0340**.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0360

Canes and Crutches

(1) Indications and Coverage: When prescribed by a practitioner for a client with a condition causing impaired ambulation and there is a potential for ambulation.

(2) A white cane for a visually impaired client is considered to be a self-help item and is not covered by the Division of Medical Assistance Programs (DMAP).

(3) Table 122-0360.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0365

Standing and Positioning Aids

(1) Indications and coverage: If a client has one aid that meets his/her medical needs, regardless of who obtained it, the Division of Medical Assistance Programs (DMAP) will not provide another aid of same or similar function.

(2) Documentation to be submitted for prior authorization (PA) and kept on file by the Durable Medical Equipment (DME) provider:

(a) Documentation of medical appropriateness, which has been reviewed and signed by the prescribing practitioner;

(b) The care plan outlining positioning and treatment regime, and all DME currently available for use by the client;

(c) The physician's order;

(d) The documentation for customized positioner must include objective evidence that commercially available positioners are not appropriate;

(e) Each item requested must be itemized with description of product, make, model number, and manufacturers suggested retail price (MSRP);

(f) Submit Positioner Justification form (DMAP 3155) or reasonable facsimile, with recommendation for most appropriate equipment. This must be submitted by physical therapist, occupational therapist, or prescribing practitioner when requesting a PA;

(3) Gait Belts:

(a) Covered when:

(A) The client weighs 60 lbs. or more; and

(B) The care provider is trained in the proper use; and

(C) The client can walk independently, but needs:

(i) A minor correction of ambulation; or

(ii) Needs minimal or standby assistance to walk alone; or

(iii) Requires assistance with transfer;

(b) Use code E0700.

(4) Standing frame systems, prone standers, supine standers or boards and accessories for standing frames are covered when:

(a) The client has been sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and,

(b) The client is following a therapy program initially established by a physical or occupational therapist; and

(c) The home is able to accommodate the equipment; and

(d) The weight of the client does not exceed manufacturer's weight capacity; and

(e) The client has demonstrated an ability to utilize the standing aid independently or with caregiver; and

(f) The client has demonstrated compliance with other programs; and

(g) The client has demonstrated a successful trial period in a monitored setting; and

(h) The client does not have access to equipment from another source.

(5) Sidelyers and custom positioners must meet the following criteria in addition to the criteria in Table 122-0365:

(a) The client must be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and

(b) The client must be following a therapy program initially established by a physical or occupational therapist; and,(c) The home must be able to accommodate the equipment; and

(d) The caregiver and/or family are capable of using the equipment appropriately.

(6) Criteria for Specific Accessories:

(a) A back support may be covered when a client:

(A) Needs for balance, stability, or positioning assistance; or

(B) Has extensor tone of the trunk muscles; or

(C) Needs for support while being raised or while completely standing;

(b) A tall back may be covered when:

(A) The client is over 5'11" tall; and

(B) The client has no trunk control and needs additional support; or

(C) The client has more involved need for assistance with balance, stability, or positioning;

(c) Hip guides may be covered when a client:

(A) Lacks motor control and/or strength to center hips; or

(B) Has asymmetrical tone which causes hips to pull to one side; or

(C) Has spasticity; or

(D) Has low tone or high tone; or

(E) Need for balance, stability, or positioning assistance;

(d) A shoulder retractor or harness may be covered when:

(A) Erect posture cannot be maintained without support due to lack of motor control or strength; or

(B) Has kyphosis; or

(C) Presents strong flexor tone;

(e) Lateral supports may be covered when a client:

(A) Lacks trunk control to maintain lateral stability; or

(B) Has scoliosis which requires support; or

(C) Needs a guide to find midline;

(f) A headrest may be covered when a client:

(A) Lacks head control and cannot hold head up without support; or

(B) Has strong extensor thrust pattern that requires inhibition;

(g) Independent adjustable knee pads may be covered when a client:

(A) Has severe leg length discrepancy; or

(B) Has contractures in one leg greater than the other;

(h) An actuator handle extension may be covered when a client:

(A) Has no caregiver; and

(B) Is able to transfer independently into standing frame; and

(C) Has limited range of motion in arm and/or shoulder and cannot reach actuator in some positions;

(i) Arm troughs may be covered when a client:

(A) Has increased tone which pulls arms backward so hands cannot come to midline; or

(B) Has poor tone, strength, or control is so poor that causes arms to hang out to side and backward, causing pain and risking injury; or

(C) Needs for posture;

(j) A tray may be covered when proper positioning cannot be accomplished by other accessories;

(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;

(l) Sandals (shoe holders) may be covered when a client:

(A) Has dorsiflexion of the foot or feet; or

(B) Has planar flexion of the foot or feet or

(C) Has eversion of the foot or feet; or

(D) Needs for safety.

(7) Table 122-0365.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0375
Walkers

(1) Indications and Limitations of Coverage:

(a) A standard walker (E0130, E0135, E0141, E0143) and related accessories are covered if both of the following criteria are met:

(A) When prescribed by a treating practitioner for a client with a medical condition impairing ambulation and there is a potential for increasing ambulation; and

(B) When there is a need for greater stability and security than provided by a cane or crutches;

(b) For an adult gait trainer, use the appropriate walker code. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157), that code may be separately billed;

(c) A heavy duty walker (E0148, E0149) is covered for clients who meet coverage criteria for a standard walker and who weigh more than 300 pounds;

(d) A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for clients who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand;

(e) When a walker with an enclosed frame (E0144) is dispensed to a client, documentation must support why a standard folding wheeled walker, E0143, was not provided as the least costly medically appropriate alternative;

(f) Enhancement accessories of walkers are noncovered;

(g) Leg extensions (E0158) are covered only for patients six feet tall or more.

(2) Coding Guidelines:

(a) A wheeled walker (E0141, E0143, E0149) is one with either two, three or four wheels. It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel;

(b) A glide-type brake consists of a spring mechanism (or equivalent) which raises the leg post of the walker off the ground when the patient is not pushing down on the frame;

(c) Code E0144 describes a folding wheeled walker which has a frame that completely surrounds the patient and an attached seat in the back;

(d) A heavy duty walker (E0148, E0149) is one which is labeled as capable of supporting patients who weigh more than 300 pounds. It may be fixed height or adjustable height. It may be rigid or folding;

(e) Code E0147 describes a 4-wheeled, adjustable height, folding-walker that has all of the following characteristics:

(A) Capable of supporting patients who weigh greater than 350 pounds;

(B) Hand operated brakes that cause the wheels to lock when the hand levers are released;

(C) The hand brakes can be set so that either or both can lock both wheels;

(D) The pressure required to operate each hand brake is individually adjustable;

(E) There is an additional braking mechanism on the front crossbar;

(F) At least two wheels have brakes that can be independently set through tension adjustability to give varying resistance;

(f) The only walkers that may be billed using code E0147 are those products listed in the Product Classification List on the SADMERC web site;

(g) An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes (other than those described in code E0147), or basket (or equivalent);

(h) A4636, A4637, and E0159 are only used to bill for replacement items for covered, patient-owned walkers. Codes E0154, E0156, E0157, and E0158 can be used for accessories provided with the initial issue of a walker or for replacement components. Code E0155 can be used for replacements on covered, patient-owned wheeled walkers or when wheels are subsequently added to a covered, patient-owned nonwheeled walker (E0130, E0135). Code E0155 cannot be used for wheels provided at the time of, or within one month of, the initial issue of a nonwheeled walker;

(i) Hemi-walkers must be billed using code E0130 or E0135, not E1399;

(j) A gait trainer is a term used to describe certain devices that are used to support a client during ambulation;

(k) Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code:

(l) **Table 122-0375-1**.

(m) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(3) Documentation: An order for each item billed must be signed and dated by the treating practitioner, kept on file by the DMEPOS provider, and made available to the Division of Medical Assistance Programs (DMAP) upon request. The treating practitioner's records must contain information that supports the medical appropriateness of the item ordered, including height and weight.

(4) **Table 122-0375-2**.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0380
Hospital Beds

(1) Definitions:

(a) Fixed Height Hospital Bed — A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment;

(b) Variable Height Hospital Bed — A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments;

(c) Semi-Electric Hospital Bed — A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

(2) Hospital Bed Criterion:

(a) 1 – Client requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last at least one month;

(b) 2 — Client requires, for alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;

(c) 3 — Client 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;

(d) 4 — Client requires traction equipment that can only be attached to a hospital bed;

(e) 5 — Client's level of functioning can only be met with a hospital bed.

(f) 6 — Client is capable of operating the controls;

(g) 7 — Client requires frequent changes in body position and/or has an immediate need for a change in body position;

(h) 8 — Client 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;

(i) 9 — Client weighs more than 350 pounds.

(3) Indications and coverage:

(a) Fixed Height Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5.

(b) Variable Height Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5 and 8.

(c) Semi-Electric Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5, 6, and 7;

(d) Heavy-Duty and Extra Heavy-Duty Hospital Beds are covered when the client meets criterion:

(A) 1, 2, 3, or 4, and;

(B) 5, 6, 7, and 9.

(4) Payment Authorization: Subject to service limitations of the Division of Medical Assistance Programs (DMAP) rules, from the initial date of service through the second date of service, a hospital bed rental may be dispensed without prior authorization. The provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting claims and will be given once all required documentation has been received and any other applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040. All subsequent services starting with the third date of service require prior authorization.

(5) Documentation:

(a) Documentation of medical appropriateness that has been reviewed and signed by the prescribing practitioner must be submitted with the request for prior authorization (PA) and kept on file by the DME provider;

(b) Document the number of hours spent in bed, the type of bed currently used by the client and why it doesn't meet the needs of the client;

(c) In addition to the above documentation requirements, you must document:

(A) The reasons why a variable height bed does not meet the needs of the client when requesting PA for semi-electric hospital beds, and;

(B) The client's height and weight when requesting PA for Heavy-Duty and Extra Heavy-Duty hospital beds.

(5) Procedure Codes — Table 122-0380.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0400

Pressure Reducing Support Surfaces

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Group 1 (A4640, E0180-E0182, E0184-E0189, and E0196-E0199):

(A) The Division of Medical Assistance Programs (DMAP) may cover a Group 1 support surface when the client meets:

(i) Criterion (I), or;

(ii) Criteria (II) or (III) and at least one of criteria (IV)-(VII):

(I) Completely immobile — i.e., client cannot make changes in body position without assistance;

(II) Limited mobility — i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(III) Any stage pressure ulcer on the trunk or pelvis;

(IV) Impaired nutritional status;

(V) Fecal or urinary incontinence;

(VI) Altered sensory perception;

(VII) Compromised circulatory status;

(B) The DMEPOS provider must provide a support surface in which the client does not "bottom out";

(C) DMAP does not cover foam overlays or mattresses without a waterproof cover, since these are not considered durable;

(D) DMAP does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(E) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(b) Group 2 (E0193, E0277, and E0371-E0373):

(A) A Group 2 support surface may be covered for up to an initial three month rental period when the client meets:

(i) Criterion (I) and (II) and (III); or

(ii) Criterion (IV); or

(iii) Criterion (V) and (VI);

(I) Multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 -707.05);

(II) Client has been on a comprehensive ulcer treatment program for at least the past month which includes the following: use of an appropriate Group 1 support surface; education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer); appropriate turning and positioning; appropriate wound care (for a stage II, III, or IV ulcer); appropriate management of moisture/incontinence; and nutritional assessment and intervention consistent with the overall plan of care;

(III) The ulcers have worsened or remained the same over the past month;

(IV) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05); A large wound is generally any wound of eight square centimeters (length x width) or more. Individual client circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the client may be taken into account;

(V) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 — 707.05);

(VI) The client has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days);

(B) The DMEPOS provider must provide a support surface in which the patient does not "bottom out";

(C) When a Group 2 surface is requested following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery;

(D) DMAP may cover continued use of a Group 2 support surface if healing continues;

(E) DMAP does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(F) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(c) DMAP may consider coverage for bariatric pressure reducing support surfaces only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility, subject to service limitations of DMAP rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric pressure reducing support surface has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(d) Group 3: Air-fluidized beds (E0194) are not covered.

(2) Definitions for Group 1 and Group 2:

(a) Bottoming out: Finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position;

(b) Plan of care: Written guidelines developed to identify specific problems and needs of the client and interventions/regimen necessary to assist the client to achieve optimal health potential. Developing the plan of care includes establishing measurable client and nursing goals with time lines and determining nursing/caregiver/other discipline-assigned interventions to meet care objectives;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers;

(3) Guidelines:

(a) Group 1:

(A) Codes E0185 and E0197-E0199 termed "pressure pad for mattress" describe nonpowered pressure reducing mattress overlays and are designed to be placed on top of a standard hospital or home mattress;

(B) A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of two inches or greater;

(C) An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump;

(D) A water mattress overlay (E0198) is characterized by a filled height of three inches or greater;

(E) A foam mattress overlay (E0199) is characterized by all of the following:

(i) Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a non-convoluted overlay; and

(ii) Foam with a density and other qualities that provide adequate pressure reduction; and

(iii) Durable, waterproof cover;

(F) Codes E0184, E0186, E0187 and E0196 describe nonpowered pressure reducing mattresses;

(G) A foam mattress (E0184) is characterized by all of the following:

(i) Foam height of five inches or greater;

(ii Foam with a density and other qualities that provide adequate pressure reduction;

(iii) Durable, waterproof cover; and

(iv) Can be placed directly on a hospital bed frame;

(H) An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

(i) Height of five inches or greater of the air, water, or gel layer (respectively);

(ii) Durable, waterproof cover; and

(iii) Can be placed directly on a hospital bed frame;

(I) Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss) and are characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 2 1/2 inches or greater; and

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out;

(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640;

(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a client-owned E0180 or E0181 mattress overlay system;

(L) A Column II code is included in the allowance for the corresponding Column I code when provided at the same time:Column I (Column II), E0180 (A4640, E0182), E0181 (A4640, E0182);

(b) Group 2:

(A) Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

(a) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress

(b) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(c) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(d) A surface designed to reduce friction and shear; and

(e) Can be placed directly on a hospital bed frame;

(B) Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above;

(C) Code E0371 describes an advanced non-powered pressure-reducing mattress overlay which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;

(ii) Total height of three inches or greater;

(iii) A surface designed to reduce friction and shear; and

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces;

(D) Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 3 1/2 inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear;

(E) Code E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;

(ii) Total height of five inches or greater;

(iii) A surface designed to reduce friction and shear;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces; and

(v) Can be placed directly on a hospital bed frame;

(F) The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by the statistical analysis durable medical equipment carrier (SADMERC);

(G) Alternating pressure mattresses and low air loss mattresses are coded using code E0277;

(H) Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with three powered air cells on top of a three foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

(3) Documentation Requirements: For all pressure reducing support surfaces, other than a Group 2 surface following a myocutaneous flap or skin graft, submit the following information with the prior authorization request:

(a) Initial Request:

(A) An order for each item requested, signed and dated by the attending physician;

(B) Documentation that supports conditions of coverage are met as specified in this rule;

(C) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following:

(i) Education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;

(ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner

(iii) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(iv) Appropriate wound care (for a stage II, III, or IV ulcer);

(v) Appropriate management of moisture/incontinence;

(vi) Nutritional assessment and intervention consistent with the overall plan of care by a licensed healthcare practitioner (by a registered dietitian for a client in a nursing facility) within the last 90 days;

(vii) Client's weight and height (approximation is acceptable, if unable to obtain);

(viii) Description of all pressure ulcers, which includes:

(I) Number;

(II) Locations;

(III) Stages;

(IV) Sizes;

(V) Dated photographs;

(ix) Lab reports, if relevant;

(x) Other treatments and products that have been tried and why they were ineffective; Interventions and goals for stepping down the intensity of support surface therapy;

(xi) For pressure ulcers on extremities, why pressure cannot be relieved by other methods;

(D) For a Group 2 surface following a myocutaneous flap or skin graft only, submit the following information with the prior authorization request:

(i) An order for each item requested, signed and dated by the treating physician;

(ii) Operative report;

(iii) Hospital discharge summary;

(iv) Plan of care;

(E) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or anyone in a financial relationship of any kind with the DMEPOS provider;

(F) Medical records must corroborate that all criteria in this rule are met when dispensing and billing for an item in **Table 122-0400-1** and **Table-122-400-2**;

(G) Medical records must be kept on file by the DMEPOS provider and made available to DMAP upon request;

(b) Subsequent Request: May be authorized contingent on progress towards healing: For all pressure reducing support surfaces, other than a Group 2 surface following a myocutaneous flap or skin graft, submit the following information with the prior authorization request:

(i) Progress notes from the attending physician;

(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare practitioner (by the RN resident care manager for a client in a nursing facility) which includes:

(I) Number;

(II) Locations;

(III) Stages;

(IV) Sizes;

(V) Dated photographs;

(iii) Current plan of care;

(iv) Any other relevant documentation;

(v) For a Group 2 surface following a myocutaneous flap or skin graft only, submit the following information with the prior authorization request:

(I) Progress notes from the attending physician;

(II) Current plan of care;

(III) Any other relevant documentation.

(4) **Table 122-0400-1** — Group 1.

(5) **Table 122-0400-2** — Group 2.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0420
Hospital Bed Accessories

(1) **Table 122-0420**.

(2) Trapeze Bars:

(a) Indications and Coverage: Trapeze bars are indicated when a client needs this device to sit up because of respiratory condition, to change body position for other medical reasons, or to get in or out of bed;

(b) The Division of Medical Assistance Programs (DMAP) may consider coverage for bariatric trapeze bars only coded as E1399 (durable medical equipment, miscellaneous) for a client residing in a nursing facility), subject to service limitations of DMAP rules, only when the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric trapeze bar has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC);

(C) Supporting documentation has been submitted to the appropriate authorizing authority for prior authorization;

(c) Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner must be kept on file by the DME provider;

(c) See **Table 122-0420** for procedure codes.

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

Stat. Auth.: ORS 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; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0475
Therapeutic Shoes for Diabetics

(1) Indications and Coverage:

(a) For each client, coverage of the footwear and inserts is limited to one of the following within one calendar year:

(A) One pair of custom — molded shoes (including inserts provided with such shoes) and two additional pair of inserts; or

(B) One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts.

(b) An individual may substitute modification(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:

(A) Rigid rocker bottoms;

(B) Roller bottoms;

(C) Metatarsal bars;

(D) Wedges;

(E) Offset heels.

(c) Payment for any expenses for the fitting of such footwear is included in the fee;

(d) Payment for the certification of the need for therapeutic shoes and for the prescription of the shoes (by a different practitioner from the one who certifies the need for the shoes) is considered to be included in the visit or consultation in which these services are provided;

(e) Following certification by the physician managing the client's systemic diabetic condition, a podiatrist or other qualified practitioner, knowledgeable in the fitting of the therapeutic shoes and inserts, may prescribe the particular type of footwear necessary.

(2) Documentation:

(a) The practitioner who is managing the individual's systemic diabetic condition documents that the client has diabetes and one or more of the following conditions:

(A) Previous amputation of the other foot, or part of either foot;

(B) History of previous foot ulceration of either foot;

(C) History of pre-ulcerative calluses of either foot;

(D) Peripheral neuropathy with evidence of callus formation of either foot;

(E) Foot deformity of either foot; or

(F) Poor circulation in either foot; and

(G) Certifies that the client is being treated under a comprehensive plan of care for his or her diabetes and that he or she needs therapeutic shoes.

(b) Documentation of the above criteria, may be completed by the prescribing practitioner or supplier but must be reviewed for accuracy of the information and signed and dated by the certifying physician to indicate agreement and must be kept on file by the DME supplier.

(3) **Table 122-0475.**

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05

410-122-0480
Pneumatic Compression Devices (Used for Lymphedema)

(1) A pneumatic compression device (lymphedema pump) is medically appropriate only for the treatment of refractory lymphedema involving one or more limbs.

(2) Causes of lymphedema include but are not limited to the following conditions with a diagnosis on the currently funded lines of the Prioritized List of Health Services:

(a) Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;

(b) Radical surgical procedures with removal of regional groups of lymph nodes;

(c) Post-radiation fibrosis;

(d) Scarring of lymphatic channels (e.g., those with generalized refractory edema from venous insufficiency 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);

(B) The client has received repeated, standard treatment from a practitioner using such methods as a compression bandage system or its equivalent;

(C) The ulcer(s) have failed to heal after six months of continuous treatment.

(e) Congenital anomalies.

(3) Pneumatic compression devices may be covered only when prescribed by a practitioner and when they are used with appropriate practitioner oversight, i.e., practitioner evaluation for the client's condition to determine medical appropriateness of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment. Used as treatment of last resort.

(4) All pressure devices require a one-month trial period prior to purchase. The rental period is applied toward purchase.

(5) All necessary training to utilize a pressure device is included in rental or purchase fee.

(6) Documentation:

(a) The practitioner must document the client's condition, medical appropriateness and instruction as to the pressure to be used, the frequency and duration of use and that the device is achieving the purpose of reduction and control of lymphedema;

(b) The determination by the practitioner of the medical appropriateness of pneumatic compression device must include:

(A) The client'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 client (or caregiver) to apply the device for continued use in the home.

(c) Documentation of medical appropriateness 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 appropriateness 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 client has been treated with regular compression bandaging for the past six months;

(D) Whether the client has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results of the treatment;

(E) Other treatment for the venous stasis ulcer(s) during the past six months;

(F) Whether the client has been seen regularly by a practitioner for treatment of venous stasis ulcer(s) during the past six months.

(7) Procedure Codes — Table 122-0480.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0500

Transcutaneous Electrical Nerve Stimulator (TENS)

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) is a device which utilizes electrical current delivered through electrodes placed on the surface of the skin. A TENS unit decreases the client's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves.

(2) A TENS unit may be covered for the treatment of:

(a) Acute post-operative pain:

(A) Coverage is usually limited to 30 days from the day of surgery; and,

(B) Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the attending physician; and,

(C) Payment is made only as a rental; and

(D) Acute pain (less than three months duration) other than post-operative pain is not covered; or

(b) Chronic, intractable pain:

(A) The pain has been present for at least three months; and,

(B) Other appropriate treatment modalities have been tried and failed; and

(C) The presumed etiology of the pain is a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be medically appropriate are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain; and,

(D) The TENS unit must be used by the client on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period is paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain;

(E) For coverage of a purchase, the physician must determine that the client is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the client at the end of the trial period, must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.

(2) Documentation Requirements: Submit the following documentation from the attending or consulting physician with the prior authorization (PA) request:

(a) For both acute post-operative pain and chronic, intractable pain:

(A) A signed and dated order by the treating physician. The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit; and,

(B) Documentation of multiple medications and/or therapies that have been tried and failed; and,

(C) A new order, when purchase is requested (after the required trial period). The initial date on this order must not overlap the dates of the trial period.

(b) In addition, for a client with acute post-operative pain: date of surgery resulting in acute post-operative pain;

(c) In addition, for a client with chronic, intractable pain: location of the pain, the duration of time the client has had the pain, and the presumed etiology of the pain;

(d) For authorization of quantities of supplies greater than those described in this policy as the usual maximum amounts:

(A) Each request must include documentation supporting the medical appropriateness for the higher utilization; and,

(B) There must be clear documentation in the client's medical records corroborating the medical appropriateness of this amount.

(e) When ordering a 4 lead TENS unit, the client's medical record must document why 2 leads are insufficient to meet the client's needs;

(f) The Division of Medical Assistance Programs (DMAP) may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities requested.

(3) Rental Guidelines: During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc.

(4) Purchase Guidelines: If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.

(5) Coding Guidelines:

(a) Separate allowance may be made for replacement supplies when they are medically appropriate and are used with a TENS unit that has been purchased and/or approved by DMAP;

(b) If 2 TENS leads are medically appropriate, then a maximum of one unit of Code A4595 would be allowed per month; if 4 TENS leads are necessary, a maximum of two units per month would be allowed;

(c) If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally;

(d) There is no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit;

(e) Codes A4556 (Electrodes, per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically appropriate TENS owned by the client) are not valid for prior authorization. A4595 should be used instead;

(f) For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service;

(g) Replacement of lead wires (A4557) will be covered when they are inoperative due to damage and the TENS unit is still medically appropriate. Replacement more often than every 12 months is rarely medically appropriate;

(h) A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used);

(i) Other supplies, including but not limited to the following, are not separately payable: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

(j) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(k) **Table 122-0500**.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0510
Osteogenesis Stimulator

(1) Definitions:

(a) An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair.

(b) A noninvasive electrical stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

(c) An ultrasonic osteogenesis stimulator is a noninvasive device that emits low intensity, pulsed ultrasound signals to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via conductive coupling gel to stimulate fracture healing;

(2) Indications of Coverage and Medical Appropriateness:

(a) Nonspinal Electrical Osteogenesis Stimulator:

(A) The Division of Medical Assistance Programs (DMAP) may cover a non-spinal electrical osteogenesis stimulator (E0747) when any of the following criteria are met:

(i) Non-union of a long bone fracture (defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenenisis stimulator);

(ii) Failed fusion of a joint other than in the spine, where a minimum of nine months has elapsed since the last surgery;

(iii) Congenital pseudarthrosis;

(B) Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;

(C) A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal or metatarsal.

(b) Spinal Electrical Osteogenesis Stimulator:

(A) DMAP may cover a spinal electrical osteogenesis stimulator (E0748) when any of the following criteria are met:

(i) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery;

(ii) Following a multilevel spinal fusion surgery;

(iii) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site;

(B) A multilevel spinal fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.);

(c) Ultrasonic Osteogenesis Stimulator:

(A) DMAP may cover an ultrasonic osteogenesis stimulator (E0760) only when all of the following criteria are met:

(i) Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and

(ii) The stimulator is intended for use prior to surgical intervention and with cast immobilization;

(B) Use of an ultrasonic osteogenic stimulator is not covered:

(i) For non-union fractures of the skull or vertebrae;

(ii) For tumor-related fractures;

(iii) For the treatment of a fresh fracture or delayed union; or

(iv) When used concurrently with other noninvasive osteogenic devices;

(C) DMAP may cover ultrasonic conductive coupling gel as a separate service when an ultrasonic osteogenesis stimulator is covered.

(2) Coding Guidelines: Use E1399 for ultrasonic conductive coupling gel.

(3) Documentation Requirements:

(a) Submit the following with the prior authorization (PA) request:

(A) Documentation that supports the coverage criteria specified in this rule for the stimulator requested are met;

(B) Copies of x-ray and operative reports;

(b) For an electrical osteogenic stimulator, a Certificate of Medical Necessity (CMN) which has been completed, signed and dated by the treating physician may substitute for a written order if it contains all the required elements of an order;

(c) Additional medical records may be requested by DMAP;

(d) The client's medical records must reflect the need for the stimulator requested. The client's medical records include, but are not limited to, the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test/diagnostic reports.

(4) Table 122-0510.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0515
Neuromuscular Electrical Stimulator (NMES)

Indications and Limitations of Coverage and Medical Appropriateness:

(1) A neuromuscular electrical stimulator (NMES) uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two broad categories of NMES.

(2) NMES for Treatment of Muscle Atrophy.

(3) NMES devices in this category stimulate the muscle when the client is in a resting state to treat muscle atrophy.

(4) The Division of Medical Assistance Programs (DMAP) will cover NMES to treat muscle atrophy specific to disuse atrophy where nerve supply to the muscle is intact (including brain, spinal cord and peripheral nerves) and to treat other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contrac-

ture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).

(5) NMES to Enhance Functional Activity of Neurologically Impaired Clients: Specifically, DMAP will cover NMES used to improve the ability to walk in clients with Spinal Cord Injury (SCI).

(6) This type of NMES is commonly referred to as functional electrical stimulation (FES). FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

(7) DMAP will only cover NMES/FES for SCI clients for walking, who meet the following criteria:

(a) Client has completed at least 32 physical therapy sessions, directly performed one-on-one with the physical therapist with the NMES/FES device over a trial period of three months, with the specific goal of using the NMES/FES device to achieve walking, not to reverse or retard muscle atrophy;

(b) Therapists with the sufficient skills to provide these services are only employed at inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities;

(c) The physician treating the client for SCI will use this trial period to properly evaluate the person's ability to use the NMES/FES frequently and for the long term; and

(d) The client meets all of the following characteristics:

(e) Intact lower motor units (L1 and below) (both muscle and peripheral nerve);

(f) Muscle and joint stability for weight bearing at upper and lower extremities that demonstrates balance and control to maintain an upright support posture independently;

(g) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction;

(h) High motivation, commitment and cognitive ability to use NMES/FES devices for walking;

(i) Can transfer independently and demonstrates independent standing tolerance for at least three minutes;

(j) Demonstrated hand and finger function to manipulate controls;

(k) At least six-month post recovery spinal cord injury and restorative surgery;

(l) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

(m) Demonstrated willingness to use the device long-term;

(n) NMES/FES for walking is not covered in an SCI client with any of the following:

(A) Cardiac pacemaker;

(B) Severe scoliosis or severe osteoporosis;

(C) Skin disease or cancer at area of stimulation;

(D) Irreversible contracture;

(E) Autonomic dysflexia; or

(F) Treatment of muscle weakness due to the following conditions (not all-inclusive):

(i) Stroke; spinal cord injury; peripheral nerve injury; other central nervous system, spinal or peripheral nerve disease/condition affecting motor and/or sensory pathways to/from the muscles being stimulated;

(ii) Documentation Requirements: Submit documentation that supports coverage criteria as specified in this rule are met.

(8) Procedure Codes:

(a) A4595, Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES) — Includes all supplies necessary for the effective use of the device — DMAP will purchase — Prior authorization (PA) required;

(b) E0745, Neuromuscular stimulator, electronic shock unit — DMAP will rent — Purchased after no more than 13 months of rental — PA required.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0520
Glucose Monitors and Diabetic Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover medically appropriate diabetic supplies including home blood glucose monitors for clients with diabetes, including gestational diabetes who can better control their blood glucose levels by checking them and contacting their treating practitioner for advice and treatment, as appropriate;

(b) Coverage of home blood glucose monitors is limited to clients meeting all of the following conditions:

(A) The client has diabetes which is being treated by a practitioner; and

(B) The glucose monitor and related accessories and supplies have been ordered by a practitioner who is treating the client's diabetes; and

(C) The client or caregiver has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and

(D) The client or caregiver is capable of using the test results to assure the client's appropriate glycemic control; and

(E) The device is designed for home use;

(c) A home blood glucose monitor with special features (E2100 or E2101) may be covered for clients who meet the basic coverage criteria (1)(b)(A)-(E) of this rule; and:

(A) For code E2100, the treating practitioner certifies that the client has a severe visual impairment (i.e., best corrected visual acuity of 20/200 or worse) requiring use of this special monitoring system; or

(B) For code E2101, the treating practitioner certifies that the client has an impairment of manual dexterity severe enough to require the use of this special monitoring system. Coverage of E2101 for a client with manual dexterity impairments is not dependent upon a visual impairment;

(d) If a glucose monitor is covered, lancets (A4259), blood glucose test reagent strips (A4253), glucose control solutions (A4256), and spring powered devices for lancets (A4258) may also be covered. Coverage limitations for these supplies are as follows:

(A) A4258 — only one spring powered device every six months;

(B) A4253 and A4259 — The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider of the test strips and lancets must maintain in its records the order from the treating practitioner. Before providing more test strips and lancets, the client must have nearly exhausted their supply. The amount of test strips and lancets covered are based on the needs of the client according to the following utilization guidelines:

(i) Up to 100 test strips and 100 lancets every three months for clients who are not currently being treated with insulin injections;

(ii) Up to 100 test strips and 100 lancets every month for clients who are currently being treated with insulin injections;

(iii) For amounts that exceed the utilization guidelines, the treating practitioner must have:

(I) Documented in the client's medical record the specific reason for the additional supplies for that particular client; and

(II) Seen the client and have evaluated their diabetes control within six months prior to ordering quantities that exceed the utilization guidelines; and

(III) Documented in the client's medical record, a specific narrative statement that adequately specifies the frequency at which the client is actually testing or a copy of the client's log; or there must be documentation in the DMEPOS provider's records, (e.g., a copy of the client's log) that the client is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the client is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months;

(e) DMEPOS providers must not dispense a quantity of supplies exceeding a client's expected utilization. DMEPOS providers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering practitioner that the atypical utilization is, in fact, warranted. Regardless of utilization, a DMEPOS provider must not dispense more than a three month quantity of glucose testing supplies at a time;

(f) Providers may contact the treating practitioner to renew an order; however, the request for renewal may only be made with the client's continued monthly use of testing supplies and only with the client's or caregiver's request to the DMEPOS provider for order renewal;

(g) An order refill does not have to be approved by the ordering practitioner; however, a client or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The DMEPOS provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the client has "authorized" this in advance;

(h) Codes in this rule ordered by the practitioner on an "as needed" basis are not covered;

(i) Purchase fee includes normal, low and high-calibrator solution/chips (A4256), a battery (A4233, A4234, A4235 or A4236) and a spring-powered lancet device (A4258).

(2) Guidelines:

(a) Insulin-treated means that the client is receiving insulin injections to treat their diabetes. Insulin does not exist in an oral form and therefore patients taking oral medication to treat their diabetes are not insulin-treated;

(b) A severe visual impairment is defined as a best corrected visual acuity of 20/200 or worse;

(c) An order renewal is the act of obtaining an order for an additional period of time beyond that previously ordered by the treating practitioner;

(d) An order refill is the act of replenishing quantities of previously ordered items during the time period in which the current order is valid;

(e) A4256 describes control solutions containing high, normal, and low concentrations of glucose that can be applied to test strips to check the integrity of the test strips. This code does not describe the strip or chip which is included in a vial of test strips and which calibrates the glucose monitor to that particular vial of test strips;

(f) For glucose test strips (A4253), 1 unit of service = 50 strips. For lancets (A4259), 1 unit of service = 100 lancets;

(g) Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor are not covered. Do not use code A4253 for these items;

(h) DMEPOS providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(3) Documentation Requirements:

(a) For codes requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;

(b) The order for home blood glucose monitors and/or diabetic testing supplies must include all of the following:

(A) All item(s) to be dispensed;

(B) The specific frequency of testing;

(C) The treating practitioner's signature;

(D) The date of the treating practitioner's signature;

(E) A start date of the order — only required if the start date is different than the signature date;

(c) A new order must be obtained when there is a change in the testing frequency;

(d) For E2100 or E2101 in a client with impaired visual acuity, submit documentation which includes a narrative statement from the practitioner that indicates the client's specific numerical visual acuity (e.g., 20/400) and that this result represents "best corrected" vision;

(e) For E2101 — clients with impaired manual dexterity, submit documentation which includes a narrative statement from the practitioner that indicates an explanation of the client's medical condition necessitating the monitor with special features;

(f) When requesting quantities of supplies which exceed utilization guidelines as specified in (1)(d)(B)(i)-(ii) (e.g., more than 100 blood glucose test strips per month for insulin-dependent diabetes mellitus), submit documentation supporting the medical appropriateness for the higher utilization as specified in (1)(d)(B)(iii)(I)-(III) to the appropriate authorization authority for PA;

(g) Documentation which supports condition of coverage requirements for codes billed in this rule must be kept on file by the DMEPOS provider and made available to DMAP on request;

(h) The ICD-9 diagnosis code describing the condition that necessitates glucose testing must be included on each claim for the monitor, accessories and supplies;

(i) If the client is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted;

(j) If the client is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted;

(k) DMEPOS providers are not prohibited from creating data collection forms in order to gather medically appropriate information; however, DMAP will not rely solely on those forms to prove the medical appropriateness of services provided;

(l) A client's medical records must support the justification for supplies dispensed and billed to DMAP.

(3) Procedure Codes: **Table 122-0520** — Diabetic Supplies.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0525
External Insulin Infusion Pump

(1) Indications and Limitations of Coverage and Medical Appropriatenes:

(a) The Division of Medical Assistance Programs (DMAP) may cover an external insulin infusion pump for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus when criterion (A) or (B) is met and criterion (C) or (D) is met:

(A) C-peptide testing requirement:

(i) The C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method; or

(ii) For a client with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method; and

(iii) A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl.

(B) Beta cell autoantibody test is positive;

(C) The client has:

(i) Completed a comprehensive diabetes education program; and

(ii) Been on a program of multiple daily injections of insulin (i.e., at least three injections per day), with frequent self-adjustments of insulin dose for at least six months prior to initiation of the insulin pump; and

(iii) Documented frequency of glucose self-testing an average of at least four times per day during the two months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple injection regimen:

(I) Glycosylated hemoglobin level (HbA1C) greater than 7 percent;

(II) History of recurring hypoglycemia;

(III) Wide fluctuations in blood glucose before mealtime;

(IV) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL;

(V) History of severe glycemic excursions.

(D) The client has:

(i) Been on an external insulin infusion pump prior to enrollment in the medical assistance program, and;

(ii) Documented frequency of glucose self-testing an average of at least four times per day during the month prior to medical assistance program enrollment.

(b) For continued coverage of an external insulin pump and supplies, the client must be seen and evaluated by the treating physician at least every three months;

(c) The external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple clients on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy;

(d) DMAP may cover supplies (including dressings) used with an external insulin infusion pump during the period of covered use of an infusion pump. These supplies are billed with codes A4221 and K0552;

(e) Code A4221 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable;

(f) A4221 is limited to one unit of service per week.

(2) Coding Guidelines:

(a) Code A4221 includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784);

(b) Code K0552 describes a syringe-type reservoir that is used with the external insulin infusion pump (E0784).

(3) Documentation Requirements:

(a) With the request for prior authorization (PA), the DMEPOS provider must submit medical justification which supports that the criteria in this rule are met;

(b) When billing and dispensing for an item in Table 122-0525, the DMEPOS provider must ensure that medical records corroborate that all criteria in this rule are met;

(c) The DMEPOS provider must keep medical records on file and make them available to the DMAP on request.

(4) Table 122-0525

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0540
Ostomy Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness: The Division of Medical Assistance Programs (DMAP) may cover ostomy supplies for a client with a surgically created opening (stoma) to divert urine or fecal contents outside the body:

(a) Only one liquid barrier may be dispensed at a time:

(A) A liquid or spray (A4369); or

(B) Individual wipes or swabs (A5120);

(b) For a client with a continent stoma, only one of the following means to prevent/manage drainage may be covered on a given day:

(A) Stoma cap (A5055);

(B) Stoma plug (A5081); or

(C) Gauze pads (A6216);

(c) For a client with a urinary ostomy, only one of the following may be covered for drainage at night:

(A) Bag (A4357); or

(B) Bottle (A5102);

(d) Provision of ostomy supplies for a client is limited to a three month supply;

(e) Ostomy clamps (A4363) are used with drainable pouches and are not covered with urinary pouches;

(f) Ostomy clamps are only payable when ordered as a replacement and are not separately payable with ostomy pouches;

(g) The following services are not covered:

(A) Pouch cover;

(B) Ostomy supplies when a client is in a covered home health episode.

(2) Documentation Requirements:

(a) For services requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;

(b) Medical records which support conditions of coverage as specified in this rule are met must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to DMAP on request;

(c) A client's medical records must support the justification for supplies billed to DMAP.

(3) **Table 122-0540-1**, Maximum Quantity of Supplies — Monthly Basis.

(4) **Table 122-0540-2**, Maximum Quantity of Supplies — 6-Month Basis.

(5) **Table 122-0540-3**, Faceplate Systems.

(6) **Table 122-0540-4,** Procedure Codes.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0560
Urological Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover the following urinary catheters, external urinary collection devices, and medically appropriate related supplies when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention;

(b) Indwelling Catheters (A4311 – A4316, A4338 – A4346):

(A) No more than one catheter per month for routine catheter maintenance;

(B) Non-routine catheter changes when documentation substantiates medical appropriateness, such as for the following indications:

(i) Catheter is accidentally removed (e.g., pulled out by client);

(ii) Catheter malfunctions (e.g., balloon does not stay inflated, hole in catheter);

(iii) Catheter is obstructed by encrustation, mucous plug, or blood clot;

(iv) History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once per month;

(C) A specialty indwelling catheter (A4340) or an all silicone catheter (A4344, A4312, or A4315) when documentation in the client's medical record supports the medical appropriateness for that catheter rather than a straight Foley type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex);

(D) A three way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) only if continuous catheter irrigation is medically appropriate;

(c) Catheter Insertion Tray (A4310-A4316, A4353, and A4354):

(A) Only one insertion tray per episode of indwelling catheter insertion;

(B) One intermittent catheter with insertion supplies (A4353) per episode of medically appropriate sterile intermittent catheterization;

(d) Urinary Drainage Collection System (A4314-A4316, A4354, A4357, A4358, A5102, and A5112):

(A) For routine changes of the urinary drainage collection system as noted in Table 122-0560-1;

(B) Additional charges for medically appropriate non-routine changes when the documentation substantiates the medical appropriateness (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection);

(C) A vinyl leg bag (A4358) or a latex leg bag (A5112) only for clients who are ambulatory or are chair or wheelchair bound.

(e) Intermittent Irrigation of Indwelling Catheters:

(A) Supplies for the intermittent irrigation of an indwelling catheter when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter;

(B) Routine intermittent irrigations of a catheter are not covered;

(C) Routine irrigations are defined as those performed at predetermined intervals;

(D) Covered supplies for medically appropriate non-routine irrigation of a catheter include either an irrigation tray (A4320) or an irrigation syringe (A4322), and sterile water/saline (A4217);

(f) Continuous Irrigation of Indwelling Catheters:

(A) Supplies for continuous irrigation of a catheter when there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically appropriate catheter changes;

(B) Continuous irrigation as a primary preventative measure (i.e., no history of obstruction) is not covered;

(C) Documentation must substantiate the medical appropriateness of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation;

(D) The records must also indicate the rate of solution administration and the duration of need;

(E) Covered supplies for medically appropriate continuous bladder irrigation include a three-way Foley catheter (A4313, A4316, and A4346), irrigation tubing set (A4355), and sterile water/saline (A4217):

(i) DMAP may cover one irrigation tubing set per day for continuous catheter irrigation;

(ii) Continuous irrigation is considered a temporary measure and may only be covered for up to 14 days.

(g) Intermittent Catheterization: Intermittent catheter supplies when basic coverage criteria are met and the client or caregiver can perform the procedure:

(A) Clean, Non-Sterile Technique: Intermittent catheter supplies (A4351-A4352) on a weekly basis:

(i) Non-sterile lubricating gel (A4402) must be billed when used for clean, non-sterile catheterization technique;

(ii) No more than eight units of A4402 (8 oz.) may be billed per month;

(iii) An individual packet of lubricant (A4332) is not covered for clean, non-sterile intermittent catheterization.

(B) Sterile Technique: Intermittent catheter supplies using sterile technique only when the client meets one of the following criteria (i-iv):

(i) The client is immunosuppressed. Examples of immunosuppressed clients include (but are not limited) clients who are:

(I) On a regimen of immunosuppressive drugs post-transplant;
(II) On cancer chemotherapy;
(III) Have AIDS;
(IV) Have a drug-induced state such as chronic oral corticosteroid use.
(ii) The client has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization;
(iii) The client is a pregnant, spinal cord-injured female with neurogenic bladder (for duration of pregnancy only);
(iv) The client has had distinct, recurrent urinary tract infections, while on a program of clean intermittent catheterization, twice within the 12 month period prior to the initiation of sterile intermittent catheterization. A urinary tract infection means a urine culture with greater than 10,000 colony forming units of a urinary pathogen; and documentation in the client's medical records of concurrent presence of one or more of the following signs, symptoms or laboratory findings:
(I) Fever (oral temperature greater than 38º C);
(II) Systemic leukocytosis;
(III) Change in urinary urgency, frequency, or incontinence;
(IV) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation);
(V) Physical signs of prostatitis, epididymitis, orchitis;
(VI) Increased muscle spasms;
(VII) Pyuria (greater than five white blood cells per high-powered field);
(v) For each episode of covered sterile catheterization, DMAP may cover either:
(I) One catheter (A4351, A4352) and an individual packet of lubricant (A4332); or
(II) One intermittent catheter kit (A4353). The kit code must be used for billing even if the components are packaged separately rather than together as a kit. The charge billed for A4353 is the total of the usual charge for each item had they been billed separately (A4332, A4351, etc.), but may not exceed DMAP's allowable for A4353;
(h) Coude (Curved) Tip Catheters:
(A) Use of a Coude (curved) tip catheter (A4352) in female clients is rarely medically appropriate;
(B) For any client, when a Coude tip catheter is dispensed and billed, there must be specific documentation in the client's medical record why a Coude tip catheter is required rather than a straight tip catheter;
(i) External Catheters/Urinary Collection Devices:
(A) Male external catheters (condom-type) or female external urinary collection devices for clients who have permanent urinary incontinence when used as an alternative to an indwelling catheter;
(B) Coverage for male external catheters (A4349) is limited to 35 per month;
Greater utilization of these devices must be accompanied by documentation of medical appropriateness;
(C) Male external catheters (condom-type) or female external urinary collection devices are not covered for clients who also use an indwelling catheter;
(D) DMAP may cover specialty type male external catheters such as those that inflate or that include a faceplate (A4326) or extended wear catheter systems (A4348) only when documentation substantiates the medical appropriateness for such a catheter;
(E) Coverage of female external urinary collection devices is limited to one metal cup (A4327) per week or one pouch (A4328) per day;
(j) Miscellaneous Supplies:
(A) Appliance cleaner (A5131): One unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5112);
(B) One external urethral clamp or compression device (A4356) every three months or sooner if the rubber/foam casing deteriorates;
(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one per month) for indwelling urethral catheters;
(D) A catheter/tube anchoring device (A5200) separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube;
(E) Non-Sterile Gloves:
(i) Up to 200 pairs of non-sterile gloves (A4927) per month only when the client or caregiver is performing intermittent catheterizations;
(ii) DMAP will not pay for more than 200 pairs of non-sterile gloves (A4927) per month;
(k) Non-Covered Items: The following are not covered:
(A) Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250);
(B) Catheter care kits (A9270);
(C) Adhesive remover (A4365, A4455);
(D) Catheter clamp or plug (A9270);
(E) Drainage bag holder or stand (A9270);
(F) Urinary suspensory without leg bag (A4359);
(G) Measuring container (A9270);
(H) Urinary drainage tray (A9270);
(I) Gauze pads (A6216-A6218) and other dressings;
(J) Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270);
(K) Irrigation supplies that are used for care of the skin or perineum of incontinent clients;
(L) Syringes, trays, sterile saline, or water used for routine irrigation.
(2) Guidelines:
(a) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical records, including the judgment of the attending treating physician, indicate the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met;
(b) A urinary intermittent catheter with insertion supplies (A4353) is a kit, which includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use;
(c) Adhesive strips or tape used with male external catheters are included in the allowance for the code and are not separately payable;
(d) Catheter insertion trays (A4310-A4316, A4353, and A4354) that contain component parts of the urinary collection system, (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts may be allowed only per the stated criteria in each section of the policy;
(e) Extension tubing (A4331) may be covered for use with a latex urinary leg bag (A5112) and is included in the allowance for codes A4314, A4315, A4316, A4354, A4357, A4358, and A5105;
(f) Use A4333 when used to anchor an indwelling urethral catheter.
(3) Documentation Requirements:
(a) For services requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;
(b) Intermittent Catheterization: When requesting quantities of supplies which exceed coverage criteria as specified in (1)(g) (e.g., more than one intermittent catheter per week), submit documentation supporting the medical appropriateness for the higher utilization as specified in (1)(g)(B) to the appropriate authorization authority for prior authorization (PA);
(c) Documentation, which supports condition of coverage requirements for codes billed in this rule, must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to DMAP on request;
(d) A client's medical records must support the justification for supplies billed to DMAP.
(4) **Table 122-0560-1**, Maximum Quantity of Supplies.
(5) **Table 122-0560-2**.
(6) **Table 122-0560-3**, Procedure Codes.
[ED. NOTE: Tables referenced rule are available from the agency.]
Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0580
Bath Supplies

(1) Indications and Coverage — A rehab shower/commode chair is covered when all of the following criteria are met:
(a) Client is unable to use a standard shower chair/bench due to a musculoskeletal condition;

(b) Client has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide;

(c) The home (shower) can accommodate a rehab/shower chair; and,

(d) Less costly alternatives have been considered and ruled out.

(2) Documentation:

(a) The prescription and medical justification for the equipment must be kept on file by the DME supplier. The prescribing practitioner's records must contain information which supports the medical appropriateness of the item ordered;

(b) Documentation of MSRP must be kept on file by the DME supplier;

(c) For a rehab/shower chair, submit documentation to support the above criteria, including a list of equipment available for client's use.

(3) **Table 122-0580**.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0590
Patient Lifts

(1) Indications and Coverage — A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the client would be bed confined.

(2) A sling or seat for a client lift may be covered as an accessory when ordered as a replacement for the original equipment item.

(3) E0621 is included in the allowance for E0630 when provided at the same time.

(4) E0635 may be covered only when a client weighs 450 pounds or more;

(5) Procedure Codes:

(a) E0621 — Sling or seat, client lift, canvas or nylon — Purchase — Prior authorization (PA) required;

(b) E0630 — Client lift, hydraulic with seat or sling (considered purchased after 13 months of rental) – Purchase, rent or repair — PA required;

(c) E0635 — Client lift, electric, with seat or sling — Rent only. This item is a capped rental and becomes the property of the client after 13 months of continuous rental or when the usual purchase price is reached, whichever is lesser. May be covered for a nursing facility client. — PA required.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0600
Toilet Supplies

(1) The Division of Medical Assistance Programs (DMAP) may consider coverage for commodes when:

(a) The client is physically incapable of utilizing regular toilet facilities. This would occur when the client is confined to:

(A) A single room; or

(B) One level of the home environment and there is no toilet on that level; or

(C) The home and there are no toilet facilities in the home.

(b) Extra-wide/heavy-duty commodes may be covered when a client weighs 300 pounds or more and meets the conditions of coverage for commodes;

(c) Only bariatric commodes coded as E1399 (durable medical equipment, miscellaneous) may be covered for a client residing in a nursing facility, subject to service limitations of DMAP rules, when all of the following requirements are met:

(A) The client meets the conditions of coverage as specified in this rule; and

(B) The bariatric commode has been assigned code E1399 by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

(2) Documentation Requirements:

(a) Documentation must include the practitioner's order, the client's height and weight and information supporting the medical appropriateness for the commode dispensed;

(b) For codes requiring prior authorization (PA), submit documentation which supports conditions of coverage are met as specified in this rule.

(3) Procedure Codes: **Table 122-0600** Toilet Supplies.

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

Stat. Auth.: ORS 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; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0620
Miscellaneous Supplies

Procedure Codes — **Table 122-0620**.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 32-1999, f. & cert. ef. 10-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0625
Surgical Dressing

Procedure Codes: **Table 122-0625** Surgical Dressing.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0630
Incontinent Supplies

(1) Incontinent supplies may be covered for urinary or fecal incontinence as follows:

(a) Category I Incontinent Supplies — For up to 220 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity;

(b) Category II Underpads:

(A) Disposable underpads (T4541 and T4542): For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month;

(B) Reusable/washable underpads: (T4537 and T4540) For up to eight units (any combination of T4537 and T4540) in a 12 month period;

(C) Category II Underpads are separately payable only with Category I Incontinent Supplies;

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months.

(c) Category III Washable Protective Underwear:

(A) For up to 12 units in a 12 month period;

(B) Category III Washable Protective Underwear are not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months.

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description.

(4) Documentation requirements: Submit the following documentation for review:

(a) For all categories, the medical reason and condition causing the incontinence; and

(b) When a client is using urological or ostomy supplies at the same time as codes specified in this rule, information which clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate.

(5) Quantity specification:

(a) For prior authorization (PA) and reimbursement purposes, a unit count for Category I — III codes is considered as single or individual piece of an item and not as multiple quantity;

(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) must be specified in the unit column on the PA request. See table 122-0630-2;

(c) For gloves (Category IV Miscellaneous), 100 gloves equal one unit.

(9) Table 122-0630-1.

(10) Table 122-0630-2.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 64-2001, f. 12-28-01, cert.ef. 1-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06

410-122-0640
Eye Prostheses

(1) Indications and Coverage:

(a) An eye prosthesis is indicated for a client (adult or child) with absence or shrinkage of an eye due to birth defect, trauma or surgical removal;

(b) Polishing and resurfacing will be allowed on a yearly basis;

(c) Replacement is covered every five years with extensions allowed when documentation supports medical appropriateness for more frequent replacement.

(2) Documentation: Documentation of medical appropriateness which has been reviewed and signed by the prescribing practitioner (for example, CMN) must be kept on file by the DME provider.

(3) Procedure Codes — Table 122-0640.

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

Stat. Auth.: ORS 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; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0655
External Breast Prostheses

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover an external breast prosthesis for a client who has had a mastectomy;

(b) An external breast prosthesis garment, with mastectomy form (L8015) may be covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(c) An external breast prosthesis of a different type may be covered if there is a change in the client's medical condition necessitating a different type of item;

(d) DMAP will pay for only one breast prosthesis per side for the useful lifetime of the prosthesis;

(e) DMAP will pay for a breast prosthesis for a client residing in a nursing facility;

(f) Two prostheses, one per side, are allowed for a client who has had bilateral mastectomies;

(g) More than one external breast prosthesis per side is not covered;

(h) An external breast prosthesis of the same type may be replaced if it is lost or is irreparably damaged (this does not include ordinary wear and tear);

(i) Replacement sooner than the useful lifetime because of ordinary wear and tear is not covered.

(2) Guidelines:

(a) Use code A4280 when billing for an adhesive skin support that attaches an external breast prosthesis directly to the chest wall;

(b) L8000 is limited to a maximum of four units every 12 months;

(c) Code L8015 describes a camisole type undergarment with polyester fill used post mastectomy;

(d) The right (RT) and left (LT) modifiers must be used with these codes. When the same code for two breast prostheses are billed for both breasts on the same date, the items (RT and LT) must be entered on the same line of the claim form using the RTLT modifier and two units of service;

(e) The useful lifetime expectancy for silicone breast prostheses is two years;

(f) For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is six months.

(3) Documentation Requirements:

(a) For services that do not require prior authorization (PA), the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider must have documentation on file which supports conditions of coverage as specified in this rule are met;

(b) For services that require PA, the DMEPOS provider must submit documentation for review which supports conditions of coverage as specified in this rule are met;

(c) Medical records must be made available to DMAP on request.

(4) **Table 122-0655** (Procedure Codes): The procedure codes in this table may be covered for purchase.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; Renumbered from 410-122-0255, DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

410-122-0660
Orthotics and Prosthetics

(1) Indications and Coverage:

(a) All of the orthotic and prosthetic "L" codes and any temporary "S" or "K" codes have been removed from the rules except for:

(A) OAR 410-122-0470 Supports and Stockings;

(B) OAR 410-122-0255 External Breast Prosthesis; and

(C) OAR 410-122-0680 Facial Prosthesis.

(b) Use the current HCPCS Level II Guide for current codes and descriptions;

(c) For adults, follow Medicare current guidelines for determining coverage;

(d) For children, the prescribing practitioner must determine and document medical appropriateness.

(2) Prior Authorization is required for the following codes:

(a) L1499;

(b) L2999;

(c) L3649;

(d) L3999;

(e) L5999;

(f) L7499;

(g) L8499;

(h) L9900.

(3) Codes Not Covered — **Table 122-0660**.

(4) Reimbursement:

(a) The hospital is responsible for reimbursing the provider for orthotics and prosthetics provided on an inpatient basis;

(b) Evaluations, office visits, fittings and materials are included in the service provided;

(c) Evaluations will only be reimbursed as a separate service when the provider travels to a client's residence to evaluate the client's need;

(d) All covered orthotic and prosthetic codes are also covered if client resides in a nursing facility except:

(A) L1500;

(B) L1510; and

(C) L1520.

(e) Use type of service "J' when billing for a tracheostomy speaking valve (L8501). See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services for rule information.

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

Stat. Auth.: ORS 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; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0678
Dynamic Adjustable Extension/Flexion Device

Procedure Codes — Table 122-0678.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0680
Facial Prostheses

(1) Indications and Coverage:

(a) Covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect;

(b) Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis are covered. Other skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are not covered;

(c) The following services and items are included in the allowance for a facial prosthesis:

(A) Evaluation of the client;

(B) Pre-operative planning;

(C) Cost of materials;

(D) Labor involved in the fabrication and fitting of the prosthesis;

(E) Modifications to the prosthesis made at the time of delivery of the prosthesis or within 90 days thereafter;

(F) Repair due to normal wear or tear within 90 days of delivery;

(G) Follow-up visits within 90 days of delivery of the prosthesis.

(d) Modifications to a prosthesis that occur more than 90 days after delivery of the prosthesis and that are required because of a change in the client's condition are covered;

(e) Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess;

(f) Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are non-covered services;

(g) Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or wear or when required because of a change in the client's condition that cannot be accommodated by modification of the existing prosthesis;

(h) When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item, whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and not separate codes for the orbit and nose. This would apply even if the prosthesis is fabricated in two separate parts.

(2) Documentation: The following must be submitted for prior authorization (PA):

(a) An order for the initial prosthesis and/or related supplies which is signed and dated by the ordering prescribing practitioner must be kept on file by the prosthetist/supplier and submitted with request for PA;

(b) A separate prescribing practitioner order is not required for subsequent modifications, repairs or replacement of a facial prosthesis;

(c) A new prescribing practitioner order is required when different supplies are ordered;

(d) A photograph of the prosthesis and a photograph of the client without the prosthesis must be retained in the supplier's record and must be submitted with the PA request;

(e) When code L8048 is used for a miscellaneous prosthesis or prosthetic component, the authorization request must be accompanied by a clear description and a drawing/copy of photograph of the item provided and the medical appropriateness;

(f) Requests for replacement, repair or modification of a facial prosthesis must include an explanation of the reason for the service;

(g) When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be clearly documented in the authorization request.

(3) Procedure Codes — Table 122-0680.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04

410-122-0700
Negative Pressure Wound Therapy Pumps

(1) Indications and Limitations of Coverage and Medical Appropriateness — Initial Coverage: The Division of Medical Assistance Programs (DMAP) may cover a negative pressure wound therapy (NPWT) pump and supplies on a monthly basis for up to four months on the most recent covered wound when either criterion (a) or (b) is met:

(a) Ulcers and wounds in the home setting or nursing facility:

(A) The client has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology;

(B) A complete wound therapy program described by criterion (i) and criteria (ii), (iii), or (iv), as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT:

(i) For all ulcers or wounds, the wound therapy program must include a minimum of all of the following general measures, which have either been addressed, applied, or considered and ruled out prior to application of NPWT:

(I) Documentation in the client's medical record of evaluation, care, and wound measurements by a licensed medical professional;

(II) Application of dressings to maintain a moist wound environment;

(III) Debridement of necrotic tissue if present;

(IV) Evaluation of and provision for adequate nutritional status;

(ii) For Stage III or IV pressure ulcers:

(I) Appropriate turning and positioning of the client;

(II) Use of a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see 410-122-0400 Pressure Reducing Support Surfaces). If the ulcer is not on the trunk or pelvis, a Group 2 or 3 support surface is not required; and

(III) Appropriate management of the client's moisture and incontinence;

(iii) For neuropathic (for example, diabetic) ulcers:

(I) The client has been on a comprehensive diabetic management program; and

(II) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities;

(iv) For venous insufficiency ulcers:

(I) Compression bandages and/or garments have been consistently applied; and

(II) Leg elevation and ambulation have been encouraged;

(b) Ulcers and wounds encountered in an inpatient setting:

(A) An ulcer or wound as described in subsection (1)(a) is encountered in the inpatient setting and, after wound treatments described in subsection (1)(a) have been tried or considered and ruled out, NPWT is initiated because the treating physician considers it the best available treatment option;

(B) The client has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical appropriateness for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the client that will not allow for healing times achievable with other topical wound treatments);

(c) In either situation described in subsection (1)(b), NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting;

(d) If criterion in subsection (1)(a) or (1)(b) above is not met, the NPWT pump and supplies are not covered;

(e) NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a client. A request for more than one NPWT pump per client for the same time period is not covered;

(f) For the purposes of this rule, a licensed health care professional may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner must be licensed to assess wounds and/or administer wound care.

(2) Indications and Limitations of Coverage and Medical Appropriateness — Continued Coverage: For wounds and ulcers described in subsection (1)(a) or (1)(b), for clients placed on an NPWT pump and supplies, DMAP will only approve continued coverage when the licensed medical professional does all the following duties:

(a) On a regular basis:

(A) Directly assesses the wound(s) being treated with the NPWT pump; and

(B) Supervises or directly performs the NPWT dressing changes;

(b) On at least a monthly basis, documents changes in the ulcer's dimensions and characteristics.

(3) Coverage for a NPWT pump and supplies ends when any of the following occur:

(a) Criteria in section (2) are not met;

(b) The treating physician determines that adequate wound healing has occurred for NPWT to be discontinued;

(c) Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound;

(d) Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound. Coverage beyond four months will be given individual consideration based upon required additional documentation;

(e) Equipment or supplies are no longer being used for the client, whether or not by the physician's order.

(4) DMAP will not cover NPWT pump and supplies if one or more of the following are present:

(a) Necrotic tissue with eschar in the wound, if debridement is not attempted;

(b) Untreated osteomyelitis within the vicinity of the wound;

(c) Cancer present in the wound;

(d) The presence of a fistula to an organ or body cavity within the vicinity of the wound.

(5) DMAP will only cover NPWT pumps and their supplies that have been specifically designated as being qualified for use of HCPCS codes E2402, A6550 and A7000 via written instructions from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

(6) DMAP covers a maximum of 15 dressing kits (A6550) per wound per month, unless there is documentation that the wound size requires more than one dressing kit for each dressing change.

(7) DMAP covers a maximum of 10 canister sets (A7000) per month, unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high-volume exudative wounds, a stationary pump with the largest capacity canister must be used. DMAP does not cover excess use of canisters related to equipment failure (as opposed to excessive volume drainage).

(8) Guidelines:

(a) Equipment:

(A) Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound. Specifically, an electrical pump (described in the definition of code E2402) intermittently or continuously conveys subatmospheric pressure through connecting tubing to a specialized wound dressing (described in the descriptor of HCPCS code A6550). The dressing includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote wound healing. Drainage from the wound is collected in a canister (described in the definition of HCPCS code A7000);

(B) Code E2402 describes a stationary or portable NPWT electrical pump which provides controlled subatmospheric pressure that is designed for use with NPWT dressings, (A6550) to promote wound healing. Such an NPWT pump is capable of being selectively switched between continuous and intermittent modes of operation and is controllable to adjust the degree of subatmospheric pressure conveyed to the wound in a range from 25 to greater than or equal to 200 mm Hg subatmospheric pressure. The pump can sound an audible alarm when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) and when its wound drainage canister (A7000) is full. The pump is designed to fill the canister to full capacity;

(b) Supplies:

(A) Code A6550 describes a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402), and contains all necessary components, including but not limited to a resilient, open-cell foam surface dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound;

(B) Code A7000 describes a canister set which is used in conjunction with a stationary or portable NPWT pump (E2402) and contains all necessary components, including but not limited to a container, to collect wound exudate. Canisters may be various sizes to accommodate stationary or portable NPWT pumps;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

(9) Documentation Requirements: Submit the following information with the prior authorization request:

(a) For Initial Coverage:

(A) A statement from the attending physician which describes the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care as specified in subsection (1)(a);

(B) From the treating clinician, history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being requested to include the following:

(i) Changes in wound conditions, including precise, quantitative measurements of wound characteristics (wound length and width (surface area), and depth), quantity of exudates (drainage), presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.);

(ii) Dated photographs of ulcers or wounds with specific location(s) identified within the last 30 days;

(iii) Length of sessions of use;

(iv) Dressing types and frequency of change;

(v) Wound healing progress;

(b) For Continued Coverage:

(A) Progress notes from the attending physician within the last 30 days;

(B) Updated wound measurements and what changes are being applied to effect wound healing including information specified in paragraph (9)(a)(B);

(c) For both initial and continued coverage of an NPWT pump and supplies, any other medical records that corroborate that all criteria in this rule are met;

(d) When requesting quantities of supplies greater than those specified in this rule as the usual maximum amounts, include documentation supporting the medical appropriateness for the higher utilization.

(10) **Table 122-0700**.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07

410-122-0720
Pediatric Wheelchairs

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a pediatric wheelchair when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADL;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the pediatric wheelchair that is being requested;

(D) Use of a pediatric wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

(E) The client is willing to use the requested pediatric wheelchair in the home, and will use it on a regular basis in the home;

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested pediatric wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

(b) Only when conditions of coverage as specified in (1)(a) of this rule are met, may DMAP authorize a pediatric wheelchair for any of the following situations:

(A) When the wheelchair can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits and the client is compliant with treatment:

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a pediatric wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a pediatric wheelchair may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of a pediatric wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a pediatric wheelchair;

(B) For a purchase request, when a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement cost;

(C) When a covered, client-owned wheelchair is in need of repair (for one month's rental of a wheelchair). See OAR 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing);

(c) A pediatric tilt-in space wheelchair (E1231- E1234) may be covered when a client:

(A) Is dependent for transfers; and

(B) Spends a minimum of four hours a day continuously in a wheelchair; and

(C) The plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(D) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting;

(d) DMAP does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

(e) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. DMAP does not reimburse for adapting living quarters;

(f) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(g) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair, as well as support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(h) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) may be covered when:

(i) The coverage criteria for a PWC (see 410-122-0325, Motorized/Power Wheelchair Base) are met; and

(ii) The client is expected to grow in height; and

(iii) Either of the following criteria is met:

(I) The Group 2 Single Power Option in 410-122-0325, Motorized/Power Wheelchair Base, (2)(a)(C)(i)(I) and (2)(a)(C)(i)(II); or

(II) Multiple Power Options in 410-122-0325, Motorized/Power Wheelchair Base, (2)(a)(D)(i)(I) and (2)(a)(D)(i)(II);

(iv) The delivery of a PWC must be within 120 days following completion of the face-to-face examination with the physician;

(v) A PWC may not be ordered by a podiatrist;

(j) A pediatric wheelchair for use only outside the home is not covered;

(k) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement, Delivery and Dispensing.

(2) Coding Guidelines:

(a) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(b) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(c) Wheelchair "poundage" (pounds) represents the weight of the usual configuration of the wheelchair with a seat and back, but without front riggings;

(d) A manual wheelchair with a seat width and/or depth of 14" or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229;

(e) A power wheelchair (PWC) with a seat width or depth of 14" or less is considered a pediatric PWC base and is coded E1239, PWC, pediatric size, not otherwise specified;

(f) Pediatric seating system codes E2291-E2294 may only be billed with pediatric wheelchair base codes;

(g) Contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) regarding correct coding. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements:

(a) Functional Mobility Evaluation:

(A) DMEPOS providers must submit DMAP 3125 form or other medical documentation which supports conditions of coverage in this rule are met for purchase and modifications of all covered, client-owned pediatric wheelchairs;

(B) Information must include, but is not limited to:

(i) Medical justification, needs assessment, order, and specifications for the wheelchair, completed by a physical therapist, occupational therapist or treating physician. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; and

(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and physical or occupational therapist.

(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order;

(b) Additional Documentation:

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a pediatric wheelchair; only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, pediatric wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs, or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a wheelchair or power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since DMAP determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a pediatric wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options, including growth capabilities; and

(E) Detailed information about client-owned equipment (including serial numbers), as well as any other equipment being used or available to meet the client's medical needs, including how long it has been used by the client and why it can't be grown or modified, if applicable; and

(F) For the home assessment, prior to delivery of the wheelchair, the DMEPOS provider or practitioner must perform an on-site, written evaluation of the client's living quarters. This assessment must support that the client's home can accommodate and allow for the effective use of a wheelchair. This assessment must include, but is not limited to, evaluation of physical layout, doorway widths, doorway thresholds, surfaces, counter/table height, accessibility (e.g., ramps), electrical service, etc.; and

(G) All Healthcare Common Procedure Coding System (HCPCS) codes, including the base, options and accessories, whether prior authorization (PA) is required or not, that will be separately billed;

(c) A written order by the treating physician, identifying the specific type of pediatric wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific pediatric wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority; and

(d) For a PWC request: See 410-122-0325, Motorized/Power Wheelchair Base for documentation requirements; and

(e) Any additional documentation that supports indications of coverage are met as specified in this policy; and

(f) For a manual wheelchair rental, submit all of the following:

(A) A written order from the treating physician, identifying the specific type of manual wheelchair needed:

(i) If the order does not specify the type of wheelchair requested by the DMEPOS provider on the authorization request, the provider must obtain another written order that lists the specific manual wheelchair that is being ordered and any options and accessories requested;

(ii) The DMEPOS provider may enter the items on this order;

(iii) This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority;

(B) HCPCS codes;

(C) Documentation from the DMEPOS provider which supports that the client's home can accommodate and allow for the effective use of the requested wheelchair;

(g) The above documentation must be kept on file by the DMEPOS provider; and

(h) Documentation that the coverage criteria have been met must be present in the client's medical records and this documentation must be made available to DMAP on request; and

(i) For PWC's furnished on a rental basis with dates of services prior to October 1, 2006, use code E1239 as appropriate.

(4) **Table 122-0720**.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07

DIVISION 123

DENTAL/DENTURIST SERVICES

410-123-1000
Eligibility

(1) If you plan to bill the Division of Medical Assistance Programs (DMAP) for your services, be sure to verify eligibility before providing any service. It is the responsibility of the dentist to verify the client's eligibility. DMAP will not pay for services provided to an ineligible client even if services were authorized. Always check the client's DMAP Medical Care ID or call the Automated Information System (AIS) to verify eligibility.

(2) The DMAP Medical Care ID guarantees eligibility only for the time period listed on the card. Refer to the front of the DMAP Dental Services rules for instructions on reading a DMAP Medical Care ID.

(3) Billing of Third Party Resources:

(a) A third party resource (TPR) is an alternate insurance resource, other than DMAP, available to pay for medical services and items on behalf of Medical Assistance Program clients. If available to the client, this alternate insurance resource must be billed before DMAP can be billed. Indian Health Services or Tribal facilities are not considered a TPR pursuant to General Rules (OAR 410-120-1280);

(b) If other health insurance is named in the "Managed Care/TPR" section of the client's DMAP Medical Care ID, it means that the client has other resources that must be billed prior to billing DMAP.

(4) Fabricated Prosthetics: If a dentist provides an eligible client with fabricated prosthetics that require the use of a dental laboratory, and the fabrication is expected to extend beyond the period of eligibility listed on the client's DMAP Medical Care ID, the dentist should use the date of impression as the date of service. This is the only exception to General Rules (OAR 410-120-1280). All other services must bill using the date the service was provided.

(5) Treatment Plans: Being consistent with established dental office protocol and the standard of care within the community, scheduling of appointments is at the discretion of the dentist. The agreed upon treatment plan established by the dentist and patient will establish appointment sequencing. Possession of a DMAP Medical Care ID does not entitle a client to any services or consideration not provided to all clients.

Stat. Auth.: ORS 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; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03

410-123-1040
Foreword

(1) The Division of Medical Assistance Programs' (DMAP) Dental Services administrative rules establish specific requirements for dental services provided to DMAP clients and:

(a) Are designed to assist dentists, dental hygienists and denturists to deliver dental care services for clients with Medical Assistance Program coverage;

(b) Contain information on policy, services requiring prior authorization, service limitations and service criteria.

(2) All DMAP rules are intended to be used in conjunction with the DMAP General Rules (chapter 410, division 120), the Oregon Health Plan (OHP) Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant DMAP OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a signed provider enrollment agreement. Providers must follow DMAP rules in effect on the date of service.

(3) Dental services are limited as directed by General Rules — Excluded Services and Limitations (OAR 410-120-1200), the Dental Services administrative rules (chapter 410, division 123), and the Health Services Commission's (HSC) Prioritized List of Health Services (List) (found in the OHP Administrative Rules — chapter 410, division 141).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 36-2005, f. & cert. ef. 8-1-05

410-123-1060
Definition of Terms

(1) Central Nervous System Anesthesia — An induced controlled state of unconsciousness or depressed consciousness produced by a pharmacologic method.

(2) Citizen/Alien-Waived Emergency Medical (CAWEM) — Persons only eligible for treatment of emergency medical conditions, including labor and delivery. Emergency medical treatment is merited for symptoms of such severity that absence of immediate medical attention would result in placing the patient's health in jeopardy, impairment to bodily functions, or serious dysfunction of a bodily organ or part.

(3) Conscious Sedation — An induced controlled state of depressed consciousness, regardless of the route of administration of the anesthetic agent, in which the client retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(4) Covered Services — Services on the Health Services Commission's (HSC) Prioritized List of Health Services (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.

(5) Deep Sedation — An induced controlled state of depressed consciousness in which the client experiences a partial loss of protective reflexes, as evidenced by the inability to respond purposefully either to physical stimulation or to verbal command but the client retains the ability to independently and continuously maintain an airway.

(6) Dental Hygienist — A person licensed to practice dental hygiene pursuant to State law.

(7) Dental Hygienist with Limited Access Certification (LAC) — A person licensed to practice dental hygiene with LAC pursuant to State law.

(8) Dental Services — Services provided within the scope of practice as defined under State law by or under the supervision of a dentist or dental hygienist with LAC, or denture services provided within the scope of practice as defined under State law by a denturist.

(9) Dental Services Documentation — Must meet the requirements of the Oregon Dental Practice Act statutes; administrative rules for client records and requirements of OAR 410-120-1360, "Requirements for Financial, Clinical and Other Records." Any other documentation requirements as outlined in the Dental Services billing and procedures rules.

(10) Dentist — A person licensed to practice dentistry pursuant to State law.

(11) Denturist — A person licensed to practice denture technology pursuant to State law.

(12) Direct Pulp Cap — The procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

(13) Emergency Dental Services:

(a) Covered services requiring immediate treatment. This includes services to treat:

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

(D) Unusual swelling of the face or gums; or

(E) Treat a tooth that has been knocked out.

(b) The emergency rule applies only to covered services. The Division of Medical Assistance Programs (DMAP) 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;

(c) Refer to OAR 410-123-1670 for the definition of an emergency and service coverage for OHP Standard clients;

(d) The following emergencies are not the responsibility of the dental provider unless they occur within the dental office or facility. Clients calling with these conditions should be referred to the emergency room or to call 911:

(A) Control hemorrhaging;

(B) Maintain an adequate airway; or

(C) Prevent life-threatening situations.

(14) General Anesthesia — An induced controlled state of unconsciousness in which the client experiences complete loss of protective reflexes, as evidenced by the inability to independently maintain an airway, the inability to respond purposefully to physical stimulation, or the inability to respond purposefully to verbal command.

(15) Hospital Dentistry — Dental services provided in an ambulatory surgical center, inpatient, or outpatient hospital setting.

(16) Nitrous Oxide Sedation — An induced controlled state of minimally depressed consciousness, produced solely by the inhalation of a combination of nitrous oxide and oxygen, in which the client retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(17) Preventive Services — Includes:

(a) Oral Prophylaxis (cleaning of teeth);

(b) Topical Fluoride;

(c) Sealants;

(d) Space maintenance; and

(e) Tobacco Counseling.

(18) Therapeutic Services — Includes:

(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; and

(e) Removable prosthesis with inability to masticate.

(19) Dentally Appropriate: Refer to OAR 410-120-0000 for definition.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

410-123-1085
Client Copayments for Oregon Health Plus Dental Benefit

(1) OHP Plus: Copyaments may be required for certain services:

(a) Clients enrolled in a Dental Care Organization are exempt from copyaments. Refer to OAR 410-120-1230 for specific details;

(b) Refer to **Table 123-1260-1** for a list of individual services covered under the OHP Plus Dental Benefit and copyaments for individual services.

(2) OHP Standard:

(a) Clients eligible for OHP Standard are exempt from copayments. Refer to OAR 410-120-1230 for specific details;

(b) Refer to **Table 123-1670-1** for a list of individual services covered under the OHP Standard Limited Emergency Dental Benefit.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 76-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05

410-123-1100
Services Reviewed by the Division of Medical Assistance Programs (DMAP)

(1) The Division of Medical Assistance Programs (DMAP) will not give prior authoriz ation (PA) for payment when the prognosis is unfavorable, the treatment impractical, or a lesser-cost procedure would achieve the same ultimate results.

(2) Rampant caries should be arrested and a period of adequate oral hygiene, as defined by the provider, demonstrated, before dental prosthetics are proposed.

(3) Consultants: For certain services and billings, DMAP contracts with a general practice consultant and an oral surgery consultant for professional review before PA of payment. DMAP will deny PA if the consultant decides that the clinical information furnished does not support the treatment or services.

(4) By Report Procedures: Request for payment for dental services listed as 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 radiographs. Payment for By Report procedures will be approved in consultation with an DMAP dental consultant.

(5) Treatment Justification: DMAP may request the treating dentist to submit appropriate radiographs or other clinical information which justifies the treatment:

(a) Before issuing PA;

(b) In the process of utilization review; or

(c) In determining responsibility for payment of dental services.

Stat. Auth.: ORS 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; OMAP 48-2002, f. & cert. ef. 10-1-02

410-123-1160
Prior Authorization

(1) Prior authorization (PA) requirements for services and supplies listed in the Dental Services provider guide are intended for clients who are not enrolled in a dental care organization. Contact the client's dental care organization for their policy governing PA requirements.

(2) PA for routine dental services in an Ambulatory Surgical Center (ASC), outpatient or inpatient setting is required. Routine dental services are defined as those dental services that are routinely done in the office setting but due to specific client need, meet guidelines from the American Dental Association and the American Academy of Pediatric Associations for hospital dentistry. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(3) PA for outpatient or inpatient services is not required for any life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(4) PA for some maxillofacial surgeries may be required. Refer to the current Medical Surgical Services guide for information.

(5) If a client is enrolled in a Fully Capitated Health Plan (FCHP), that FCHP may require PA for ASC, outpatient or inpatient dental services. It is the responsibility of the provider to check with the FCHP for any required authorization prior to the service being rendered.

(6) PA does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service by:

(a) Checking the client's Division of Medical Assistance Programs (DMAP) Medical Care ID or;

(b) Confirming eligibility through the Automated Information System (AIS); or

(c) Contacting the local branch office.

(7) When radiographs are required they must be:

(a) Readable copies;

(b) Mounted or loose;

(c) In an envelope, stapled to the PA form; and

(d) Clearly labeled with dentist's name and address and client's name.

(8) Do not send in radiographs unless required by Dental Services rules or requested.

(9) Requests for PA must be made through the DMAP Dental Program Coordinator in writing on an ADA form, listing the specific services requested. No phone calls requesting PA will be accepted.

(10) Send requests for PA to: Dental Program Coordinator — DMAP.

(11) Upon approval of the request for payment, a nine-digit PA number will be entered on the requesting form and the form will be returned to the treating provider. Claims cannot be paid without this number.

(12) DMAP will issue a decision on PA requests within 30 days of receipt of the request.

Stat. Auth.: ORS 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; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02

410-123-1200
Services Not Considered Separate

The following services do not warrant an additional fee and are considered to be either minimal, 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) Direct pulp cap.
(7) Discing.
(8) Dressing change.
(9) Electrosurgery.
(10) Equilibration.
(11) Gingival curettage — per tooth.
(12) Gingivectomy/gingivoplasty — per tooth.
(13) Indirect pulp cap.
(14) Local anesthesia.
(15) Medicated pulp chambers.
(16) Occlusal adjustments.
(17) Occlusal analysis.
(18) Odontoplasty.
(19) Oral hygiene instruction.
(20) Peridontal charting, probing.
(21) Polishing fillings.
(22) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction.
(23) Pulp vitality tests.
(24) Smooth broken tooth.
(25) Special infection control procedures.
(26) Surgical procedure for isolation of tooth with rubber dam.
(27) Surgical splint.
(28) Surgical stent.
(29) Suture removal.

Stat. Auth.: ORS 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; OMAP 48-2002, f. & cert. ef. 10-1-02

410-123-1220
Services Not Funded on the Health Services Commission's Prioritized List of Health Services

The following general categories of Dental Services are not funded on the Health Services Commission's (HSC) Prioritized List of Health Services (List) and are not covered for any client:

(1) Desensitization;
(2) Implant and implant services;
(3) Mastique or veneer procedure;
(4) Orthodontia (except when it is treatment for cleft palate with cleft lip);
(5) Overhang removal;
(6) Procedures, appliances or restorations solely for aesthetic/cosmetic purposes;
(7) Temporomandibular Joint Dysfunction treatment;
(8) Tooth bleaching;
(9) Table 123-1260-1 contains all covered dental services. This table is subject to change if there are funding changes to the Health Services Commission List of Prioritized Services.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03

410-123-1230
Buy-Ups

(1) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (DMAP) or a managed care plan for a covered service when:

(a) A non-covered service has been provided; and

(b) Additional payment is sought or accepted from the client.

(2) For example, an additional client payment to obtain a gold crown (not covered) instead of the stainless steel crown (covered); an additional client payment to obtain eyeglass frames not on the DMAP or plan contract. If a client wants to purchase a non-covered service or item, they must be responsible for full payment. DMAP or plan payment for a covered service cannot be credited toward the non-covered service.

(3) Buy-ups are prohibited. Refer to General Rules (OAR 410-120-1350) for specific language on buy-ups.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 14-1999(T), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 29-1999, f. 6-9-99, cert. ef. 6-10-99; OMAP 48-2002, f. & cert. ef. 10-1-02

410-123-1240
Dental Claims

(1) The Division of Medical Assistance Programs (DMAP) will only accept claims for professional dental services, in the following formats:

(a) Electronic claims — the "837" dental electronic claim format is used for all professional dental services provided in any setting:

(A) Submission of an electronic claim directly or through an Agent must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et seq.;

(B) The "835" professional electronic claim format is used when billing for any service identified in OAR 410-123-1260 or in Table 123-1260-2.

(b) Paper claims:

(A) ADA paper claims (only the 2000, 2002 and 2004 versions) — this format is used for all professional dental services provided in any setting;

(B) Effective August 1, 2005, claims received by DMAP that are not in the correct format will be returned to the provider unprocessed;

(C) The provider will be responsible for making corrections and submitting a valid claim in accordance with these rules;

(D) CMS-1500 paper claim format must be used when billing for any service identified in OAR 410-123-1260 or in Table 123-1260-2.

(2) Specific information regarding HIPAA requirements can be found on the DMAP website.

(3) Refer to the Dental Supplemental Materials for information regarding DMAP forms.

(4) Do not include DMAP copayments when billing for dental services.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 76-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 36-2005, f. & cert. ef. 8-1-05

410-123-1260
Dental Exams, Diagnostic and Procedural Services

(1) Refer to Table 123-1260-1 for information regarding dental services requiring prior authorization and surgical report:

(a) Procedure codes listed in Table 123-1260-1 are subject to change without notification;

(b) Services funded on the Health Services Prioritized List of Health Services may change and not reflected in OARs 410-123 until the following rule change period.

(2) The client's records must include appropriate documentation to support the service and level of care rendered.

(3) Dental services that are not dentally appropriate or are for the convenience of the client is not covered:

(4) Restorative treatments are limited:

(a) When prognosis is unfavorable;

(b) When treatment impractical;

(c) Until rampant caries are arrested; or

(d) A lesser-cost procedure would achieve the same ultimate result.

(5) Exams:

(a) Codes are based on the American Dental Association CDT-5, except where noted for restorations. Refer to the CDT-5 publication for code descriptions;

(b) For services billed that do not require a tooth number or surface, leave blank;

(c) Exams (billed as D0120, D0150, D0160 or D0180) by the same practitioner are payable once every twelve months;

(d) For each emergent episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams.

(6) Radiographs:

(a) Routine radiographs are limited to once every 12 months, except panoramic (D0330) and intraoral complete series (D0210) which are payable once every five years. The exception to these limitations is if the client is new to the office or clinic and the office or clinic was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the client's records. A maximum of six radiographs are payable for any one emergency;

(b) When billing for radiographs, do not use tooth number or tooth surface;

(c) The minimum age for billing code D0210 is six years. For clients under age six, radiographs may be billed separately as follows:

(A) D0220 — once;

(B) D0230 — a maximum of five times;

(C) D0270 — a maximum of twice, or D0272 once.

(d) The minimum standards for payment of intraoral complete services are:

(A) For clients age six through 11, a minimum of 10 periapicals and two bitewings for a total of 12 films;

(B) There is a minimum of 10 periapicals and four bitewings for a total of 14 films for ages 12 and older.

(e) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Division of Medical Assistance Programs (DMAP) will pay for complete series;

(f) Bitewing radiographs for routine screening are payable every 12 months;

(g) Payment for routine panoramic films or complete series intraoral radiograph is limited to one every five years. This does not mean that panoramic or complete series intraoral radiographs can both be done within a five-year period. Additional films are covered when medically justified, e.g., fractures;

(h) Payment for some or all-multiple radiographs of the same tooth or area may be denied if DMAP determines the number to be excessive;

(i) Note: When billing additional films (D0230 and D0260), do not use a separate line for each additional film. Use only one line: add up the total additional films being billed and enter this number under the Quantity column, or create a "Q" column, depending on which form you use.

(7) Preventive Services:

(a) Prophylaxis — Limited to once every 12 months. Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care;

(b) Topical Fluoride Treatment (Office Procedure) is limited to once every 12 months. Additional topical fluoride treatments may be available for a client up to a total of 4 treatments within a 12- month period:

(A) Additional topical fluoride provisions may be available for persons with high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(B) Who is pregnant with high-risk oral condition limited to periodontal disease or rampant caries;

(C) With physical disabilities that cannot perform adequate daily oral health care;

(D) Who have a developmental disability or other severe cognitive impairment that cannot perform adequate daily oral health care;

(E) Who is six years or younger with high-risk oral health factors.

(c) Sealants:

(A) Sealants are covered for permanent molars only for children 15 or younger;

(B) Limited to one treatment per tooth every five years except for visible evidence of clinical failure.

(d) Space Management — Removable space maintainers will not be replaced if lost or damaged.

(8) Tobacco Cessation:

(a) Use CDT-5 code D1320 on an American Dental Association (ADA) claim form when billing for tobacco cessation services as outlined. Maximum of 10 services within a three-month period;

(b) Follow criteria outlined in OAR 410-130-0190.

(9) Restorations — Amalgam and Composite:

(a) Payment for restorations is limited to the maximum restoration fee of four surfaces per tooth. Refer to American Dental Association Current Dental Terminology for definitions of restorative procedures;

(b) All surfaces must be combined and billed one line per tooth using the appropriate code. For example, tooth #30 has a buccal amalgam and a MOD amalgam — bill MOD, B, using code D2161;

(c) Payment for an amalgam or composite restoration and a crown on the same tooth will be denied;

(d) Payment is made for a surface once in each treatment episode 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) Posterior composite restorations will be paid at the same rate as amalgam restorations.

(g) Replacement of posterior composite restorations is limited to once every five years.

(10) Crowns:

(a) Acrylic Heat or Light Cured Crowns — allowed for anterior permanent teeth only;

(b) Prefabricated Plastic Crowns — allowed for anterior teeth only, permanent or primary;

(c) Permanent crowns — allowed for anterior permanent teeth only. Clients must be 16 or older. Radiographs required; history, diagnosis, and treatment plan may be requested;

(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) Payment for retention pins is limited to four per tooth;

(g) Crowns are covered only when there is significant loss of clinical crown and no other restoration will restore function. The following is not covered:

(A) Endodontic therapy alone (with or without a post) is not covered;

(B) Aesthetics.

(h) Crown replacement is limited to one every five years per tooth. Exceptions to this limitation may be made for crown damage due to acute trauma, based on the following factors:

(A) Extent of crown damage;

(B) Extent of damage to other teeth or crowns; and

(C) Extent of impaired mastication.

(i) Crowns will not be covered in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.

(11) Endodontics:

(a) Pulp Capping: Direct and indirect pulp caps are included in the restoration fee — no additional payment will be made;

(b) Endodontic Therapy:

(A) Endodontics is covered only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(B) Retreatment is not covered for bicuspid or molars;

(C) Retreatment is limited to anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodonitcs,

(B) Separate reimbursement for open-and-drain as a palliative procedure is allowed only when the root canal is not completed on the same date of service, or if the same practitioner or dental practitioner in the same group practice did not complete the procedure;

(C) The client's record must include appropriate documentation to support the services and level of care rendered;

(D) Root canal therapy is not covered for third molars.

(c) Endodontic Therapy on Permanent Teeth — Apexification is limited to a maximum of five treatments on permanent teeth only.

(12) Periodontics:

(a) When billing for quadrants, use Health Insurance Portability and Accountability Act (HIPAA) compliant codes;

(b) D4210 — covered for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., dilantin hyperplasia;

(c) D4240, D4241 and D4260 — allowed once every three years unless there is a documented medical/dental indication;

(d) D4341 — 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 5 mm or greater;

(e) D4910 — allowed once every six months. For further consideration of more frequent periodontal maintenance benefits, office records must clearly reflect clinical indication, i.e., chart notes, pocket depths and radiographs;

(f) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;

(g) Surgical procedures include six months routine postoperative care;

(h) Note: DMAP will not reimburse for the following procedures if performed on the same date of service:

(A) D1110;

(B) D1120;

(C) D4210;

(D) D4220;

(E) D4260;

(F) D4341;

(G) D4355;

(H) D4910.

(13) Removable Prosthodontics:

(a) Removable cast metal prosthodontics and full dentures are limited to clients 16 or older;

(b) Adjustments to removable prosthodontics during the six-month period following delivery to clients are included in the fee;

(c) Replacement:

(A) Replacement of dentures and partials is limited to once every five years and only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every five years, but only when Dentally Appropriate;

(B) The limitation of once every five years applies to the client regardless of Dental Care Organization (DCO) or Fee-for-Service (FFS) enrollment status. This includes clients that move from FFS to DCO, DCO to FFS, or DCO to DCO. For example: a client receives full dentures on February 1, 2000, while FFS and a year later enrolls in a DCO. The client would not be eligible for another full denture until February 2, 2005, regardless of DCO or FFS enrollment;

(C) Replacement of partial dentures with full dentures is payable five years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene will not warrant replacement.

(d) Relines:

(A) Reline of complete or partial dentures is allowed once every two years;

(B) Exceptions to this limitation may be made under the same conditions warranting replacement;

(C) Laboratory relines are not payable within five months after placement of an immediate denture.

(e) Tissue Conditioning:

(A) Tissue conditioning is allowed once per denture unit in conjunction with immediate dentures;

(B) One tissue conditioning is allowed prior to new prosthetic placement.

(f) Cast Partial Dentures:

(A) Cast partial dentures will not be approved if stainless steel crowns are used as abutments;

(B) Cast partial dentures must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) Teeth to be replaced and teeth to be clasped are to be noted in the "remarks" section of the form.

(g) Denture Rebase Procedures:

(A) Rebase should only be done if a reline will not adequately solve the problem. Rebase is limited to once every three years;

(B) Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions.

Severe periodontal disease due to neglect of daily oral hygiene will not warrant rebasing.

(h) Laboratory Denture Reline Procedures — Limited to once every two years.

(14) Maxillofacial Prosthetics:

(a) For clients enrolled in managed care, maxillofacial prosthetics are to be billed using CPT or HCPCS coding on a CMS-1500 to the client's medical managed care organization (FCHP). Provision of maxillofacial prosthetics is included in the FCHP capitation and is not the DCO's responsibility;

(b) For fee-for-service clients, bill DMAP using CPT or HCPCS codes on a CMS-1500 listed in Table 123-1260-2. Payment is based on the physician fee schedule.

(15) Oral Surgery:

(a) Oral surgical services performed in a dental office setting do not require prior authorization (PA), and include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits;

(b) Oral surgical services performed in a dental office setting are billed on an American Dental Association (ADA) dental claim form. For clients enrolled in a Dental Care Organization (DCO), the oral surgical services are the responsibility of the DCO;

(c) Oral surgical services performed in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting and related anesthesia services require PA. Oral surgical procedures directly related to the teeth and supporting structures must be billed on an ADA claim form;

(d) If the services requiring hospital dentistry are the result of a medical condition/diagnosis (i.e., fracture, cancer), use appropriate American Medical Association (AMA) CDT-5 procedure codes and bill procedures on a CMS-1500 claim form. For clients enrolled in a Fully Capitated Health Plan (FCHP), the facility charge and anesthesia services are the responsibility of the FCHP. See rule 410-123-1490 Hospital Dentistry for requirements;

(e) All codes listed as By Report require an operative report;

(f) Payment for tooth reimplantation is covered only in cases of traumatic avulsion where there are good indications of success;

(g) Surgical Assistance:

(A) Reimbursement for surgical assistance is restricted to services provided 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.

(h) Extractions — Includes local anesthesia and routine postoperative care;

(i) Surgical Extractions:

(A) Includes local anesthesia and routine post-operative care:

(B) The following codes are limited to treatment for symptomatic pain, infection, bleeding, or swelling:

(i) D7220;

(ii) D7230;

(iii) D7240;

(iv) D7241 — By Report;

(v) D7250.

(j) Note: The following procedures on the Health Services Commission's (HSC) Prioritized List of Health Services (List) are covered as medical procedures. Bill on a CMS-1500, using CPT coding. If a client is enrolled in a Fully Capitated Health Plan (FCHP) it is the responsibility of the provider to contact the FCHP for any required authorization before the service is rendered:

(A) D7430;

(B) D7431;

(C) D7460;

(D) D7461;

(E) D7810;

(F) D7820;

(G) D7830.

(16) Orthodontia:

(a) Orthodontia services are limited to eligible clients for the ICD-9-CM diagnosis of cleft palate with cleft lip;

(b) Prior authorization (PA) is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/lip must be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record must include diagnosis, length and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontia treatment for cleft palate/cleft lip is evaluated as two phases. Each phase is reimbursed individually (separately);

(f) 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 client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to DMAP any unused amount of payment, after applying the following formula: Total payment minus $300.00 (for Banding) multiplied by the percentage of treatment remaining;

(g) The length of the treatment plan from the original request for authorization will be used to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment no refund will be required even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8999 — PA required.

(17) Anesthesia:

(a) General anesthesia or IV sedation is to be used only for those clients with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, and D9240);

(b) General anesthesia is paid using D9220 for the first 30 minutes and use D9221 for each additional 15-minute period, up to three hours on the same day of service. When using D9221, use care when entering quantity. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;

(c) Nitrous oxide is paid per date of service, not by time;

(d) IV sedation is paid per date of service;

(e) Oral premedication anesthesia for conscious sedation:

(A) Limited to clients through 12 years of age;

(B) Limited to four times per year;

(C) Monitoring and nitrous oxide included in the fee; and

(D) Use of multiple agents is required to receive payment.

(f) Upon request, providers must submit to DMAP a copy of their permit to administer anesthesia, analgesia and/or sedation;

(g) Anesthesia — For the purpose of Title XIX and Title XXI, D9630 is limited to those oral medications used during a procedure and is not intended for "take home" medication.

(18) D9430 is limited to three visits per year. Table 123-1260-1, Table 123-1260-2.

[ED. NOTE: Tables are available from the Agency.]

Stat. Auth.: ORS 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; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05

410-123-1490
Hospital Dentistry

(1) Hospital Dentistry is defined as routine dental services provided in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting under general anesthesia.

(2) The purpose of Hospital Dentistry is to provide safe, efficient dental care for clients who present special challenges requiring general anesthesia.

(3) The use of general anesthesia is sometimes necessary to provide quality dental care for the client. Depending on the client, this can be done in an ASC, a day surgery center, outpatient hospital or inpatient hospital setting with the use of pre- and/or postoperative patient admission to the hospital.

(4) General anesthesia is a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

(5) The need to diagnose and treat, as well as the safety of the client and the practitioner, must justify the use of general anesthesia. The decision to use general anesthesia must take into consideration:

(a) Alternative behavior management modalities;

(b) Client's dental needs;

(c) Quality of dental care;

(d) Quantity of dental care;

(e) Client's emotional development;

(f) Client's physical considerations;

(g) Client's requiring dental care for whom the use of general anesthesia may protect the developing psyche.

(6) Client, parental or guardian written consent must be obtained prior to the use of general anesthesia.

(7) The following information must be included in the client's dental record:

(a) Informed consent;

(b) Justification for the use of general anesthesia.

(8) Indications for the use of general anesthesia for children 18 or younger is limited to:

(a) If a child is under 3 years old with extensive dental needs;

(b) If a child is over 3 years old, treatment is attempted in the office setting with some type of sedation or nitrous oxide. If treatment in an office setting is not possible, documentation in the client's dental record as to why, in the estimation of the dentist, the client will not be responsive to office treatment;

(c) Acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;

(d) Requiring dental care for whom the use of general anesthesia is to protect the developing psyche;

(e) Client who has sustained extensive orofacial or dental trauma;

(f) Physical, mental or medically compromising conditions;

(g) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia;

(h) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(10) The intent to cover hospital dentistry in adults is limited to:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia;

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia;

(c) Client who has sustained extensive orofacial or dental trauma.

(11) Contraindications for general anesthesia:

(a) Client convenience. Refer to OAR 410-120-1200;

(b) A healthy, cooperative client with minimal dental needs;

(c) Medical contraindication to general anesthesia.

(12) Hospital Dentistry requires prior authorization (PA) regardless of whether or not a client is enrolled in a Fully Capitated Health Plan (FCHP) or Dental Care Organization (DCO). All requests for PA require the DMAP 3301 form to be completed.

(13) Obtaining PA:

(a) If a client is enrolled in an FCHP and a DCO:

(A) The attending dentist is responsible for contacting the FCHP for PA requirements and arrangements when provided in an inpatient hospital, outpatient hospital or ambulatory surgical center;

(B) The attending dentist is responsible for submitting documentation to the FCHP and simultaneously to the DCO on the DMAP 3301 form;

(C) The medical and dental plans should review the DMAP 3301 form and raise any concerns they have to the other, in addition to contacting the attending dentist. This allows for mutual plan involvement and monitoring;

(D) The total response turn around time should not exceed 20 calendar days from the date of submission of all required documentation for routine dental care and should according to the urgent/emergent dental care timelines;

(E) The FCHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services.

(b) If a client is fee-for-service for medical services and enrolled in a DCO:

(A) The attending dentist is responsible for faxing the DMAP 3301 form and a completed ADA form to the Division of Medical Assistance Programs (DMAP) Dental Program Coordinator;

(B) DMAP is responsible for payment of facility and anesthesia services. The DCO is responsible for payment of all dental professional services.

(c) If a client is enrolled in an FCHP and is fee-for-service dental:

(A) The individual dentist is responsible for contacting the FCHP, obtaining PA and arrangement for hospital dentistry;

(B) It is the responsibility of the individual dentist to submit required documentation on the DMAP 3301 form to the FCHP;

(C) The FCHP is responsible for all facility and anesthesia services. DMAP is responsible for payment of all dental professional services.

(d) If a client is fee-for-service for both medical and dental:

(A) The individual dentist is responsible for faxing the DMAP 3301 form and a completed ADA form to the DMAP Dental Program Coordinator;

(B) DMAP is responsible for payment of all facility, anesthesia services and dental professional charges.

(14) DMAP will not approve any subsequent hospital dentistry requests without clinical documentation as to why the treatment plan provided, as outlined in the prior authorization request, was not completed.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04

410-123-1540
Citizen/Alien-Waived Emergency Medical

(1) The Citizen/Alien-Waived Emergency Medical (CAWEM) program provides treatment of emergency medical conditions, including delivery of newborns. CAWEM is defined in OAR 410-120-0000 and further explained in OAR 410-120-1200 of the Division of Medical Assistance Programs (DMAP) General Rules.

(2) People covered under the CAWEM program are NOT Oregon Health Plan clients. They DO NOT receive the Basic Benefit Package and ARE NOT enrolled into managed care plans. In the past, they have not received a DMAP Medical Care ID.

(3) Beginning March 1, 2000, people covered under the CAWEM program will receive a DMAP Medical Care ID, with the following message shown in the Benefit Package Section: "Coverage is limited to emergency medical services. Labor and delivery services for pregnant women are considered an emergency."

(4) Emergency services provided for anyone with a DMAP Medical Care ID displaying the above message should continue to be billed directly to DMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02

410-123-1600
Managed Care Organizations

(1) The Division of Medical Assistance Programs (DMAP) has contracted with Managed Care Organizations (MCO) and Primary Care Case Managers (PCCM) for medical services provided for clients under DMAP (Title XIX and Title XXI services). MCOs include Fully Capitated Health Plans (FCHP), Mental Health Organizations (MHO), Dental Care Organizations (DCO) and Chemical Dependency Care Organizations (CDO).

(2) Many Oregon Medical Assistance Program eligible clients are enrolled in one or more of these MCOs. Some clients that are not enrolled in an FCHP may be assigned a PCCM. Please see rule 410-123-1490 regarding Hospital Dentistry.

(3) DCOs are prepaid to cover dental services, including the professional component of any services provided in an ambulatory surgical care (ASC) facility, outpatient hospital or inpatient hospital setting for hospital dentistry.

(4) Services covered by an FCHP will not be reimbursed by DMAP, reimbursement is a matter between the FCHP and the provider. Emergent dental services do not require prior authorization from the FCHPs.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02

410-123-1620
ICD-9-CM

(1) Diagnosis codes are not required for dental claims submitted on an American Dental Association (ADA) form. Diagnosis codes are required for dental services that require by rule to be submitted on a CMS-1500 claim form.

(2) The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit. Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable x-ray providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment and supplies.

(3) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnoses codes may be listed on the claim for documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment, or management.

(4) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth-digit subcategories and/or fifth-digit subcategories are provided, they must be assigned. A code is invalid if it has not been coded to its highest specificity.

(5) The Division of Medical Assistance Programs (DMAP) requires accurate coding and applies the national standards that are in effect for Calendar Year 2003 and 2004 set by the ADA, the American Hospital Association and the American Medical Association. DMAP has unique coding and claim submission requirements for Administrative Examinations; specific diagnosis coding instructions are provided in the Administrative Examination Rules which is available on the DMAP website.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03

410-123-1640
Prescriptions

(1) Follow criteria outlined in OAR 410-121-0144.

(2) Practitioner-Managed Prescription Drug Plan (PMPDP) — Follow criteria outlined in PMPDP — OAR 410-121-0030.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03

410-123-1670
OHP Standard Emergency Dental Benefit

(1) The definition of Dental Emergency is limited to section (2) in this rule for clients eligible for OHP Standard.

(2) The intent of the OHP Standard Limited Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth.

(3) Services are limited to those procedures listed in Table 123-1670-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain;

(d) Tooth re-implantation when clinically appropriate; and

(e) Extraction of teeth are limited only to those teeth that are symptomatic.

(4) Hospital Dentistry is not a covered benefit for the OHP Standard population except:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(5) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit. Table 123-1670-1

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05

DIVISION 124

TRANSPLANT SERVICES

410-124-0000
Transplant Services

(1) The Division of Medical Assistance Programs (DMAP) will make payment for prior authorized and emergency transplant services identified in these rules as covered for eligible clients receiving the Basic Benefit Health Care Package and when DMAP transplant criteria described in OAR 410-124-0010 and 410-124-0060 through 410-124-0160 is met. All other Benefit Packages do not cover transplant.

(2) DMAP will only prior authorize and reimburse for transplants if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(3) Simultaneous multiple organ transplants are covered only if specifically identified as paired on the same currently funded line on the Oregon Health Plan (OHP) Prioritized List of Health Services whether the transplants are for the same underlying disease or for unrelated, but concomitant, underlying diseases.

(4) Not Covered Transplant Services: The following types of transplants are not covered by DMAP:

(a) Transplants which are considered experimental or investigational or which are performed on an experimental or investigational basis, as determined by DMAP;

(b) Transplant services which are contraindicated, as described in OAR 410-124-0060 through 410-124-0160;

(c) Transplants which have not been prior authorized for payment by DMAP or the client's managed health care plan;

(d) Transplants which do not meet the guidelines for an emergency transplant in OAR 410-124-0040;

(e) Transplants which are not described as covered in OAR 410-141-0480 and 410-141-0520.

(5) Selection of Transplant Centers: Transplant services will be reimbursed only when provided in a transplant center that provides quality services, demonstrates good patient outcomes and compliance with all DMAP 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 DMAP 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 DMAP clients. No DMAP transplant contract, prior approval or reimbursement will be made to consortia for transplant services where, as determined by DMAP, there is no assurance that the individual facilities that make up the consortia independently meet DMAP criteria. DMAP 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 DMAP transplant services, it is obliged to report immediately to DMAP 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 DMAP coverage of transplants performed at the facility;

(c) Fully Capitated Health Plans (FCHPs) that contract with non-DMAP 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 the DMAP 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) DMAP will discontinue the contract with a transplant center when the graft and/or survival rates fall below the standards indicated in this rule for a period of two consecutive years.

(6) Standards for Transplant Centers:

(a) Heart, heart-lung and lung transplants:

(A) Heart: One-year patient survival rate of at least 80%;

(B) Heart-Lung: One-year patient survival rate of at least 65%;

(C) Lung: One-year patient survival rate of at least 65%.

(b) Bone Marrow (autologous and allogeneic), peripheral stem cell (autologous and allogeneic) and cord blood (allogeneic) transplants: One-year patient survival rate of at least 50%;

(c) Liver transplants: One year patient survival rate of at least 70% and one year graft survival rate of at least 60%;

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants: One year patient survival rate of at least 90% and one year graft survival rate of at least 60%;

(e) Kidney transplants: One year patient survival rate of at least 92% and one year graft survival rate of at least 85%.

(7) Selection of transplant centers by geographic location: If the services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers. Out-of-state centers will be considered only if:

(a) The type of transplant required is not available in the state of Oregon and/or the type of transplant (for example, liver transplant) is available in the state of Oregon but the Oregon transplant center does not provide that type of transplant for all clients or all covered diagnoses, (e.g., pediatric transplants); and

(b) An in-state transplant center requests the out-of-state transplant referral; and

(c) An in-state transplant facility recommends transplantation based on in-state facility and DMAP criteria; or

(d) It would be cost effective as determined by DMAP. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant center; or

(e) It is a contiguous, out-of-state transplant center that has a contract or special agreement for reimbursement with DMAP.

(8) Professional and other services will be covered according to administrative rules in the applicable provider guides.

(9) Reimbursement for covered transplants and follow-up care for transplant services is as follows:

(a) For transplants for fee-for-service or Primary Care Case Manager (PCCM) clients:

(A) Transplant facility services — by contract with DMAP;

(B) Professional services — at DMAP maximum allowable rates.

(b) For emergency services, when no special agreement has been established, the rate will be:

(A) 75% of standard inpatient billed charge; and

(B) 50% of standard outpatient billed charge; or

(C) The payment rate set by the Medical Assistance program of the state in which the center is located, whichever is lower.

(c) For clients enrolled in FCHPs, reimbursement for transplant services will be by agreement between the FCHP and the transplant center.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2004(Temp), f. 9-14-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 92-2004(Temp), f.& cert. ef. 12-10-04 thru 3-15-05; OMAP 95-2004(Temp), f. & cert. ef, 12-30-04 thru 3-15-05; Administrative correction, 3-17-05

410-124-0005
Donor Services

(1) Living and cadaver donor search and procurement services are covered for covered transplants.

(2) All living or cadaver donor services are payable under the recipient's Medicaid identification number and not under the donor.

(3) Living donor services — prior authorization requirements for fee-for-service and Primary Care Case Manager (PCCM) clients:

(a) Bone marrow, stem cells and cord blood:

(A) Screening of potential living related donors does not require prior authorization;

(B) Unrelated/voluntary donor search requires prior authorization;

(C) Collection and testing of related cord blood requires prior authorization;

(D) Donor search costs up to the maximum amount of $15,000 are covered only if donor search is prior authorized;

(E) Procurement requires prior authorization of the transplant.

(b) Kidney alone — no prior authorization required for testing of or procurement from living or cadaver donors;

(c) Other solid organs — testing and procurement are covered if transplant is prior authorized;

(d) Payment is limited to donor expenses incurred directly in connection with the transplant. Complications of the donor that are directly and immediately related or attributable to the donation procedure are covered.

(4) Cadaver procurement services — prior authorization requirements for fee-for-service and PCCM clients:

(a) Covered if transplant is prior authorized;

(b) Procurement charges are included in the Organ Procurement Organization (OPO) charges to the transplant facility;

(c) Payable only to the transplant facility per contract.

(5) For Fully Capitated Health Plan (FCHP) clients, contact the client's FCHP for authorization requirements.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00

410-124-0010
Eligibility for Transplant Services

(1) To be eligible for transplant services the client must be on the Basic Health Care Package at the time the transplant services are provided.

(2) Clients covered under the following Benefit Packages do not have coverage for transplants:

(a) Limited Benefit Package (LMH, LMM) — coverage only for mental health, alcohol/drug, pharmacy, and medical transportation services;

(b) Qualified Medicare Beneficiary (MED) — coverage only for services covered by Medicare;

(c) Citizen/Alien-Waived Emergency Medical (CAWEM) — Federal rules exclude coverage of transplants, even if emergent.

(3) If an individual is not eligible for the Basic Health Care Package at the time the transplant is performed, but is later made retroactively eligible for the Basic Health Care Package, the Division of Medical Assistance Programs (DMAP) 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) DMAP prior authorization is valid for transplant services provided only while the client is enrolled under fee-for-service or a Primary Care Case Manager. If a client moves from the fee-for-service arena to a Fully Capitated Health Plan (FCHP), any prior authorizations which had been approved by DMAP are void and prior authorization must be obtained from the new FCHP. If a client moves out of an FCHP into another FCHP, or into fee-for-service, any prior authorizations approved by the original FCHP or DMAP are void, and prior authorization must again be obtained from the new FCHP or DMAP.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00

410-124-0020
Prior Authorization for All Covered Transplants, Except Cornea and Kidney

(1) Prior authorization is required as follows:

(a) All non-emergency transplant services require prior authorization of payment, except for kidney alone and cornea transplants which require prior authorization only if performed out-of-state;

(b) Pre-transplant evaluations provided by the transplant center 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 or the transplant physi-

cian. The initial request should contain all available information outlined in subsection (3) of this rule, below:

(a) For fee-for-service and Primary Care Case Manager (PCCM) clients, the request should be sent to the Division of Medical Assistance Programs (DMAP);

(b) For clients enrolled in a Fully Capitated Health Plan (FCHP), requests for transplant services should be sent directly to the FCHP.

(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 requests for evaluations only:

(a) The name, age, Medical Assistance Identification number, and birth date of the client;

(b) A description of the medical condition and full ICD-9-CM coding which necessitates a transplant;

(c) The type of transplant proposed, with CPT code;

(d) The results of a current HIV test, (completed within 6 months of request for transplant authorization);

(e) Any other evidence of contraindications for the type of transplant being considered (see contraindications under each transplant type);

(f) The client's prognosis, with and without a transplant, including estimated life expectancy with and without the transplant;

(g) Transplant treatment alternatives:

(A) A history of other treatments which have been tried;

(B) Treatments that have been considered and ruled out, including discussion of why they have been ruled out.

(h) An evaluation based upon a comprehensive examination completed by a board certified specialist in a field directly related to the condition of the client which necessitates the transplant;

(i) If already done before requesting prior authorization, the results of any medical and/or social evaluation completed by a transplant center should be included in the prior authorization request. The completion of an evaluation by a transplant center before receiving prior authorization from DMAP does not obligate DMAP 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, DMAP 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 DMAP criteria.

(b) For Oregon Health Plan (OHP) transplant eligible clients who are in an FCHP: Refer to the FCHP for approval process and requirements;

(c) The prior authorization request will be approved if:

(A) All DMAP criteria are met; and

(B) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(C) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services.

(5) The referring physician, transplant center, and the client will be notified in writing by DMAP 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 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-124-0040
Emergency Transplants

(1) An Emergency Transplant is one in which medical appropriateness requires that a covered transplant be performed less than five days after determination of the need for a transplant.

(2) Emergency transplants are subject to post transplant review of the client's medical records by the Division of Medical Assistance Programs (DMAP), or the Fully Capitated Health Plan (FCHP), to determine if the client and the transplant center met the criteria in these rules at the time of the transplant. Related charges, including transportation, physician's services, and donor charges will be covered if payment is approved. DMAP will make payment as described in OAR 410-124-0000(9) for DMAP-covered transplants. FCHPs will make payment as described in their contract.

(3) Transplants are not covered by Citizen/Alien-Waived Emergency Medical (CAWEM) clients, even when emergent.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-124-0060
Criteria and Contraindications for Heart Transplants

(1) Prior authorization for a heart transplant will only be approved for a client in whom irreversible heart disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart transplant must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early congenital heart disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;

(e) Irreversible pulmonary hypertension;

(f) Serious psychological disorders;

(g) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (DMAP) will only prior authorize and reimburse for heart transplants if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 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; OMAP 18-2000

f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

410-124-0063
Criteria and Contraindications for Heart-Lung Transplants

(1) Prior authorization for a heart-lung transplant will only be approved for a client in whom irreversible cardio-pulmonary disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart-lung transplant must have cardio-pulmonary failure with a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart-lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early cardio-pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart-lung transplant services:

(a) Untreatable systemic vasculitis;
(b) Incurable malignancy;
(c) Diabetes with end-organ damage;
(d) Active infection which will interfere with the client's recovery;
(e) Refractory bone marrow insufficiency;
(f) Irreversible renal disease;
(g) Irreversible hepatic disease;
(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;
(b) Curable malignancy;
(c) Significant cerebrovascular or peripheral vascular disease;
(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;
(e) Serious psychological disorders;
(f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (DMAP) will only prior authorize and reimburse for heart-lung transplants if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

410-124-0065
Criteria and Contraindications for Single Lung Transplants

(1) Prior authorization for a single lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of single lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for single lung transplant services:

(a) Untreatable systemic vasculitis;
(b) Incurable malignancy;
(c) Diabetes with end-organ damage;
(d) Active infection which will interfere with the client's recovery;
(e) Refractory bone marrow insufficiency;
(f) Irreversible renal disease;
(g) Irreversible hepatic disease;
(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;
(b) Curable malignancy;
(c) Significant cerebrovascular or peripheral vascular disease;
(d) Unresolved continuing thromboembolic disease or pulmonary infarction;
(e) Serious psychological disorders;
(f) Drug or alcohol abuse.

(7) The Division of Medical Assistance Programs (DMAP) will only prior authorize and reimburse for single lung transplants if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

410-124-0070
Criteria and Contraindications for Bilateral Lung Transplants

(1) Prior authorization for a bilateral lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of bilateral lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for bilateral lung transplant services:

(a) Untreatable systemic vasculitis;
(b) Incurable malignancy;
(c) Diabetes with end-organ damage;
(d) Active infection which will interfere with the client's recovery;
(e) Refractory bone marrow insufficiency;
(f) Irreversible renal disease;
(g) Irreversible hepatic disease;
(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;
(b) Curable malignancy;
(c) Significant cerebrovascular or peripheral vascular disease;
(d) Unresolved continuing thromboembolic disease or pulmonary infarction;
(e) Serious psychological disorders;
(f) Drug or alcohol abuse.

(7) the Division of Medical Assistance Programs (DMAP will only prior authorize and reimburse for bilateral lung transplants if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

410-124-0080
Criteria and Contraindications for Autologous and Allogeneic Bone Marrow, Autologous and Allogeneic Peripheral Stem Cell and Allogeneic Cord Blood Transplants

(1) The following criteria will be used to evaluate the prior authorization request for all bone marrow and peripheral stem cell transplants:

(a) Transplantation must be the most effective medical treatment, when compared to other alternatives, in prolonging life expectancy to a reasonable degree;

(b) The client must have a maximum probability of a successful clinical outcome and the expectation of not less than a 20 percent five (5) year survival rate, subsequent to the transplant, as supported by medical literature considering each of the following factors:

(A) The type of transplant, i.e., autologous or allogeneic;

(B) The specific diagnosis of the individual;

(C) The stage of illness, i.e., in remission, not in remission, in second remission;

(D) Satisfactory antigen match between donor and recipient in allogeneic transplants;

(c) All alternative treatments with a one year survival rate comparable to that of bone marrow transplantation must have been tried or considered.

(2) Allogeneic transplants will be approved for payment only when there is a minimum of 5-out-of-6 antigen match for bone marrow and peripheral stem cell transplants, or 4-out-of-6 match for cord blood transplants, considering the HLA-A, B, and DR loci. Donor search costs up to an amount of $15,000 will be covered only if prior authorized.

(3) Donor leukocyte infusions are covered only when:

(a) An early failure or relapse post allogeneic bone marrow transplant occurs; and

(b) Peripheral stem cells are from the original donor.

(4) The following are contraindications for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(5) The following may be considered contraindications to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(6) The Division of Medical Assistance Programs (DMAP) will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants only if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(7) DMAP will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants for pediatric solid malignancies only if:

(a) Requirements of 410-124-0080(6)(a), (b) and (c) are met; and

(b) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520.

(8) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant; the patient must meet the criteria specified above and in 410-124-0020 at the time the transplant is performed.

Stat. Auth.: ORS 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; OMAP 14-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 29-1998, f. & cert. ef. 9-1-98; OMAP 33-1999(Temp), f. & cert. ef. 10-1-99 thru 2-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 49-2002, f. & cert. ef. 10-1-02

410-124-0090
Criteria and Contraindications for Harvesting Autologous Bone Marrow and Peripheral Stem Cells

(1) The following are contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a potential transplant. The potential transplant recipient has:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(2) The following may be considered contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a transplant to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process. The potential transplant recipient has:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(3) The Division of Medical Assistance Programs (DMAP) will prior authorize and reimburse for the harvesting and storage of autologous bone marrow or autologous peripheral stem cells for a potential transplant recipient only if:

(a) All DMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and the CPT bone marrow or peripheral stem cell harvesting for transplantation procedure code(s) are paired on a currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520; and

(d) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520; and

(e) The client's marrow meets the clinical standards of remission at the time of storage; and

(f) A board certified hematologist/oncologist with specific experience in bone marrow transplant (BMT) services (i.e., cryopreservation and immunosuppressive treatment) has recommended the storage of autologous bone marrow or peripheral stem cell collection for possible future transplant/reinfusion; and

(g) The client has no contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells; and

(h) The client has no contraindications for bone marrow transplant or peripheral stem cell transplant.

(4) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant. The client must meet the criteria specified in this rule and OAR 410-124-0080, and the transplant must be prior authorized by DMAP before reimbursement will be approved.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 49-2002, f. & cert. ef. 10-1-02

410-124-0100
Criteria and Contraindications for Liver and Liver-Kidney Transplants

(1) Prior authorization for liver or liver-kidney transplants will be approved only for a client in whom irreversible, progressive liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Liver-kidney transplant is covered only for a medically documented diagnosis of Caroli's disease (ICD-9-CM 751.62).

(3) The following are contraindications for liver or liver-kidney transplants:

(a) Incurable and untreatable malignancy outside the hepatobiliary system;

(b) Terminal state due to diseases other than liver disease;
(c) Uncontrolled sepsis, or active systemic infection;
(d) HIV positive test results;
(e) Active alcoholism or active substance abuse;
(f) Alternative effective medical or surgical therapy;
(g) Presence of uncorrectable significant organ system failure other than liver (excluding short-bowel syndrome or congenital intractable diarrhea).

(4) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:
(a) Crigler-Najjar Syndrome Type II;
(b) Amyloidosis;
(c) Other major system diseases affecting brain, lung, heart, or renal systems;
(d) Major, not correctable congenital anomalies;
(e) Serious psychological disorders.

(5) The transplant center will review for current risk of alcohol or other substance abuse and risk of recidivism and will inform the Division of Medical Assistance Programs (DMAP) of its findings prior to the provision of the transplant.

(6) DMAP will only prior authorize and reimburse for liver and liver-kidney transplants if:
(a) All DMAP criteria are met; and
(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

410-124-0105
Criteria and Contraindications for Intestine and Intestine-Liver Transplants

(1) Prior authorization for intestine and intestine-liver transplants will be approved only for:

(a) A client who has failed Total Parenteral Nutrition (TPN) or who has developed life-threatening complications from TPN;

(b) A client in whom irreversible, progressive intestine and/or liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate subsequent to the transplant, is at least twenty (20) percent as supported by the medical literature.

(2) Intestine and Intestine-Liver transplant is covered only for a medically documented diagnosis of Short Bowel Syndrome and for patients age 5 years or under with diagnosis of ICD-9-CM 557, ICD-9-CM 579.3, or ICD-9-CM 777.5.

(3) Small intestine transplant using a living related donor is considered investigational and will not be covered by The Division of Medical Assistance Programs (DMAP).

(4) The following are contraindications for intestine or intestine-liver transplants:
(a) Incurable and untreatable malignancy outside the hepatobiliary system;
(b) Terminal state due to diseases other than liver or intestinal disease;
(c) Uncontrolled sepsis, or active systemic infection;
(d) HIV positive test results;
(e) Alternative effective medical or surgical therapy;
(f) Presence of uncorrectable significant organ system failure other than liver or Short-Bowel Syndrome.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:
(a) Crigler-Najjar Syndrome Type II;
(b) Amyloidosis;
(c) Other major system diseases affecting brain, lung, heart, or renal systems;
(d) Major, non-correctable congenital anomalies;
(e) Serious psychological disorders.

(6) DMAP will prior authorize and reimburse for intestine and intestine-liver transplant if:
(a) All DMAP criteria are met; and
(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
(c) The ICD-9-CM diagnosis code(s) and CPT procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05

410-124-0120
Criteria and Contraindications for Simultaneous Pancreas-Kidney and Pancreas After Kidney Transplants

(1) Prior authorization for a Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplant will be approved only for a client in whom irreversible kidney and/or pancreatic disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Simultaneous pancreas-kidney (SPK) transplant is covered only for Type I diabetes mellitus with end stage renal disease (ICD-9-CM codes 250.41 or 250.43).

(3) Pancreas after kidney (PAK) transplantation will be considered for clients suffering from insulin dependent Type I diabetes after prior successful renal transplant. Pancreas after kidney (PAK) transplant is covered only for Type I diabetes mellitus (ICD-9-CM codes 250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.51, 250.53, 250.61, 250.63, 250.81, 250.83, 250.91, 250.93, 996.81 or 996.86) with a secondary diagnosis V42.0.

(4) The following are contraindications to SPK and PAK transplants:
(a) Uncorrectable severe coronary artery disease;
(b) Major irreversible disease of any other major organ system likely to limit life expectancy to five years or less;
(c) HIV positive test results.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:
(a) Serious psychological disorders;
(b) Drug abuse or alcohol abuse.

(6) The Division of Medical Assistance Programs (DMAP) will only prior authorize and reimburse for Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplants if:
(a) All DMAP criteria are met; and
(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and
(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 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; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

410-124-0140
Kidney Transplants

(1) Kidney transplants do not require prior authorization when accomplished in-state.

(2) Out-of-state kidney transplant services are prior authorized by the Division of Medical Assistance Programs (DMAP) or the Fully Capitated Health Plan (FCHP):
(a) Submit the request to the FCHP or DMAP;
(b) The request must contain the following information:
(A) Name and Medical Assistance Identification number of the client;
(B) A description of the condition which necessitates a transplant;
(C) The results of any evaluation performed by an in-state provider of kidney transplant services;
(D) An explanation of the reason out-of-state services are requested.

Stat. Auth.: ORS 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; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-124-0160
Cornea Transplants

(1) Cornea transplants do not require prior authorization when accomplished in-state.

(2) Out-of-state corneal transplant services are prior authorized by the Division of Medical Assistance Programs (DMAP) or the Fully Capitated Health Plan (FCHP):

(a) Submit the request to the FCHP or DMAP;

(b) The request must contain the following information:

(A) Name and Medical Assistance Identification number of the client;

(B) A description of the condition which necessitates a transplant;

(C) The results of any evaluation performed by an in-state provider of cornea transplant services;

(D) An explanation of the reason out-of-state services are requested.

Stat. Auth.: ORS 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; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

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 Automated Information System (AIS) each time services are provided in order to assure that the client is eligible. Contact information can be found in the Hospital Services Supplemental Information and on the Division of Medical Assistance Programs (DMAP) web site.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0150; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0020
Retroactive Eligibility

(1) The Division of Medical Assistance Programs (DMAP) 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 (PA) for service. However authorization for payment may be given after the service is provided under some circumstances. For additional PA information see OAR 410-125-0080 and 410-125-0047.

NOTE: See OAR 410-125-0102 for exception for Medically Needy Program clients.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0160, 461-015-0230 & 461-015-0370; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0160 & 410-125-0440; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0030
Hospital Hold

(1) A hospital hold is a process which allows an in-state general hospital or an out-of-state contiguous general hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the Oregon Health Plan due to inpatient hospitalization.

(2) The Division of Medical Assistance Programs (DMAP) will accept hospital holds for inpatient stays. Hospitals must either submit a DMAP 3261 or a hospital generated form to DMAP within 24 hours of the admission time or the next working day. If a hospital uses its own form, the form must contain all the information found on the DMAP 3261.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 12-2000(Temp), f. 8-16-00, cert. ef. 8-17-00 thru 2-1-01; OMAP 39-2000, f. 11-14-00, cert. ef. 11-15-00; OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0040
Title XIX/Title XXI Clients

(1) Title XIX /Title XXI clients are eligible for medical assistance through programs established by the Federal government and for which the State receives federal assistance. Most Title XIX/Title XXI clients are eligible for the Plus or Standard Benefit packages. See the General rules (chapter 410 division 120) for more information on eligibility, benefit package, and covered services. Most Title XIX/Title XXI clients are enrolled in a FCHP, a MHO and a DCO. Some Title XIX clients are Medicare Beneficiaries.

(2) The Division of Medical Assistance Programs (DMAP) contracts with Prepaid Health Plans (PHPs): Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), and Dental Care Organizations (DCOs), to provide certain medical, mental health and dental services on a prepaid basis.

(a) FCHPs provide a comprehensive package of health care benefits including hospital, physician, laboratory, X-ray and other diagnostic imaging, Medicheck (EPSDT), pharmacy, physical therapy, speech-language therapy, occupational therapy, case management, and other services;

(b) MHOs provide mental health services. They can be fully capitated health plans, community mental health programs, private behavioral organizations or a combination thereof;

(c) DCOs provide dental care;

(d) If the client is enrolled in a Prepaid Health Plan, the name, address and phone number of the plan will appear on the Medical Care Identification. Always check with the plan listed if there is a question about coverage;

(e) PHP clients receive most of their primary care services through the PHP or upon referral from the PHP. In emergency situations, all services may be provided without prior authorization or referral. However, all claims for emergency services must be sent to the prepaid health plan. The hospital must work with the client's prepaid health plan to arrange for billing and payment for emergency and non-emergency services;

(f) DMAP will not reimburse for services that can be provided by the client's PHP and are included in the PHP's contract as covered services. Reimbursement is between the service provider and the PHP.

(3) Medicare Clients: Some Title XIX clients also have Medicare coverage. Most Medicare beneficiaries who are also eligible for Medicaid will have the full range of covered benefits for both Medicare and Medicaid. However, a few individuals who are Medicare eligible are eligible for only partial coverage through Medicaid. Refer to the General rules (chapter 410 division 120) for information on eligibility.

Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0170 & 461-015-0180; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0060; HR 22-1992, f. 7-31-92, cert. ef. 8-1-92; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0041
Non-Title XIX/XXI Clients

(1) State-funded clients are clients who have not qualified for medical assistance through a federal program but have access to medical benefits through state funded programs. There are two categories of clients who are in State-funded programs.

(2) Program GA clients: Program GA clients are children in foster care, in SCF custody, who are not eligible for Title XIX/Title XXI programs. They have access to the full range of Medicaid covered services, but payment for services provided to these children may be different from that for Title XIX/Title XXI clients. For additional reimbursement information see the Hospital Services Supplemental Information on the Division of Medical Assistance Programs (DMAP) web site.

(3) Program SF clients: Program SF clients are individuals who are receiving treatment in a state facility, such as Oregon State Hospital, or the Eastern Oregon Training Center. They sometimes need to receive hospital care outside the state facility. They are entitled to the full range of Medicaid covered hospital services. These individuals will be referred

by the state facility for services. They do not have Medical Care Identification cards. They are not enrolled in a Fully Capitated Health Plan. The state will contact the hospital regarding billing instructions for these clients.

Stat. Auth.: ORS 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; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0045
Coverage and Limitations

In general, most medically appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the General rules for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are:

(1) Prior authorization (PA): Some services require prior authorization. The Plus and Standard Benefit Packages may have different PA requirements. For the Plus Benefit Package check OAR 410-125-0080. Detailed PA information for the Standard Benefit Package is on the web site http://www.dhs.state.or.us/healthplan/guides/hospital.

(2) Non-Covered services:

(a) Services that are not medically appropriate, unproven medical efficacy or services that are the responsibility of another Division are not covered by the Division of Medical Assistance Programs (DMAP);

(b) Service coverage is based on the Health Services Commission's Prioritized List of Services and the benefit package;

(c) See the General rules (chapter 410 division 120) and other program divisions in chapter 410 for a list of not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

(3) Limitations on Hospital Benefit Days: Clients have no hospital benefit day limitations for treatment of covered services.

(4) Dental Services: Clients have dental/denturist services identified as covered on the Health Services Commission Prioritized List (OAR 410-141-0520).

(5) Services provided outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by DMAP 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 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; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0047
Limited Hospital Benefit Package for the OHP Standard Population

(1) The Oregon Health Plan (OHP) Standard population has a limited hospital benefit for urgent or emergent inpatient and emergency room services effective on August 1, 2004 through August 31, 2004. The limited hospital benefit for inpatient, outpatient, and emergency room services is effective on and after September 1, 2004.

(2) The limited hospital benefit includes the ICD-9 CM codes listed in the OHP Standard Population — Limited Hospital Benefit Code List. This rule incorporates by reference the OHP Standard Population — Limited Hospital Benefit Code List. This list includes diagnoses requiring prior authorization indicated by letters prior authorization (PA) next to the code number. The most current list, dated September 1, 2004, is available on the web site (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact the Division of Medical Assistance Programs (DMAP) for hardcopy.

(3) DMAP will reimburse hospitals for inpatient (diagnostic and treatment) services, outpatient (diagnostic and treatment services) and emergency room (diagnostic and treatment) based on the following:

(a) For treatment, the diagnosis must be listed in the OHP Standard Population — Limited Hospital Benefit Code List;

(b) For treatment the diagnosis must be above the funding line on the Prioritized List of Health Services (HSC List) (OAR 410-141-0520);

(c) The diagnosis (ICD-9) must pair with the treatment (CPT code); and

(d) Prior authorization (PA) must be obtained for codes indicated in the OHP Standard Population — Limited Hospital Benefit Code List. PA request should be directed to the DMAP contracted Quality Improvement Organization (QIO) and will follow the present (current) PA process. PAs must be processed as expeditiously as the client's health condition requires;

(e) Medically appropriate services required to make a definitive diagnosis are a covered benefit.

(4) Some non-diagnostic outpatient hospital services (e.g. speech, physical or occupational therapy, etc.) are not a covered benefits for the OHP Standard population (see the individual program for coverage).

(5) For benefit implementation process and PA requirements for the client enrolled in a Fully Capitated Health Plan (FCHP) and/or Mental Health Organization (MHO), contact the client's FCHP or MHO. The FCHP and/or MHO may have different requirements than DMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 52-2004(Temp), f. & cert. ef. 9-1-04 thru 2-15-05; OMAP 84-2004, f. & cert. ef. 11-1-04

410-125-0050
Client Copayments

Copayments may be required for certain services and/or benefit package(s). See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 77-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0080
Prior Authorization/Prior Notification

(1) Elective (Not Urgent or Emergent) Admission:

(a) Fully Capitated Health Plan (FCHP) and Mental Health Organization (MHO) Clients — contact the client's MHO or FCHP (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than the Division of Medical Assistance Programs (DMAP);

(b) Medicare Clients — DMAP does not require prior authorization for inpatient services provided to clients with Medicare Part A or B coverage;

(c) For DMAP clients covered by the Oregon Health Plan (OHP) Plus Benefit Package:

(A) Hospital admissions for any of the medical and surgical procedures shown in Table 125-0080-1 require prior authorization, unless they are urgent or emergent;

(B) For prior authorization contact the DMAP contracted Quality Improvement Organization (QIO) unless otherwise indicated in Table 125-0080-1.

(d) DMAP clients covered by the OHP Standard Benefit Package have a limited hospital benefit package. Specific coverage and prior authorization requirements are listed in the DMAP Hospital Services Supplemental Information or at DMAP website http://www.dhs.state.or.us/healthplan/guides/hospital (referenced in OAR 410-125-0047).

(2) Transplant services:

(a) Complete rules for transplant services are in the DMAP Transplant Services rules (OAR 410 division 124);

(b) Clients are eligible for transplants covered by the Health Services Commission's Prioritized List of Health Services. See the Transplant Services rules for criteria. For clients enrolled in a FCHP, contact the plan for authorization. Clients not enrolled in an FCHP, contact the DMAP Medical Director's office.

(3) Out-of-State non-contiguous hospitals:

(a) All non-emergent/non-urgent services provided by hospitals more than 75 miles from the Oregon border require prior authorization;

(b) Contact the DMAP Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-state contiguous hospitals: services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, are prior authorized following the same rules and procedures as in-state providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in Table 125-0080-1, e.g., inpatient physical rehabilitation care, require prior authorization — contact SMAP contracted QIO;

(b) Transfers to a skilled nursing facility, intermediate care facility or swing bed — contact Seniors and People with Disabilities (SPD). SPD

reimburses nursing facilities and swing beds through contracts with the facilities. For FCHP clients — transfers require authorization and payment (for first 20 days) from the FCHP;

(c) Transfers to the same or lesser level of inpatient care — DMAP 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) In state or contiguous 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 Table 125-0080-1 of this rule;

(C) All non-urgent transfers to out-of-state non-contiguous hospitals require prior authorization.

(6) Dental procedures provided in a hospital setting:

(a) DMAP will reimburse for hospital services when covered dental services are provided in a hospital setting for clients not enrolled in a FCHP, when a hospital setting is medically appropriate. For prior authorization, contact the DMAP Dental Services Program coordinator;

(b) For clients enrolled in a FCHP, contact the client's FCHP;

(c) Emergency dental services do not require prior authorization.

(7) Prior notification is required for the following radiology tests: MRI, MRA, CT, CTA, and SPECT scans:

(a) Providers ordering these procedures must submit a prior notification form to DMAP prior to the performance of the tests;

(b) Refer to OAR 410-130-0200, Table 130-0200-2 for radiology test codes requiring prior notification;

(c) Refer to the Medical-Surgical Supplemental Information guide for instructions and forms.

(8) Prior notification is not required when these tests are performed during an emergency department visit or an inpatient stay.

Table 125-0080-1

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

Stat. Auth.: ORS 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 461-015-0190; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 7-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 9-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05

410-125-0085
Outpatient Services

(1) Outpatient services that may require prior authorization include (see the individual Program rules):

(a) Physical Therapy (chapter 410 division 131);

(b) Occupational Therapy (chapter 410 division 131);

(c) Speech Therapy (chapter 410 division 129);

(d) Audiology (chapter 410 division 129);

(e) Hearing Aids (chapter 410 division 129);

(f) Dental Procedures (chapter 410 division 123);

(g) Drugs (chapter 410 division 121);

(h) Apnea monitors, services, and supplies (Chapter 410 Division 131);

(i) Home Parenteral/Enteral Therapy (Chapter 410 Division 148);

(j) Durable Medical Equipment and Medical supplies (Chapter 410 Division 122);

(k) Certain hospital services.

(2) Outpatient Surgical procedures:

(a) FCHP Clients: Contact the client's FCHP (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than the Division of Medical Assistance Programs (DMAP). Some services are not covered under FCHP contracts and require prior authorization from the DMAP contracted Quality Improvement Organization (QIO), or the the DMAP Dental Program coordinator;

(b) Medicare Clients enrolled in FCHPs: 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) For the Plus benefit package DMAP 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 DMAP contracted QIO (unless indicated otherwise in OAR 410-125-0080).

(d) For the Standard benefit package DMAP client's outpatient surgical procedures: see OAR 410-125-0047 and the OHP Standard Population — Limited Hospital Benefit Package Code List (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact DMAP for a hardcopy, for coverage and prior authorization requirements;

(e) Out-of-State Services — 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. For clients enrolled in an FCHP, contact the plan for authorization. For clients not enrolled in a prepaid health plan, contact the DMAP Medical Director's office.

Stat. Auth.: ORS 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; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0086
Prior Authorization for FCHP/MHO Clients

Most non-emergent inpatient and outpatient services require prior authorization by a Fully Capitated Health Plan (FCHP) or a Mental Health Organization (MHO). Emergency hospital services must be covered by an FCHP or MHO without regard to prior authorization or the emergency care provider's contractual relationship with the FCHP or MHO. Emergency hospital services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. Once a client's condition is considered stabilized, or a medical screening examination has determined that the client's medical condition is not emergent, an FCHP or MHO may require prior authorization for hospital admission, follow-up care, or further treatment. Failure to obtain prior authorization from the FCHP or MHO may result in a denial of payment for services. Contact the client's FCHP or MHO for further information on prior authorization.

Stat. Auth.: ORS 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; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01

410-125-0090
Inpatient Rate Calculations — Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except Laboratory and Radiology services are based on the Division of Medical Assistance Programs (DMAP) fee schedule;

(b) Retrospective cost-based reimbursement is made during the annual cost settlement period for all covered inpatient services, except for the hospitals that have payment contracts with managed care plans;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

(3) Type A, Type B, and Critical Access Hospitals are:

(a) Eligible for disproportionate share reimbursements, but must meet the same criteria as other hospitals. See OAR 410-125-0150 for eligibility criteria and reimbursement calculation;

(b) Type A, Type B, and Critical Access Hospitals do not receive cost outlier, capital, or medical education payments.

(4) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered inpatient services is as follows:

(a) Interim reimbursement for inpatient-covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory services which are based on the DMAP fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered inpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect the Medicaid mix of services.

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-0095
Hospitals Providing Specialized Inpatient Services

(1) Some hospitals provide specific highly specialized inpatient services by arrangement with the Division of Medical Assistance Programs (DMAP).

(2) Reimbursement is made according to the terms of a contract between DMAP and the hospital.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860

410-125-0100
Quality Improvement Organization (QIO) Procedures

(1) The Division of Medical Assistance Programs (DMAP) contracts with a Quality Improvement Organization (QIO) to provide prior authorization for selected services. The contracted QIO approves or denies a request for non-emergency inpatient services based on recommendations from the QIO's physician review findings. Requests to the QIO for non-emergency inpatient hospital admissions may be submitted in writing (mail, fax) or by phone.

(2) The QIO has three working days to respond to a completed request for prior authorization. A completed request must contain all the information necessary for the QIO staff to recommend approval, denial, or to require a second opinion.

(3) Criteria used by the QIO to screen requests are: the QIO developed surgical criteria, InterQual Adult and Pediatric Medical criteria, the QIO Specialty Criteria for Psychiatric and Inpatient Rehabilitation Services, CMS Generic Quality Screens, and criteria for services developed by DMAP in conjunction with the QIO.

(4) The QIO staff can require a client seek a second opinion from a contracted second opinion physician if the appropriate criteria has not been met, or if the physician has not submitted adequate information. If the requesting physician disagrees with second opinion physician, the QIO can require a client have a third opinion. The requesting physician may ask the QIO 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, appropriate, or reasonable, DMAP will deny the request for prior authorization of payment based upon the recommendation of the QIO.

(6) The requesting physician may appeal a decision to deny reimbursement to DMAP.

(7) No payment will be made to the hospital or to the attending physician providing services for an inpatient hospital stay if the service is not authorized.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0200; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0101
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 Seniors and People with Disabilities (SPD). These services must be provided, billed, and accounted for separately from other hospital services and in accordance with SPD rules. Contact SPD client's branch office for further information.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0102
Medically Needy Clients

(1) The QIO can give prior authorization for non-emergency inpatient services for clients who are in the Medically Needy Program but have not yet met their spend-down. Only Medically Needy Program clients under age 21 and pregnant women have coverage for inpatient services if enrolled in the Medically Needy Program.

(2) Prior authorization cannot be granted for outpatient services, which require prior authorization. However, you may contact the Division of Medical Assistance Programs (DMAP) 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; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0103
Medicare Clients

When Medicare is the primary payer, services provided in the inpatient or out patient setting do not require prior authorization. However, if the Division of Medical Assistance Programs (DMAP) is the primary payer because the service is not covered by Medicare; the prior authorization requirements listed in chapter 410 division 125 would apply.

Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0115
Non-Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with Division of Medical Assistance Programs (DMAP) for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for non-contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations from Other Hospitals, DRG Rate Methodology, OAR 410-125-0141 for the methodology used to calculate the unit value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. 11-18-91, Renumbered from 410-125-0840; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04

410-125-0120
Transportation To and From Medical Services

(1) Transportation to and from medical services, including hospital services, is a covered service. However, all non-emergency transports require prior authorization in order for the transportation provider to be paid.

(2) The transportation must be the least expensive obtainable under existing conditions and appropriate to the client's needs.

(3) Contact the 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 instructions contained in the Hospital Supplemental Information on the Division of Medical Assistance Programs (DMAP) website for additional information.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0210; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0121
Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with Division of Medical Assistance Programs (DMAP) for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations for Other Hospitals, DRG Rate Methodology OAR 410-125-0141 for the methodology). Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04

410-125-0124
Retroactive Authorization

Retroactive authorization for payment can be granted after the service is provided only in the following circumstances:

(1) The person was not yet eligible for Medicaid/CHIP at the time the services were provided. Payment can be made if the services are covered Medicaid/CHIP services and the client's eligibility is extended back to the date the hospital provided services. See: the Hospital Services Supplemental Information on the Division of Medical Assistance Programs (DMAP) website for additional billing information.

(2) If another insurer denied the claim because the service is not covered by that insurer, and the hospital did not seek prior authorization because it had good reason to believe the service was covered by the insurer. Payment can be made by DMAP if the services are covered by Medicaid. See: the Hospital Services Supplemental Information on the DMAP website for additional billing information.

Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0125
Free-Standing Inpatient Psychiatric Facilities (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, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987 (Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989 (Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991 (Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860

410-125-0140
Prior Authorization Does Not Guarantee Payment

(1) Prior authorization (PA) is valid for the date range approved only as long as the client remains eligible for services. For example, a client may become ineligible after the 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 the Division of Medical Assistance Programs (DMAP) for payment.

(2) All prior authorized treatment is subject to retrospective review. If the information provided to obtain prior authorization can not 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 for the service from DMAP or the DMAP contracted Quality Improvement Organization (QIO).

(4) For the Plus Benefit Package PA information refer to the Prior Authorization Chart in the Hospital Services rules (OAR 410-125-0080-1).

(5) For the Standard Benefit Package PA information refer to the Standard Population — Limited Hospital Benefit Package Covered Code List at the website www.dhs.state.or.us/policy/healthplan/guides/hospital.

(6) Hospitals may also verify PA requirements by calling the DMAP Provider Services Unit or the RN Benefit Hotline (contact phone numbers are located on the DMAP website).

Stat. Auth.: ORS 184.750, 409.010, 409.110, 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 461-015-0220; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0141
DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 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 an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Division of Medical Assistance Programs (DMAP) 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, DMAP may modify the logic of the grouper program. DMAP will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. DMAP DRG weight tables can be found on the DHS web site.

(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, DMAP establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, DMAP uses the following methodology: Using the formula N = where Z = 1.15 (a 75% confidence level), S is the standard deviation, and R = 10% of the mean. DMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, DMAP sets a relative weight using:

(A) DMAP non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the DMAP Title XIX caseload.

(c) When a test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the DMAP Title XIX population in that DRG, the weight derived from DMAP Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State specific relative weights shall be adjusted, as needed, as determined by DMAP. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty (50) beds are reimbursed using the Diagnosis Related Grouper (DRG) as described in (2). Effective for services on or after:

(a) March 1, 2004, the Unit Value payment is 80% of the 2004 Medicare Unit Value and related data published in Federal Register/Vol.68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(b) August 15, 2005, the operating unit payment is 100% of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out of state hospitals do not receive the capital amount).

(7) Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients;

(b) For dates of service on and after March 1, 2004 the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold ($25,000 or 270% of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270% of the DRG or $25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50%), equals;

(vii) Cost Outlier Payment.

(E) Third party reimbursements are deducted from the DMAP calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and DMAP 42, adjusted to reflect the Medicaid mix of services.

(8) 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. DMAP uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004 the Capital cost per discharge is one hundred (100) percent of the published Medicare capital rate for fiscal year 2004, see (5). The capital cost is added to the Unit Value and paid per discharge.

(9) 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. DMAP uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct Medical Education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX Direct Medical Education Cost per discharge;

(B) The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment.

(c) Direct Medical Education Payment Per Discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors;

(C) Notwithstanding subsection (9) of this rule, this subsection becomes effective for dates of service on and after July 1, 2006 and thereafter Direct Medical Education payments will not be made to hospitals, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained.

(10) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to instate 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 (DMAP) indirect medical education factor. This factor is used for the entire Oregon fiscal year;

(d) For dates of service on and after March 1, 2004 the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital specific February 29, 2004 Unit Value, multiplied by the Indirect Factor equals the Indirect Medical Education Payment;

(e) 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.

(d) Notwithstanding subsection (10) of this rule, this subsection becomes effective for dates of service on and after July 1, 2006 and thereafter Indirect Medical Education payment will not be made to hospitals, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained.

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

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570, 461-015-0590, 461-015-0600 & 461-015-0610; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 42-1990, f. & cert. ef. 11-30-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840, 410-125-0880, 410-125-0900, 410-125-0920, 410-125-0960 & 410-125-0980; HR 35-1993(Temp), f. & cert. ef. 12-1-93; HR 23-1994, f. 5-31-94, cert. ef. 6-1-94; HR 11-1996(Temp), f. & cert. ef. 7-1-96; HR 22-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 45-1998, f. & cert. ef. 12-1-98; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 37-2005(Temp) f. & cert. ef. 8-15-05 thru 1-15-06; OMAP 70-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0142
Graduate Medical Education Reimbursement for Public Teaching Hospitals

(1) Graduate Medical Education (GME) payment is reimbursement made to an institution for the costs of an approved medical training program. The State makes GME payments to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. Funding for public teaching hospital GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans.

(2) For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (becomes base year).

(3) The GME payment is calculated as follows:

(a) Total Direct Medical Education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME.

(b) Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount — other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

(c) The total net Title XIX GME is the sum of Title XIX IME and DME costs. The GME reimbursement is made quarterly. Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population. GME is rebased yearly.

(4) Total GME payments will not exceed that determined by using Medicare reimbursement. The Medicare upper limit will be determined from the most recent Medicare Cost Report and performed for all inpatient acute hospitals and separately for State operated inpatient acute hospitals in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the GME payment is made.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 30-1999(Temp), f. & cert. ef. 6-15-99 thru 11-1-99; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0145
Proportionate Share (Pro-Share) Payments for Public Academic Teaching Hospitals

(1) Proportionate Share (Pro-Share) payments will be made to public academic teaching hospitals in the State of Oregon with 200 or more interns or residents. Inpatient and outpatient Pro-Share payments are subject to the federal Medicare upper payment limit for inpatient hospital payments. The Medicare upper payment limit analysis will be performed prior to making the payments.

(2) Eligible academic hospitals will be classified as either a:

(a) State owned or operated hospital; or

(b) Non-state government owned or operated hospital.

(3) The Inpatient Pro-Share payment will be specific to each classification and determined as follows:

(a) The federal upper payment limit determined in accordance with the specific requirements for each hospital classification for all eligible hospitals during the State Fiscal Year 2001;

(b) The Inpatient Pro-Share payment is calculated by the determination of Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments;

(c) The State of Oregon Medicaid Management Information System (MMIS) is the source of the charge and payment data.

(4) Inpatient Proportionate Share payments will be made quarterly during each federal fiscal year. Payments made during federal fiscal year will not exceed the Medicare upper limit calculated from January 1, 2001 through September 30, 2001 and quarterly for each federal fiscal year thereafter.

(5) The Outpatient Pro-Share payment will be specific to each classification and determined as follows:

(a) The federal upper payment limit determined in accordance with the specific requirements for each hospital classification for all eligible hospitals during the State Fiscal Year 2001;

(b) The Outpatient Pro-Share payment is calculated by the determination of the Medicare upper payment limit of Medicaid Fee-For-Service Outpatient charges converted to what Medicare would pay, less Medicaid payments, third party liability payments, and the net Outpatient cost settlement payment determined in the Medicaid Cost Settlement (Form 42);

(c) The State of Oregon Medicaid Management Information System (MMIS) and the provider's Medicare Cost Report are the source of the charge and payment data.

(6) Outpatient Pro-Share payment will be made annually following the finalization of the Medicaid Cost Settlement. The Outpatient Pro-Share payment will not exceed the Medicare upper payment limit calculated from January 1, 2001 through September 30, 2001 and annually for each federal fiscal year thereafter.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 52-2005, f. 9-30-05, cert. ef. 10-1-05

410-125-0146
Supplemental Reimbursement for Public Academic Teaching University Medical Practitioners

(1) Effective for dates of service on or after November 17, 2005, physician and other practitioner services provided by practitioners affiliated with a public academic medical center that meets the following eligibility standards shall be eligible for a supplemental teaching practitioner's payment for these services provided to eligible Medicaid recipients and paid for directly on a fee-for-service basis, subject to subsections (3) and (4) of this rule. This supplemental payment shall be equal to the difference between the Medicare allowable and Medicaid reimbursement received.

(2) Eligible academic medical centers must be:

(a) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(b) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(3) Payments under this rule shall be made only to the eligible academic medical centers in accordance with the terms of an Intergovermental Agreement between the eligible academic medical center and Division of Medical Assistance Programs (DMAP). Such payments may be made quarterly, but shall be at least paid annually, at the end of each federal fiscal year. Calculation of the payment amount will be based on the annual difference between the practitioners' Medicare allowable and the Medicaid allowable payments to eligible practitioners for the Medicaid claims paid during the most recently completed state fiscal year. Services included are physician and other practitioners' services with RVU weights and physician-administered drugs. The RVU rates used for the payment calculation are the DMAP fee established in rule for the date of service payment period.

(4) Allowable Medicaid payments including this supplemental payment remain subject to OAR 410-125-0220(12) and 410-130-0225. For purposes of this rule, the allowable Medicaid payments used to calculate the supplemental payment shall be limited to the services that are billed fee-for-service to DMAP on the electronic 837P or the paper CMS-1500, and as to which the physician or practitioner is receiving no reimbursement from the eligible academic medical center and the cost of their service is not reported as a direct medical education cost on the Medicare and DMAP cost report.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
Hist.: OMAP 33-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 43-2006, f. 12-15-06, cert. ef. 1-1-07

410-125-0150
Disproportionate Share (Effective for services rendered on or after January 1, 2001)

(1) The Disproportionate Share Hospital (DSH) payment is an additional reimbursement made to hospitals that serve a disproportionate share of low-income patients with special needs.

(2) A hospital's eligibility for DSH payments is determined at the beginning of each fiscal year. Hospitals that are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1.

(3) Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state:

(a) Criteria 1:

(A) The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) to total inpatient days is one or more standard deviations above the mean for all Oregon hospital;

(B) Information on total inpatient days is taken from the most recent audited Medicare Cost Report. The total paid Medicaid inpatient days is based on DMAP records for the same cost reporting period;

(C) Information on total paid Medicaid days is taken from Division of Medical Assistance Program (DMAP) 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 for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus any cash subsidies received directly from State and local governments in 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 Medicare cost reporting period. The result is expressed as a percentage;

(ii) The Charity Care Percentage: The total hospital charges for inpatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period, is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage;

(iii) Charity care is provided to individuals who have no source of payment, including third party and personal resources.

(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 third party payers, such as FCHPs, Medicare, Medicaid, etc;

(D) The information used to calculate the Low Income Utilization rate is taken from the following sources:

(i) The most recent Medicare Cost Reports;

(ii) DMAP records of payments made during the same reporting period;

(iii) Hospital provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period;

(iv) Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period;

(v) Any other information that DMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

(E) DMAP 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 Payment Calculations:

(A) To receive DSH payments, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital that performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital that had discontinued or did not offer non-emergency obstetric services as of December 21, 1987. No hospital may qualify for disproportionate share payments, unless the hospital has, at a minimum, a Medicaid utilization rate of 1 percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another State are also accounted for;

(B) Information on total inpatient days is taken from the most recent Medicare Cost Report.

(d) Disproportionate Share Payment Calculations:

(A) Eligibility Under Criteria 1 — The quarterly DSH 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 DSH payment for the current quarter. The Unit Value used for eligible Type A, Type B, and Critical Access Hospitals is set at the same rate as for out-of-state hospitals. The calculation is as follows:

(i) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5% to determine the DSH payment;

(ii) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. The amount is multiplied by 0.10 to determine the DSH payment.

(iii) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 0.25 to determine the DSH payment.

(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 DMAP 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 quarterly DSH payment is 5% of the out-of-state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals that have entered into agreements with DMAP for payment are reimbursed according to the terms of the agreement or contract.

(e) Additional Disproportionate Share Adjustments:

(A) Public academic medical centers that meet the following eligibility standards shall be deemed eligible for additional DSH payments up to 100% of their cost for serving Medicaid fee for service clients and indigent and uninsured patients:

(i) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and

(ii) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(iii) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

(B) 100% of the costs for hospitals qualifying for this DSH payment will be determined from the following sources:

(i) The most recent Medicare Cost Reports; or

(ii) DMAP's record of payments made during the same reporting period; or

(iii) Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period; or

(iv) Any information which DMAP, working in conjunction with representatives of Oregon hospitals, determines necessary to establish cost.

(f) Disproportionate Share Payment Schedule:

(A) Hospitals qualifying for DSH payments under section (3)(d) will receive quarterly payments based on claims paid during the preceding quarter. Hospitals that were eligible during one fiscal year but are not eligible for disproportionate share status during the next fiscal year will receive DSH payments based on claims paid in the quarter in which they were eligible. Hospitals qualifying for DSH payments under section (3)(c) will receive quarterly payments of 25 percent of the amount determined under this section;

(B) Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, DSH payments to hospitals will not exceed 100 percent of the "basic limit" which is:

(i) The inpatient and outpatient costs for services to Medicaid patients, less the amounts paid by the State under the non-DSH payment provisions of the State plan, plus;

(ii) The inpatient and outpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who has no other resources to cover the costs of services delivered. The costs attributable to uninsured patients are determined through disclosures in the Medicare (HCFA-2552) cost report and state records on indigent care.

(C) The State has a contingency plan to assure that disproportionate share hospital payments will not exceed the "State Disproportionate Share Hospital Allotment." A reduction in payments in proportion to payments received will be effected to meet the requirements of section 1923(f) of the Social Security Act. DSH payments are made quarterly. Before payments are made for the last quarter of the Federal fiscal year, payments for the first three quarters and the anticipated payment for the last quarter are cumulatively compared to the "State Disproportionate Share Hospital Allotment."

(i) If the Allotment will be exceeded, the DSH payments for the last quarter will be adjusted proportionately for each hospital qualifying for payments under section (3)(e).

(ii) If the allotment will still be exceeded after this adjustment, DSH payments to out-of-state hospitals will be adjusted in proportion to DSH payments received during the previous three quarters.

(iii) If this second adjustment still results in the allotment being exceeded, hospitals qualifying for payments under section (3)(d) (Criteria 1 and 2) will be adjusted by applying each hospital's proportional share of payments during the previous three quarters to total DSH payments to all hospitals for that period.

(D) Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to DSH payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0620; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0940; HR 36-1993, f. & cert. ef. 12-1-93; HR 24-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 6-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 23-1998, f. & cert. ef. 7-15-98; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0155
Upper Limits on Payment (UPL) of Hospital Claims

(1) Payments will not exceed total of billed charges:

(a) Upper limits on payment of claims does not apply to Proportional Share (Pro-Share) eligible academic hospitals, as defined in OAR 410-125-0145 and 410-125-0215.

(b) The total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost outlier, capital, and graduate medical education payments shall not exceed the individual hospital's total billed charges for the period for these services;

(c) If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total DMAP payment for those services, the overpayment shall be recovered;

(d) For Type A, Type B, and Critical Access Hospitals, reimbursement 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 DMAP'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 and outpatient reimbursements to all hospitals made during DMAP'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 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; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0165
Transfers and Reimbursement

(1) When a patient is transferred between hospitals, the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the Per Diem Inter-Hospital Transfer Payment rate.

(2) The Per Diem Inter-Hospital Transfer Payment rate = the DRG payment divided by the geometric mean length of stay for the DRG. The geometric mean length of stay is reported in the DRG tables on the DMAP website.

(3) Payment to the transferring hospital will not exceed the DRG payment.

(4) The final discharging hospital receives the full DRG payment.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 44-1985, f. & ef. 7-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0135; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0390; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0480; HR 53-1991, f. & cert. ef. 11-18-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0170
Death Occurring on Day of Admission

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840

410-125-0175
Hospitals Providing Specialized Outpatient Services

Some hospitals provide specific highly specialized outpatient services by arrangement with DMAP. 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 Division of Medical Assistance Programs (DMAP) cannot exceed the facility's public billing rate.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0015; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0240; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0181
Non-Contiguous and Contiguous Area Out-of-State Hospitals — Outpatient Services

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Division of Medical Assistance Programs (DMAP) 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 DMAP fee schedule.

(2) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(3) Notwithstanding subsections (1)–(2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained. Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with DMAP regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(a) Clinical laboratory services will be reimbursed under an DMAP fee schedule;

(b) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0181
Outpatient Rate Calculations — Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services which are based on the Division of Medical Assistance Programs (DMAP) fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

(3) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory, which are based on the DMAP fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-

1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0195
Outpatient Services In-State DRG Hospitals

In-State DRG Hospitals DRG hospital outpatient and emergency services are reimbursed under a cost-based methodology.

(1) Interim reimbursement:

(a) The interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges;

(b) The interim payment is the estimated percentage needed to achieve 80% of hospital cost in aggregate.

(c) This interim percentage is applied to all outpatient charges except for clinical laboratory services. The Division of Medical Assistance Programs (DMAP) fee schedule is used as interim reimbursement for clinical laboratory.

(2) Settlement reimbursement:

(a) For Title XIX/Title XXI clients; an adjustment to 80 percent of outpatient costs is made during the cost settlement process;

(b) For GA clients, outpatient hospital services are reimbursed at 50 percent of billed charges or 59 percent of costs, whichever is less.

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 43-2006, f. 12-15-06, cert. ef. 1-1-07

410-125-0200
Time Limitation for Submission of Claims

Division of Medical Assistance Programs (DMAP) 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, 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 461-015-0250; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91

410-125-0201
Independent ESRD Facilities

(1) Independent End Stage Renal Dialysis (ESRD) Facilities:

(a) ESRD Facilities are reimbursed for Continuous Ambulatory Peritoneal Dialysis.

(b) (CAPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemodialysis:

(A) Composite at 80% of the Medicare allowed amount, except for Epoetin.

(B) Epoetin is reimbursed at 100% of the Medicare maximum allowed amount.

(2) Other dialysis related charges which are allowed by Medicare, are reimbursed at 80% of the Medicare maximum allowed amount. Allowable clinical laboratory charges are reimbursed according to the DMAP fee schedule. Billed charges may not exceed the Medicare maximum allowable amount.

(3) DMAP follows Medicare's criteria for coverage of Epoetin, Intradialytic Parenteral Nutrition services, and the frequency schedule for laboratory tests for ESRD services. When laboratory tests are performed at a frequency greater than specified by Medicare, the additional tests must be billed separately, and are covered by DMAP only if the tests are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests.

Stat. Auth.: ORS 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0560; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0820; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-0210
Third Party Resources and Reimbursement

(1) The Division of Medical Assistance Programs establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the DMAP maximum allowable payment.

(2) DMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the DMAP reimbursement. DMAP 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) DMAP 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 DMAP allowable payment, less the Medicare payment, up to the amount of the deductible and/or coinsurance due. For clients who are Qualified Medicare Beneficiaries DMAP does not make any reimbursement for a service that is not covered by Medicare. For clients who are Qualified Medicare/Medicaid Beneficiaries DMAP payment is the DMAP 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. DMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations Section above. Payment is the DMAP 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. DMAP payment is the DMAP 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), DMAP payment is the DMAP 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. DMAP refers to these clients as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. DMAP refers to these clients as Qualified Medicare Beneficiaries (QMB). For QMB clients, DMAP does not make reimbursement for a service that is a not covered service for Medicare.

(d) Clients who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services that are not covered by Medicare if those services are covered by DMAP.

(5) For clients with Physician Care Organization (PCO) or Managed Care Organization (MCO) Coverage, DMAP payment is limited to those services that are not the responsibility of the PCO or MCO. Payment is made at DMAP rates.

(6) Other Insurance:

(a) DMAP pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any third party payments;

(b) DMAP will not make additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the DMAP reimbursement, or 100 percent of billed charges.

(7) Medically Needy with Spend-Down. Reimbursement is the DMAP maximum allowable payment for covered services less the amount of the spend-down due.

Stat. Auth.: ORS 184.750, 184.770, 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; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0056; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0640; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-1000; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-0220
Services Billed on the Electronic 837I or on the Paper CMS 1450 (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 electronic 837I (837 Institutional) or on the paper CMS 1450 (UB-92) claim form.(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper CMS 1450 (UB-92) along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost.

(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by DMAP through graduate medical education, for the hospitals that qualify (See OAR 410-125-0141) for payments and may not be billed on the electronic 837I or paper CMS 1450 (UB-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 electronic 837I or paper CMS 1450 (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. DMAP will not reimburse the other provider or hospital; and

(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. DMAP will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper CMS 1450 (UB-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 electronic 837I or the paper CMS 1450 (UB-92), along with all other inpatient services. The hospital is responsible for reimbursing the provider. DMAP will not reimburse the provider;

(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the Durable Medical Equipment supplier or by the hospital if the hospital is the supplier.

(6) Pharmaceutical and Home Parenteral/ Enteral Services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB-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 rules (chapter 410 division 148);

(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services rules (chapter 410 division 121).

(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper CMS 1450 (UB-92). Reimbursement for dental services provided by hospitals is restricted to those identified in the Dental Services rules (chapter 410 division 123) as covered services.

(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper CMS 1450 (UB-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 rules (chapter 410 division 130) contain information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-92); and

(b) Providers must bill using Revenue Code 569.

(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Home Health Care Services rules (chapter 410 division 127).

(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to DMAP 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. DMAP will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation rules (chapter 410 division 136).

(12) Supervising physicians providing services in a teaching setting:

(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper CMS 1450 (UB-92) with other inpatient or outpatient charges only when:

(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and

(B) The hospital does not report these services as a direct medical education cost on the Medicare and DMAP cost report.

(b) The services of supervising faculty physicians are not to be billed to DMAP on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper CMS 1450 (UB-92) if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and DMAP cost report; and

(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (chapter 410 division 130) or additional information on billing on the electronic 837P or the paper CMS-1500.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 461-015-0055, 461-015-0130, 461-015-0135; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0260, 461-015-0290, 461-015-0300, 461-015-0310, 461-015-0320, 461-015-0420, 461-015-0430; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0280, 410-125-0300, 410-125-0320, 410-125-0340, 410-125-0540 & 410-125-0560; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 13-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0221
Payment in Full

The payment made by Medicaid towards any inpatient or outpatient services, including cost outlier, disproportionate share, and capital payments, constitutes payment in full for the service.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989 (Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989 (Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990 (Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0360
Definitions and Billing Requirements

(1) Total days on an inpatient claim must equal the number of accommodation days. Do not count the day of discharge when calculating the number of accommodation days.

(2) Inpatient services are services to patients who typically are admitted to the hospital before midnight and listed on the following day's census, with the following exceptions:

(a) A patient admitted and transferred to another acute care hospital on the same day is considered an inpatient;

(b) A patient who expires on the day of admission is an inpatient; and

(c) Births.

(3) Outpatient services:

(a) Outpatient services are services to patients who are treated and released the same day;

(b) Outpatient services also include services provided prior to midnight and continuing into the next day if the patient was admitted for ambulatory surgery, admitted to a birthing center, a treatment or observation room, or a short-term stay bed;

(c) Outpatient observation services are services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation will be reimbursed. An outpatient observation stay that exceeds 48 hours must be billed as inpatient; and

(d) Outpatient observation services do not include the following:

(A) Services provided for the convenience of the patient, patient's family or physician but which are not medically necessary;

(B) Standard recovery period; and

(C) Routine preparation services and recovery for diagnostic services provided in a hospital outpatient department.

(4) 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:

(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.

(5) Outpatient procedures which result in an 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.

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

Stat. Auth.: ORS 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 461-015-0055; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0330, 461-015-0340 & 461-015-0380; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0380 & 410-125-0460; HR 22-1993 (Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

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 DMAP 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, DMAP will assume that a transfer has occurred. DMAP 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 DMAP 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 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
Definitions: Emergent, Urgent, and Elective Admissions

(1) EMERGENT ADMISSION — an admission which occurs after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) Placing their health or the health of an unborn child in serious jeopardy;

(b) Serious impairment of bodily functions; or

(c) Serious dysfunction of any bodily organ or part. "Immediate medical attention" is defined as medical attention which could not be delayed by 24 hours.

(2) URGENT ADMISSION — an admission which occurs for evaluation or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychological suffering by the patient. An urgent admission is defined as one which could not have been delayed for a period of 72 hours.

(3) ELECTIVE ADMISSION — an admission which is or could have been scheduled in advance and for which a delay of 72 hours or more in the delivery of medical treatment or diagnosis would not have substantially affected the health of the patient. See Prior Authorization section of the Hospital Services guide for requirements.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01

410-125-0410
Readmission

(1) A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status, and both admissions must be combined into a single billing. The DMAP will make one payment for the combined service. Examples of planned readmissions include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

(2) A patient whose discharge and readmission to the hospital is within fifteen (15) days for the same or related diagnosis must be combined into a single billing. DMAP will make one payment for the combined service.

(3) This rule does not apply to:

(a) Readmissions for an unrelated diagnosis;

(b) Readmissions occurring more than 15 days after the date of discharge;

(c) Readmissions for a diagnosis that may require episodic (a series) acute care hospitalizations to stabilize the medical condition such as, but not limited to: diabetes, asthma, or chronic obstructive pulmonary disease.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 36-1993, f. & cert. ef. 12-1-93; ; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 13-2005, f. 3-11-05, cert. ef. 4-1-05

410-125-0550
X-Ray or EKG Procedures Furnished in Emergency Room

DMAP pays for only one interpretation of an x-ray or EKG procedure furnished to an emergency room patient, and that is for the interpretation and report that directly contributed to the diagnosis and treatment of the patient. A second interpretation of an x-ray or EKG is considered to be for quality control purposes only, and is not reimbursable. Payment will be made for a second interpretation only under unusual circumstances, such as questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

Stat. Auth.: ORS 409
Stats. Implemented : ORS 414.065
Hist.: OMAP 28-2000, 9-29-00, cert. ef. 10-1-00

410-125-0600
Non-Contiguous Out-of-State Hospital Services

(1) Non-contiguous out-of-state hospitals are those hospitals located more than 75 miles from the Oregon border.

(2) The hospital must be enrolled as a provider with Oregon Medical Assistance Programs to receive payment. Contact DMAP 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 DMAP 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: DMAP.

(6) Claims must be billed on the electronic 837I or on a paper CMS 1450 (UB-92), unless other arrangements are made for billing through the DMAP.

Stat. Auth.: ORS 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 461-015-0450; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0620
Special Reports and Exams and Medical Records

Refer to the DMAP Administrative Exams and Reports Billing rules (chapter 410 division 150) for information and instructions on billing for administrative exams and reports.

Stat. Auth.: ORS 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 461-015-0040; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0460; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 3-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0640
Third Party Payers — Other Resources, Client Responsibility and Liability

(1) Medicare: Do not send claims to DMAP 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 DMAP without billing Medicare first;

(b) See: billing instructions in the Hospital Services Supplemental Information on DMAP's website for additional information on billing Medicare claims.

(2) Other Insurance. With the exception of services described in the General Rules, bill all other insurance first before billing DMAP. Report the payments made by the other insurers.

(3) 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 DMAP. Do not bill the Motor Vehicle Accident Fund.

(4) Employment Related Injuries: Enter 04 (Employment Related Accident) in Form Locators 32–35 and give the date of occurrence.

(5) Liability:

(a) Liability refers to insurance that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages;

(b) The provider may bill the insurer for liability prior to billing DMAP. The provider may not bill both DMAP and the insurer;

(c) The provider may bill DMAP after receiving a payment denial from the insurer; however, the DMAP billing must be within 12 months of date of service. Payment accepted from DMAP is payment in full;

(d) The provider may bill DMAP without billing the liability insurer. However, payment accepted from DMAP is payment in full. The payment made by DMAP may not later be returned in order to pursue payment from the liability insurer. When the provider bills DMAP, 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 DMAP. No payment will be made by DMAP under any circumstances once the one year limit has passed if no billing has been received within that time.

(6) Adoption Agreements. Adopting parents and/or an adoption agency may be considered a prior resource. In some instances, DMAP makes reimbursement to hospitals and other providers for services provided to a mother whose baby is to be adopted. DMAP 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 DMAP for this service.

(7) Veteran's Administration Benefits:

(a) Some clients have limited benefits through the Veterans' Administration. Hospitals must bill the Veterans' Administration for VA covered services before billing DMAP;

(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.

(8) Trust Funds. Some individuals will have trust funds that will pay for medical expenses. Occasionally a special trust fund will be set up to pay for extraordinary medical expenses, such as a transplant. These, and other trusts which pay medical expenses, are considered a prior resource.

Bill the trust fund prior to billing DMAP for services that are covered by the trust fund.

(9) Billing the Client. A provider may bill the client or any financially responsible relative or representative of that individual only as allowed in OAR 410-120-1280.

(10) The hospital may not bill the client under the following circumstances:

(a) For services which are covered by DMAP;

(b) For services for which DMAP has made payment;

(c) For services billed to DMAP for which no payment is made because third party reimbursement exceeds the DMAP maximum allowed amount;

(d) For any deductible, coinsurance or co-pay amount;

(e) For services for which DMAP has denied payment to the hospital as a result of one of the following:

(A) The hospital failed to supply the correct information to DMAP to allow processing of the claim in a timely manner as described in these rules and the General Rules;

(B) The hospital failed to obtain prior authorization as described in these rules;

(C) The service provided by the hospital was determined by or DMAP not to be medically appropriate; or

(D) The service provided by the hospital was determined by the QIO not to be medically appropriate, necessary, or reasonable.

Stat. Auth.: ORS 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 461-015-0080 & 461-015-0126; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0470 & 461-015-0480; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0660; HR 22-1992, f. 7-31-92, cert. ef. 8-1-92; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0641
Medicare

(1) A Medicare/Medicaid claim can automatically be sent to DMAP after adjudicated by Medicare. This saves the effort of a second submission, as well as ensuring a more accurate and speedier payment by the DMAP. Medicare will automatically transmit the correct Medicare payment, coinsurance, and deductible information to DMAP.

(2) Hard copy billings sent to Medicare can also be automatically sent to DMAP. Refer to the Hospital Services Supplemental Information for specific billing instructions.

Stat. Auth.: ORS 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; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-0720
Adjustment Requests

(1) Most overpayment and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a CMS 1450 (UB-92) for processing. All overpayments must be reported. Overpayments will be taken from future payments.

(2) Much of the information required on the Adjustment Request Form is printed on the paper Remittance Advice or the electronic 835. Documentation may be submitted to support the request. Attach a copy of the claim and paper Remittance Advice or the electronic 835 to the Adjustment Request (DMAP 1036). Adjustment requests must be submitted in writing to the Division of Medical Assistance Programs.

(3) Complete adjustment instructions can be found in Hospital Services Supplemental Information.

[Publications: Publications referenced are available from the agency.]
Stat Auth.: ORS 184.750, 184.770, 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 461-015-0510; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-1020
Filing of Cost Statement

(1) The hospital must file with DMAP, an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital:

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with DMAP, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the DMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(2) Twelve months after the hospital's fiscal year end, DMAP will send the hospital a computer printout listing all transactions between the hospital and DMAP during that auditing period. The Calculation of Reasonable Cost statement (DMAP 42) is due within 90 days of receipt by the hospital of the computer printout. Failure to file within 90 days may result in a 20 percent reduction in the payment rate:

(a) Hospitals without an agreement with Medicare may be subject to a field audit;

(b) Hospitals without an agreement with Medicare are required to submit a financial statement giving details of all assets, liabilities, income, and expenses, audited by a Certified Public Accountant.

(3) Improperly completed or incomplete Calculation of Reasonable Cost statements will be returned to the hospital for proper completion. The statement is not considered to be filed until it is received in a correct and complete form.

(4) If a hospital knowingly, or has reason to know, files a cost statement containing false information, such action constitutes cause for termination of its agreement with DMAP. Hospitals filing false reports may also be referred to prosecution under applicable statutes.

(5) Each Calculation of Reasonable Cost statement submitted to DMAP must be signed by the individual who normally signs the hospital's Medicare reports, federal income tax return, and other reports. If the hospital has someone, other than an employee prepare the cost statement, that individual will also sign the statement and indicate his or her status with the hospital.

(6) Notwithstanding subsection (1) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained. The hospital must file with DMA), an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital:

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with DMAP, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the DMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

Stat. Auth.: ORS 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; Former (2) thru (5) Renumbered to 461-015-0121 thru 461-015-0124; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 39-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0105, 461-015-0120 & 461-015-0122; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0650; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

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 DMAP personnel and Department of Health and Human Services (DHS) 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 DMAP 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, 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 461-015-0120(2); AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0121; HR 21-1990, f. & cert ef. 7-9-90, Renumbered from 461-015-0660; HR 42-1991, f. & cert. ef. 10-1-91

410-125-1060
Fiscal Audits

(1) Year-end fiscal audits will include retrospective examination and verification of claims and the determination of allowable charges and costs of hospital services provided to DMAP clients.

(2) The principal source document for the fiscal audit of Title XIX/Title XXI and General Assistance patient billings and payments for a given fiscal period is the DMAP data processing printout. This printout includes all transactions for the audit period. Using gross totals from this printout and applying other information from DMAP records, information received from the hospital, and other sources, DMAP will compile detailed schedules of adjustments and revise the gross totals. A revised Calculation of Reasonable Cost Statement (DMAP 42) will be prepared using revised totals and information from the Medicare report.

(3) Cost Settlements: DMAP will send the hospital a letter stating the amount of underpayment or overpayment calculated by DMAP for the fiscal year examined. The letter will also state the hospital's inpatient/outpatient interim reimbursement rate for the period from the effective date of the change until the next fiscal year's audit is completed. Payment of the cost-settlement amount is due and payable within 30 days from the date of the letter.

(4) DMAP, at its discretion, may grant a (30) thirty-day extension for the purpose of reviewing the cost settlement upon a written request by the hospital. If a (30) thirty-day extension is granted, payment of the cost settlement amount is due within sixty (60) days from the date of the letter. If the provider chooses to appeal the decision or rate, a written request for an administrative review, or contested case must be received by DMAP within (30) thirty-days of the date of the letter notifying the hospital of the settlement amount and interim rate, or within sixty (60) days if DMAP has granted a thirty (30) day extension, not withstanding the time limits in OAR 410-120-1580(3) or 410-120-1660(1). Upon receipt of the request, DMAP will attempt to resolve any differences informally with the provider before scheduling the administrative review or hearing.

(5) Under extraordinary circumstances, DMAP, at its discretion, may negotiate a repayment schedule with a hospital. The hospital may be required to submit additional information to support the hospital's request for a repayment schedule. The hospital will be required to pay interest associated with extended payments granted by DMAP.

(6) The revised Calculation of Reasonable Cost, copies of adjustment schedules, and a copy of the printout are available to the hospital upon request. For Type A rural hospitals the Calculation of Reasonable Cost Statement will reflect the difference between payment at 100% of costs and payment for dates-of-services on or after January 1, 2006 under the fee schedule for clinical laboratory services provided by the hospital. An adjustment to the Cost Settlement will be made to reimburse a Type A hospital at 100% of costs for laboratory and radiology services provided to Medical Assistance Program clients during the period the hospital was designated a Type A hospital. Settlements to Type B and Critical Access hospitals will be made within the legislative appropriation.

(7) The adjusted Professional Component Cost-to-Charge ratio(s) will be applied to all corresponding revenue code charges as listed on the Hospital Claim Detail Reports for cost settlements finalized on or after October 1, 1999.

(8) Hospital Based Rural Health Clinics shall be subject to the rules in the Hospital Services for the Oregon Health Plan Guide for Type A and B Hospitals. Hospital Based Rural Health Clinics cost settlements for dates of service from January 1, 2001 shall be finalized to cost.

(9) No interim settlements will be made. No settlements will be made until after receipt and review of the audited Medicare cost report.

Stat. Auth.: ORS 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 461-015-0120(3); AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0122; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0670; HR 33-1990(Temp), f. & cert. ef. 10-1-90; HR 43-1990, f. & cert. ef. 11-30-90; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; HR 24-1995, f. 12-29-95, cert. ef. 1-1-96; HR 3-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06

410-125-1070
Type A and Type B Hospitals

(1) Type A and Type B hospitals must submit the following information to the Division of Medical Assistance Programs (DMAP):

(a) The aggregate percent increase in patient charges and the effective date of the increase within 30 days following the end of their fiscal year for increases in the preceding year. Aggregate percent increase in patient charges is defined as the percent increase in patient revenues due to charge increases; and

(b) The amount of payment received by the hospital, from each DMAP contracted managed care plan and third-party payers, for inpatient and outpatient hospital services provided to managed care members, within the hospital's fiscal year.

(2) When a hospital is contracted with a Managed Care Organization (MCO), within thirty (30) days of DMAP's request the hospital will supply DMAP the following information:

(a) The name of the contracting MCO; and

(b) The dates for which the contract will be effective; and

(c) The contracted services and reimbursement rates.

(3) The hospital and MCO must coordinate payment information to verify and return the MCO payment data file sent by DMAP within ninety (90) days from date the data file is received by the hospital.

(4) Failure to supply the requested information within timelines stated may result in a discretionary sanction or fine (see OAR 410-120-1440). No sanction or fine will be imposed if DMAP determines, at its sole discretion, that the hospital was unable to coordinate payment information with the MCO through no fault of the hospital's own.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2005, f. 6-20-05, cert. ef. 7-1-05

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 DMAP upon request (**42 CFR 431.107**).

(2) All applicants for Title XIX or general assistance complete Form DMAP 415A or 415B authorizing the release of any records regarding his or her health. When requested by DMAP 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. DMAP may request sufficient information to evaluate the accuracy and appropriateness of ICD-9-CM Coding for the claim. In addition, DMAP may request an itemized billing for all services provided. DMAP will specify in its request what documentation is required

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0040; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0680

410-125-2000
Access to Records

(1) Providers must furnish requested medical and financial documentation within 30 calendar days from the date of request. Failure to comply within 30 calendar days will result in recovery of payment(s) made by DMAP for services being reviewed.

(2) DMAP contracts with a Quality Improvement Organization (QIO) to conduct post payment review of admissions and claim records. The QIO may request records from a hospital or may request access to records while at the hospital. The QIO has the same right to medical information as DMAP.

(3) The hospital has 30 days to provide DMAP or the QIO with copies of records. In some cases, there may be a more urgent need to review records.

(4) The Medical Payment Recovery Unit (MPRU) conducts recovery activities for DMAP involving third party liability resources. MPRU may request records from the hospital. This unit has the same right to medical and financial information as DMAP.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0040; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0690; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

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 DMAP or the contracted Quality Improvement Organization (QIO). 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 and DRG assignment;

(e) The appropriateness of the setting selected for service delivery;

(f) The quality of care of the services provided;

(g) The nature of any service coded as emergent;

(h) The accuracy of the billing;

(i) The care furnished is appropriately documented.

(2) If the QIO determines that a hospital service was not within DMAP coverage parameters, the hospital and attending physician will be notified in writing and will have twenty days to provide additional written documentation to support the medical necessity of the admission and/or procedure(s).

(3) If the recommendation for denial is upheld by the reviewing contracted QIO, the hospital and/or practitioner may request a reconsideration of the denial within 30 days of the receipt of the denial.

(4) If the reconsidered decision is to uphold the denial, payment to all providers of service will be recovered.

(5) The hospital and/or practitioner may appeal any final decision through the DMAP administrative appeals process.

(6) No payment will be made by DMAP for inpatient services if the QIO or Medicare has determined the service is not medically necessary and/or appropriate.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 1-1984, f. & ef. 1-9-84; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0090; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0700; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-2030
Recovery of Payments

(1) Payments made by DMAP will be recovered for:

(a) Services identified by the provider as emergent or urgent, but determined on retrospective review not to have been emergent or urgent. Payment will also be recovered from the admitting and/or performing physician;

(b) Services determined by the DMAP contracted Quality Improvement Organization (QIO) that the readmission to the same hospital was the result of a premature discharge;

(c) Services were billed but not provided;

(d) Services provided at an inappropriate level of care, which includes the setting selected for service delivery;

(e) DMAP non-covered services;

(f) Services, which were covered by a third party payer or other resources; or

(g) Services denied by a third party payer as not medically necessary.

(2) Payment to a physician and other providers of service for inpatient non-urgent or non-emergent services requiring prior authorization is subject to recovery by DMAP if recovery is made from the hospital.

(3) If review by DMAP results in a denial, the hospital may appeal any final decision through the DMAP Administrative Appeals process. See Administrative Hearings (chapter 410 division 120).

(4) As part of the Utilization Review Program, DMAP 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, DMAP may initiate focused reviews. Any practitioner or hospital subject to a focused review will be notified in advance of the review.

(5) All providers having a pattern of inappropriate utilization or inappropriate quality of care according to the current standards of the medical community and/or abuse of DMAP rules or procedures, will be subject to corrective action. Actions taken will be those determined appropriate by DMAP, the QIO, or sanctions established under the Oregon Revised Statues (ORS) or Oregon Administrative Rule and/or referral to a State or Federal authority, licensing body or regulatory agency for appropriate action.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-2040
Provider Appeals — Administrative Review

(1) A provider may request an administrative review regarding the decision(s) by DMAP that affect the services they provide or have provided. See General Rules (chapter 410 division 120).

(2) A requests for an Administrative Review must be submitted in writing to the Medicaid Administrator, 500 Summer Street NE, E49, Salem, OR 97301-1079.

(3) The request must be received within 30 days of the date of notification of the payment decision or notification of change in reimbursement.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0710; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-2060
Provider Appeals — Hearing Request

If the hospital disagrees with the DMAP 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 DMAP in accordance with the General rules (chapter 410 division 120). A hearing request must be received not later than 30 days following the date of the notice of action. At the time of appeal, the hospital must submit any data the hospital wants DMAP to consider in support of the appeal. The appeal will be conducted as described in General rules.

Stat. Auth.: ORS 184.750, 184.770 & 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 461-015-0120(4); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 49-1989 (Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0123; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0720; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04

410-125-2080
Administrative Errors

(1) If a hospital has been given incorrect information by Division of Medical Assistance Programs, Children, Adults, and Families Programs, or Seniors and People with Disabilities/staff, and services were provided on the basis of this information, and payment has been denied as a result, the hospital may submit a request for payment as an Administrative Error.

(2) Include the following:

(a) An explanation of the problem;

(b) Any documents supporting the request for payment;

(c) A copy of any paper Remittance Advice or electronic 835 printouts received on this claim;

(d) A copy of the original claim.

(3) Send the request: Division of Medical Assistance Programs, Provider Inquiry, Administrative Errors, 500 Summer Street NE, E-44, Salem, OR 97301-1077.

Stat. Auth.: ORS 184.750, 184.770, 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 461-015-0730; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

DIVISION 127

HOME HEALTH CARE SERVICES

410-127-0020
Definitions

(1) Acquisition Cost — The purchase price plus shipping.

(2) Custodial Care — Care that is not related to a plan of care. Supervision is not required.

(3) Department — The Department of Human Services (DHS) which includes Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD) and Health Services (HS). Included in HS is Health Planning and Community Relations, Public Health Systems, Family Health Services, Disease Prevention and Epidemiology, Division of Medical Assistance Programs (DMAP), Oregon State Public Health Laboratories, and the Addictions and Mental Health Division (AMH).

(4) Home — A place of temporary or permanent residence used as a person's home. This does not include a hospital, nursing facility, or intermediate care facility, but does include assisted living facilities, residential care facilities and adult foster care homes.

(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 Health Services, Health Care Licensure and Certification 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 — Services of a Home Health Aide must be provided under the direction and supervision of a registered nurse or licensed therapist. The focus of care shall be to provide personal care and/or other services under the plan of care which supports curative, rehabilitative or preventive aspects of nursing. These services are provided only in support of skilled nursing, physical therapy, occupational therapy, or speech therapy services. These services do not include custodial care.

(8) Home Health Services — Only the services described in the Division of Medical Assistance Programs (DMAP) Home Health Services provider guide.

(9) Medicaid Home Health Provider — A Home Health Agency licensed by Health Services, Health Care Licensure and Certification certified for Medicare and enrolled with DMAP as a Medicaid provider.

(10) Medical Supplies — Supplies prescribed by a physician as a necessary part of the plan of care being provided by the Home Health Agency.

(11) Occupational Therapy Services — Services provided by a registered occupational therapist or certified occupational therapy assistant supervised by a registered occupational therapist, due to the complexity of the service and client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a client's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function and/or independence in the activities of daily living is included in this skilled service. Occupational Therapy Licensing Board ORS 675.210–675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.

(12) Physical Therapy Services — Services provided by a licensed physical therapist or licensed physical therapy assistant under the supervision of a licensed physical therapist, due to the inherent complexity of the service and the client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver the necessary techniques, exercises or precautions for treatment and/or prevention of illness or injury is included in this skilled service. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapy Assistant established by the American Physical Therapy Association govern the practice of physical therapy.

(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;
(i) 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) Responsible Unit — The agency responsible for approving or denying payment authorization.

(15) Skilled Nursing Services — The client care services pertaining to the curative, restorative or preventive aspects of nursing performed by a registered nurse or under the supervision of a registered nurse, pursuant to the plan of care established by the prescribing practitioner in consultation with the Home Health Agency staff. Skilled nursing emphasizes a high level of nursing direction, observation and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct client care and the teaching, delegation and supervision of others who provide tasks of nursing care to clients, as well as phlebotomy services. Such services will comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing and Health Division — division 27 — Home Health Agencies, which rules are by this reference made a part hereof.

(16) Speech and Language Pathology Services — Services provided by a licensed speech-language pathologist due to the inherent complexity of the service and the patient's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatment for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function, and/or compensatory techniques to improve the level of functional communication ability is included in this skilled service. Speech-Language Pathology and Audiologist Licensing Board ORS 681.205 to 681.991 and the Standards of Ethics established by the American Speech and Hearing Association, govern the practice of speech and language pathology.

(17) Title XVIII (Medicare) — Title XVIII of the Social Security Act.

(18) Title XIX (Medicaid) — Title XIX of the Social Security Act.

(19) OASIS (Outcome and Assessment Information Set) — a client specific comprehensive assessment that identifies the client's need for home care and that meets the client's medical, nursing, rehabilitative, social and discharge planning needs.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 411-075-0001; HR 12-1991, f. & cert. ef. 3-1-91; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-

95; OMAP 4-1998(Temp), f. & cert. ef. 2-5-98 thru 7-15-98; OMAP 24-1998, f. & cert. ef. 7-15-98; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 36-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03

410-127-0040
Coverage

(1) Home health services are made available on a visiting basis to eligible clients in their homes as part of a written Plan of Care.

(2) Home health services must be prescribed by a physician and the signed order must be on file at the Home Health Agency. The prescription must include the ICD-9-CM diagnosis code indicating the reason the Home Health services are requested. The orders on the plan of care must specify the type of services to be provided to the client, with respect to the professional who will provide them, the nature of the individual services, specific frequency and specific duration. The orders must clearly indicate how many times per day, each week and/or each month the services are to be provided.

(3) The plan of care must be reviewed and signed by the physician every two months to continue services.

(4) The following services or items are covered, if diagnoses are on the portion of the prioritized list above the line funded by the Legislature:

(a) Skilled nursing services;

(b) Skilled nursing evaluation (includes OASIS Assessment);

(c) Home Health aide services;

(d) Occupational therapy services;

(e) Occupational therapy evaluation;

(f) Physical therapy services;

(g) Physical therapy evaluation (includes OASIS Assessment);

(h) Speech and language pathology services;

(i) Speech and language pathology evaluation (includes OASIS Assessment);

(j) Medical/surgical supplies.

Stat. Auth.: ORS 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 461-019-0400 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0000; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00

410-127-0050
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 79-2002, f. 12-24-02, cert. ef. 1-1-03

410-127-0055
Copayment for Standard Benefit Package

(1) Home Health Services are not covered for clients receiving the Standard Benefit Package. See General Rules 410-120-1210 for additional information.

(2) The OHP Standard Benefit Package includes limited home enteral/parenteral services and intravenous services (see 410-148-0090).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

410-127-0060
Reimbursement and Limitations

(1) Reimbursement. The Division of Medical Assistance Programs (DMAP) reimburses home health services on a fee schedule (see table 127-0060) basis by type of visit. Effective October 1, 2003, reimbursement rates were recalculated using a methodology that includes actual cost as reported on Medicare Cost Reports and the application of the DRI — WEFA home health trend rates (as recommended by the DMAP independent actuary). This budget-neutral fee schedule is based on DMAP home health reimbursement rates set as a percentage of cost.

(2) Future reimbursement rate changes, if applicable, will be calculated by applying an administratively determined percentage to each service rate to determine the new rate.

(3) DMAP reimburses only for service, which is medically appropriate.

(4) Limitations:

(a) Limits of Covered Services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) All therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy or speech and language pathology services. Therapy visits require payment authorization;

(C) DMAP will authorize home health visits for clients with uterine monitoring only for medical problems, which could adversely affect the pregnancy and are not related to the uterine monitoring;

(D) Medical supplies must be billed at acquisition cost and the total of all medical supplies revenue codes may not exceed $75 per day. Only supplies that are used during the visit are billable. Clients visit notes must include documentation of supplies used;

(E) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not Covered Service:

(A) Service not medically appropriate;

(B) A service whose diagnosis does not appear on a line of the Prioritized List of Health Services which has been funded by the Oregon Legislature (OAR 410-141-0520);

(C) Medical Social Worker Service;

(D) Registered dietician counseling or Instruction;

(E) Drug and or Biological;

(F) Fetal Non-Stress Testing;

(G) Respiratory therapist service;

(H) Flu shot;

(I) Psychiatric Nursing Service.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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 461-019-0420 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0010; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 77-2003, f. & cert. ef. 10.1.03

410-127-0065
Signature Requirements

(1) The Division of Medical Assistance Programs (DMAP) requires practitioners to sign for services they order. This signature may be handwritten, electronic, or stamped, and it must be in the client's medical record.

(2) The ordering practitioner is responsible for the authenticity of the signature. If a practitioner allows a signature stamp, the provider performing the service must retain a signed statement in their records that this practitioner is the only person who has and uses the stamp.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 38-2006, f. 12-15-06, cert. ef. 1-1-07

410-127-0080
Payment Authorization

Payment authorization (PA) is approval by the responsible unit for services:

(1) Payment authorization is required for home health services as indicated in the Revenue 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. It is the provider's responsibility to obtain payment authorization.

(2) A payment authorization number must be present on all claims for home health services which require payment authorization or the claim will be denied.

(3) An initial authorization is given for 60 days. Each continuation of an authorization is for a period of 60 days.

(4) Where to request payment authorization:

(a) Managed health care clients — Services for clients identified on their Division of Medical Assistance Programs (DMAP) Medical Care Identification as having an "DMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;

(b) Children, Adults and Families (CAF) clients (formerly known as Adult and Family Services and State Office for Services to Children and Families): Services for clients identified on Medical Care Identification as AFS or CSD clients are authorized by DMAP;

(c) Seniors and People with Disabilities (SPD) clients (formerly Senior and Disabled Services Division) will be authorized by DMAP;

(d) Medically Fragile Children's Unit (MFCU) clients: Services for clients identified as Medically Fragile Children will be authorized by MFCU;

(e) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, authorization must be obtained from the MCM Contractor prior to the initiation of services. For FFS MCM clients, DMAP will not reimburse for a service that requires payment authorization if the service is provided prior to receiving authorization from the MCM Contractor.

(A) For enteral/parenteral IV services, call DMAP;

(B) Services for clients utilizing a Group 2 pressure-reducing support service will be authorized by DMAP.

(5) Each payment authorization must include:

(a) Client's name;

(b) Medicaid recipient ID number;

(c) Revenue codes;

(d) Date range;

(e) Frequency of service;

(f) Performing provider number;

(g) Medical justification;

(h) Diagnosis and Primary ICD-9-CM code; (as indicated as the reason for the request);

(i) Goals and Objectives;

(j) Assessment of availability of other resources to care for the client.

(6) OASIS documentation does not need to be submitted with PA request.

(7) To continue an authorization, submit the most current visit notes and justification for continuing services.

(8) 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.

(9) Payment authorization does not guarantee eligibility or payment. It is the provider's responsibility to verify eligibility on the date of service.

(10) Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of services.

(11) For skilled nursing visits involving home enteral/parenteral nutrition and IV services, refer to the DMAP Home Enteral/Parenteral Nutrition and IV Services provider guide.

(12) For skilled nursing visits involving a Group 2 pressure-reducing support surface, refer to the DMAP Durable Medical Equipment and Medical Supplies provider guide.

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

Stat. Auth.: ORS 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 461-019-0410 by Chapter 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 6-1986, f. & ef. 4-24-86; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0005; HR 12-1991, f. & cert. ef. 3-1-91; HR 30-1992(Temp), f. & cert. ef. 9-25-92; HR 2-1993, f. 2-19-93, cert. ef. 2-20-93; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 15-1999, f. & cert. ef. 4-1-99; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; OMAP 91-2003, f. 12-30-03 cert. ef. 1-1-04

410-127-0200
Home Health Revenue Center Codes

Payment authorization is required for those services indicated by the Code PA. Following are the procedure codes to be used for billing:

(1) Medical/surgical supplies and devices:

(a) 270 — General classification;

(b) 271 — Non sterile supply;

(c) 272 — Sterile supply.

(2) Physical Therapy:

(a) 421 — Visit charge — PA;

(b) 424 — Evaluation (includes OASIS assessment) or re-evaluation.

(3) Occupational Therapy:

(a) 431 — Visit charge — PA;

(b) 434 — Evaluation or re-evaluation.

(4) Speech-language pathology:

(a) 441 — Visit charge — PA;

(b) 444 — Evaluation (includes OASIS assessment) or re-evaluation.

(5) Skilled nursing:

(a) 551 — Visit charge — PA;

(b) 559 — Other skilled nursing — evaluation (includes OASIS assessment).

(6) Home health aid — 571 — Visit charge — PA.

(7) Total charge — 001 — Total Charge.

Stat. Auth.: ORS 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; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00

DIVISION 129

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID SERVICES

410-129-0020
Therapy Goals/Outcome

(1) Therapy will be based on a prescribing practitioner's written order and a therapy treatment plan with goals and objectives developed from an evaluation 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 409

Stats. Implemented: ORS 414.060

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0040
Maintenance

(1) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached; or

(b) There is no progress toward the therapy treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The patient, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are responsible for the maintenance therapy.

(2) Therapy that becomes maintenance is not a covered service.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99

410-129-0060
Prescription Required

(1) The prescription is the written order by the prescribing practitioner pursuant to state law governing speech-pathology, audiology and hearing aid services. Prescription must specify the ICD-9-CM diagnosis code for all speech-pathology, audiology and hearing aid services that require payment/prior authorization.

(2) The provision of speech therapy services must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner. A practitioner means a person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(3) A written order:

(a) Is required for the initial evaluation;

(b) For therapy, must specify the ICD-9-CM diagnosis code, service, amount and duration required.

(4) Written orders must be submitted with the payment (prior) authorization request and a copy must be on file in the provider's therapy record. The written order and the treatment plan must be reviewed and signed by the prescribing practitioner every six months.

(5) Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.096
Hist.: AFS 67-1985, f. 11-19-85, ef. 12-1-85; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91, Renumbered from 461-021-0301; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; DMAP 6-2007, f. 6-14-07, cert. ef. 7-1-07

410-129-0065
Licensing Requirements

(1)(a) ORS 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology 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 students in speech-language pathology, under supervision of a licensed Speech Pathologist during training or during the Clinical Fellowship Year are reimbursable to the licensed supervising speech pathologist. Graduate speech-language pathologists who are performing a clinical fellowship year need to hold a provisional license issued by the Oregon Board of Examiners in Speech Pathology and Audiology. ORS 681.325 "Issuance of Conditional License Scope of Practice and Renewal";

(c) Services of a licensed speech pathologist while teaching or supervising students in speech pathology will not be reimbursed;

(d) Services of a certified speech-language pathology assistant are reimbursable to the supervising licensed speech-language pathologist. Only covered services within the scope of duties of a certified speech-language pathologist assistant, as defined in OAR 335-095-0060, will be reimbursed.

(2) Audiologists. ORS 681, 681.420 and 681.460, Board of Examiners in Speech Pathology and Audiology 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 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 409
Stats.Implemented: ORS 414.065
Hist.: HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 59-2003, f. 9-5-03, cert. ef. 10-1-03

410-129-0070
Limitations

(1) The rules contained in OAR 410-129-0010–410-129-0080 and 410-129-0220 also apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. They do 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.

(2) Speech Pathology:

(a) All speech pathology services will be performed by a licensed speech pathologist or a graduate student in training or a graduate speech pathologist in the Clinical Fellowship Year being supervised by a licensed speech pathologist. Only therapy and evaluation services rendered on-site are billable under the codes listed in the Speech-Language Pathology, Audiology and Hearing Aid Services provider guide;

(b) 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 authorization period;

(c) Therapy records must include:

(A) Documentation of each session;

(B) Therapy provided and amount of time spent; and

(C) Signature of the therapist.

(d) Documentation (progress notes, etc.) must be retained in the provider's records. All report and clinical notes by graduate students in training or graduate speech pathologists in the clinical fellowship year must be countersigned by the supervising licensed speech pathologist;

(e) Services of a graduate student in training or a graduate speech pathologist during the clinical fellowship year, under direct supervision of a licensed speech pathologist 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) Strict supervision requirements adhering to the American Speech-Language-Hearing Association requirements must be followed, which includes a minimum amount of time the supervisor must be physically present during therapy and evaluation time. Therapy is 15 minutes per hour and evaluation time is 30 minutes per hour;

(C) 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;

(D) Documentation by the graduate student in training or the Clinical Fellow must demonstrate to the satisfaction of the agency that services are medically appropriate in continuing the plan and treatment plan for the client in clear, legible notation.

(f) Services That Do Not Require Payment Authorization:

(A) Two Evaluations of Speech/Language will be reimbursed per calendar year;

(B) Two Evaluations for Dysphagia will be reimbursed per calendar year;

(C) One Evaluation for speech-generating/augmentative communication system or device will be reimbursed per recipient per calendar year;

(D) One Evaluation for voice prosthesis or artificial larynx will be reimbursed per calendar year;

(E) Purchase, repair or modification of electrolarynx;

(F) Supplies for speech therapy will be reimbursed up to two times per calendar year, not to exceed $5.00 each.

(g) Services That Require Payment Authorization:

(A) All speech pathology therapy treatments;

(B) Speech-generating/augmentative communication system or device, purchase or rental. Rental of a speech-generating/ augmentative communication system or device is limited to one month. All rental fees must be applied to the purchase price;

(C) Repair/modification of a speech-generating/augmentative communication system or device.

(h) 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 410-129-0040.

(3) Audiology and Hearing Aid Dealer Services:

(a) All hearing services will be performed by licensed audiologists or hearing aid dealers;

(b) Reimbursement is limited to one (monaural) hearing aid every five years for adults who meet the following criteria: Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, and 3000 Hertz (Hz) in the better ear;

(c) Adults who meet the criteria above and, in addition, have vision correctable to no better than 20/200 in the better eye, may be authorized for two hearing aids for safety purposes. Submit a vision evaluation with the payment authorization request;

(d) Two (binaural) hearing aids will be reimbursed no more frequently than every three years for children who meet the following criteria:

(A) Pure tone average of 25dB for the frequencies of 500Hz, 1000Hz and 2000Hz; or

(B) High frequency average of 35dB for the frequencies of 3000Hz, 4000Hz and 6000Hz.

(e) An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear, or who cannot benefit from, a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a particular listening situation. It is restricted to a hand-held amplifier and headphones;

(f) Services That Do Not Require Payment Authorization:

(A) One basic audiologic assessment in a 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 — maximum of 60 individual batteries per 12 month period. Must meet the criteria for a hearing aid.

(g) Services That Require Payment Authorization:

(A) Hearing aids;

(B) Repair of hearing aids, including ear mold replacement;

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices;

(E) Cochlear implant batteries.

(h) Services Not Covered:

(A) FM systems — vibro-tactile aids;

(B) Earplugs;

(C) Adjustment of hearing aids is included in the fitting and dispensing fee, and is not reimbursable separately;

(D) Aural rehabilitation therapy is included in the fitting and dispensing fee, and is not reimbursable separately;

(E) Tinnitis masker(s).

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05

410-129-0080
Prior Authorization of Payment

(1) Payment authorization (PA) is approval by Division of Medical Assistance Programs (DMAP), the Medically Fragile Children's Unit (MFCU), the Fee-For-Service (FFS) Medical Case Management (MCM) Contractor or the Managed Care Organizations (MCOs) for services that are medically appropriate.

(2) Payment authorization is required for speech-language pathology, audiology and hearing aid services as indicated in the Procedure Codes section of the DMAP Speech-Language Pathology, Audiology and Hearing Aid Services rules. For services requiring authorization from DMAP or MFCU, providers must contact DMAP or MFCU for authorization within five working days following initiation of services. Requests for payment authorization for speech-language pathology services and audiology and hearing aid services must be submitted on the appropriate DMAP 3071 form or reasonable facsimile. Authorization will be given based on medical appropriateness and appropriateness of the therapy given. Hearing aids and other devices must be authorized prior to delivery of any services. For services requiring payment authorization from the FFS Medical Case Management (MCM) Contractor, authorization must be obtained prior to the initiation of services. For FFS MCM clients, DMAP will not reimburse for a service that requires payment authorization if provided prior to receiving authorization from the Medical Case Management Contractor. It is the provider's responsibility to obtain a payment authorization.

(3) Services for clients identified on the DMAP Medical Care Identification as having a "DMAP Contracted Plan" will be authorized by the plan. Contact the Managed Care Organization to determine their procedures.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1982, f. 2-16-82, ef. 3-1-82; AFS 49-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 67-1985, f. 11-19-85, ef. 12-1-85; AFS 7-1988, f. & cert. ef. 2-1-88; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91, Renumbered from 461-021-0310; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 85-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 57-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 40-2006, f. 12-15-06, cert. ef. 1-1-07

410-129-0100
Medicare/Medicaid Claims

(1) When an individual, not in managed care, 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. Refer to OAR 410-120-1210 (General Rules) for information on DMAP reimbursement. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

(2) Audiologists must bill all hearing aids and related services directly to DMAP on a DMAP 505. Payment authorization is required on most of these services. (See OARs 410-129-0240 and 410-129-0260)

(3) If Medicare transmits incorrect information to DMAP, or if an out-of-state Medicare carrier or intermediary was billed, providers must bill DMAP using a DMAP 505 form. If any payment is made by DMAP, an Adjustment Request must be submitted to correct payment, if necessary.

(4) Send all completed DMAP 505 forms to the Division of Medical Assistance Programs.

(5) Hearing Aid Dealers must bill all services directly to DMAP on a CMS-1500. Payment authorization is required on most services (See OARs 410-129-0240 and 410-129-0260).

(6) When a client, not in managed care, has both Medicare and Medicaid coverage, speech-language pathologists must bill services to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 (General Rules) for information on DMAP reimbursement. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 57-2004, f. 9-10-04, cert. ef. 10-1-04

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 the Division of Medical Assistance Programs (DMAP) **Medical-Surgical Services Provider Guide** and must bill DMAP using the processes and procedure codes identified in that Guide.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110
Stats. Implemented:
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93

410-129-0190
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist. OMAP 80-2002, f. 12-24-02, cert. ef. 1-1-03

410-129-0195
Standard Benefit Package

(1) Hearing aids, hearing aid repairs, and examinations and audiological diagnostic services only performed to determine the need for or the appropriate type of hearing aid(s) are not covered under the Standard Benefit Package.

(2) Diagnostic testing, including hearing and balance assessment services, performed by an audiologist is covered under the Standard Benefit Package when a physician orders testing to obtain information as part of the physician's diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. Audiological diagnostic services are not covered under the Standard Benefit Package when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of hearing aid.

(3) Speech-language pathology services are not covered under the Standard Benefit Package.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

410-129-0200
Speech-Language Pathology Procedure Codes

(1) Inclusion of a CPT/HCPCS code in the following tables does not imply a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Speech Therapy Services codes: Table 200-1.

(3) Other Speech Services codes: Table 200-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 6-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0220
Augmentative Communications System or Device

(1) The Division of Medical Assistance Programs (DMAP) 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 appropriateness.

(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 DMAP, 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 reevaluate 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 DMAP;

(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 augmentative communication system or device:

(A) A formal augmentative communication assessment report — required elements are listed on the reverse of the DMAP 3047 form;

(B) A physician's prescription of diagnosis and prognosis (not a prescription for an augmentative device).

(6) DMAP will reimburse for the lowest level of service that meets the medical need.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 40-1990(Temp), f. & cert. ef. 11-15-90; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 59-2003, f. 9-5-03, cert. ef. 10-1-03

410-129-0240
Audiologist and Hearing Aid Procedure Codes

(1) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Audiologist and Hearing Aid Procedure Codes: Table 0240-1.

(3) Special Otorhinolaryngologic Services codes: Table 0240-2. These codes only apply to services for cochlear implants. These services include medical diagnosis evaluation by the otology physician.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0260
Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing Aids must be billed to the Division of Medical Assistance Programs (DMAP) at the provider's Acquisition Cost, and will be reimbursed at such rate. For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for hearing aids.

(3) Procedure codes: Table 129-0260.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0280
Hearing Testing for Diagnostic Purposes (On Physician's Referral Only)

A physician's referral is required for the tests shown in this rule. The tests may only be performed and billed by a licensed audiologist or a licensed physician. Procedure codes: Table 0280.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

DIVISION 130

MEDICAL-SURGICAL SERVICES

410-130-0000
Foreword

(1) The Division of Medical Assistance Programs (DMAP) Medical-Surgical Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers should follow the DMAP rules in effect on the date of service.

(2) DMAP enrolls only the following types of providers as performing providers under the Medical-Surgical program:

(a) Doctors of medicine, osteopathy and naturopathy;
(b) Podiatrists;
(c) Acupuncturists;
(d) Licensed Physician assistants;
(e) Nurse practitioners;
(f) Laboratories;
(g) Family planning clinics;
(h) Social workers (only maternity case management);
(i) Licensed Direct entry midwives;
(j) Portable x-ray providers;
(k) Ambulatory surgical centers;
(l) Chiropractors;
(m) Nutritionists (only maternity case management);
(n) Licensed Dieticians (only maternity case management);
(o) Registered Nurse First Assistants;
(p) Certified Nurse Anesthetists.

(3) For clients enrolled in a managed care plan, contact the client's plan for coverage and billing information.

(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All DMAP rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Health Services Commission's Prioritized List of Health Services is found at website http://www.ohpr.state.or.us/hsc/index hsc.htm.

Stat. Auth.: ORS 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 461-014-0001; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0500; HR 6-1994, f. & cert. ef. 2-1-94; HR 23-1997, f. & cert. ef. 10-1-97; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04

410-130-0160
Codes

(1) ICD-9-CM Diagnosis Codes:

(a) Always use the principal diagnosis code in the first position to the highest degree of specificity. List up to three additional diagnosis codes if the claim includes charges for services that relate to the additional diagnoses. However, it is not necessary to include more than one diagnosis code per procedure code;

(b) Diagnosis codes are required on all billings including those from independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers;

(c) Always supply the ICD-9-CM diagnosis code to ancillary service providers when prescribing services, equipment and supplies.

(2) CPT, and HCPCS Codes:

(a) Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;

(b) Effective January 1, 2005, HIPAA regulations prohibit the use of a grace period for codes deleted from CPT or HCPCS. In the past the grace period was from January 1st through March 31st;

(c) CPT category II (codes with fifth character of "F") and III codes (codes with fifth character "T") are not Medical Assistance Program covered services;

(d) Use the most applicable CPT or HCPCS code. Do not fragment coding when services can be included in a single code (see the "Bundled Services" section of this rule). Do not use both CPT and HCPCS codes for the same procedure. This is considered duplicate billing.

(3) The Medical-Surgical Service rules list the 2005 HCPCS/CPT codes that require authorization, or have limitations. The Health Services Commission's Prioritized List of Health Services (rule 410-141-0520) determines covered services.

(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT and HCPCS codebook. Use the definitions to verify your level of service, especially for office visits. Unless otherwise specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.

(5) Bundled Services — Reimbursements for some services are "bundled" into the payment for another service (e.g., payment for obtaining a PAP smear is bundled into the payment for the office visit). Bundled services cannot be billed separately to the Division of Medical Assistance Programs (DMAP) or the client. The abbreviation "BND" in the code lists in the DMAP Medical-Surgical Services provider rule indicates the procedure is bundled into another one.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0610; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f, 2-28-92, cert. ef. 3-1-92; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05

410-130-0163
Standard Benefit Package

(1) The Division of Medical Assistance Programs (DMAP) does not cover some services under the Standard Benefit Package. Refer to General Rule 410-120-1210 for restrictions in other programs.

(2) The following services are not covered:

(a) Acupuncture (except for chemical dependency provided through local alcohol/drug treatment providers);

(b) Chiropractic and osteopathic manipulations;

(c) Hearing exams for the sole purpose of determining the need for or the type of hearing aid;

(d) Occupational therapy;

(e) Ophthalmological exams for the purpose of prescribing glasses or contacts and glaucoma screenings;

(f) Physical therapy;

(g) Speech therapy.

(3) DMAP covers medical supplies and equipment only when applied by the practitioner in the office setting for treatment of the acute medical condition. DME and medical supplies dispensed by DME providers are limited. Refer to DME Rules 410-122-0055 for specific information on coverage.

(4) Refer to Table 130-0163-1 for a list of not covered codes.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

410-130-0180
Drugs

(1) The Division of Medical Assistance Programs' (DMAP) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. DMAP does not reimburse practitioners for drugs that are self-administered by the client, EXCEPT contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate CPT therapeutic injection code for administration of injections;

(b) Use an appropriate HCPCS code for the specific drug. Do not bill for drugs under code 99070;

(c) When billing unclassified drugs and other drug codes listed below, bill at acquisition cost (purchase price plus postage) and use the following codes:

(A) J1815-J1816;
(B) J3490;
(C) J7699;
(D) J7799;
(E) J8499;
(F) J8999
(G) J9999;
(H) Include the name of the drug, NDC number, and dosage.

(d) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(2) DMAP requires both the NDC number and HCPCS codes for claim submission on the electronic 837P form.

(3) For Not Covered/Bundled services or Prior Authorization Requirements refer to OAR 410-130-0200 Table 130-0200-1 and 410-130-0220 Table 130-0220-1.

(4) 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;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc (J7319).

(5) Follow criteria outlined in the following:

(a) Billing Requirements — OAR 410-121-0150;

(b) Brand Name Pharmaceuticals — OAR 410-121-0155;

(c) Prior Authorization Procedures — OAR 410-121-0060;

(d) Drugs and Products Requiring Prior Authorization — OAR 410-121-0040;

(e) Drug Use Review — OAR 410-121-0100;

(f) Participation in Medicaid's Prudent Pharmaceutical Purchasing Program — OAR 410-121-0157.

(6) Clozapine Therapy:

(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;

(b) Clozapine Supervision is the management and record keeping of Clozapine dispensing as required by the manufacturer of Clozapine:

(A) Providers billing for Clozapine supervision must document all of the following:

(i) Exact date and results of White Blood Counts (WBC), upon initiation of therapy and at recommended intervals per the drug labeling;

(ii) Notations of current dosage and change in dosage;

(iii) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;

(iv) Dates provider sent required information to manufacturer.

(B) Only one provider (either a physician or pharmacist) may bill per week per client;

(C) Limited to five units per 30 days per client;

(D) Use code 90862 with modifier TC to bill for Clozapine supervision.

[ED. NOTE: Tables & forms referenced are available from the agency.]
Stat. Auth.: ORS 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; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0620; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 33-2002, f. & cert. ef. 8-1-02; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 52-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0190
Tobacco Cessation

(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.

(2) Basic tobacco cessation treatment includes the following services:

(a) Ask — systematically identify all tobacco users — usually done at each visit;

(b) Advise — strongly urge all tobacco users to quit;

(c) Assess — the tobacco user's willingness to attempt to quit using tobacco within 30 days;

(d) Assist — with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(e) Arrange — follow-up support and/or referral to more intensive treatments, if needed.

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions generally are provided during a visit for other conditions, and additional billing is not appropriate.

(4) Intensive tobacco cessation treatment is on the Health Services Commission's Prioritized List of Health Services and is covered if a documented quit date has been established. This treatment is limited to ten sessions every three months. Treatment should be reserved for those clients who are not able to quit using tobacco with the basic intervention measures.

(5) Intensive tobacco cessation treatment includes the following services:

(a) Multiple treatment encounters (up to ten in a 3 month period);

(b) Behavioral and tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(c) Individual or group counseling.

(6) Telephone calls: A telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment may be reimbursed as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:

(a) The call should last five to ten minutes and provides support and follow-up counseling;

(b) The call should be conducted by the provider or other trained staff under the direction or supervision of the provider;

(c) Enter proper documentation of the service in the client's chart.

(7) Diagnosis Code ICD-9-CM 305.1 (Tobacco Use Disorder):

(a) Use as the principal diagnosis code when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services;

(b) Use as a secondary diagnosis code when the primary purpose of this visit is not for tobacco cessation or when the tobacco use is confirmed during the visit.

(8) Billing Information: Managed care plans may have tobacco cessation services and programs. This rule shall not limit or prescribe services a Prepaid Health Plan provides to clients receiving the Basic Health Care Package.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 36-1992, f. & cert. ef. 12-1-92; OMAP 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0200
Prior Authorization/Prior Notification

(1) Prior Authorization (PA):

(a) PA for services provided to clients enrolled in a prepaid health plan (PHP) must be obtained from the appropriate PHP. Contact the PHP for their PA requirements and billing instructions.

(b) PA is not required for services covered by Medicare to clients who have both Medicare and Medical Assistance Program coverage. However, PA is required for most transplants, even if they are covered by Medicare.

(c) PA is not required for kidney and cornea transplants unless they are performed out-of-state.

(d) PA must be obtained from the Division of Medical Assistance Program's (DMAP) Transplant Coordinator for transplants and non-emergent, non-urgent out-of-state services. Refer to the DMAP Transplant Services rules (chapter 410, division 124) for further information on transplants and refer to the DMAP General Rules (chapter 410, division 120) for further information concerning out-of-state services.

(e) PA must be obtained from the Department of Human Services (DHS) Medically Fragile Children's Unit (MFCU) for services provided to MFCU clients.

(f) PA for services provided to clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program must be obtained from the Case Management Contractor shown on the client's Medical Care ID. See the Medical-Surgical Services Supplemental Information guide for details.

(g) PA is required for all procedure codes listed in Table 130-0200-1 in this rule. PA for these procedures must be obtained from the Oregon Medical Professional Review Organization (OMPRO) regardless of the setting they are performed in. A second opinion may be requested by DMAP or OMPRO before PA is given for a surgery;

(h) PA is not required for hospital admissions unless the procedure requires PA;

(i) PA is not required for emergent or urgent procedures or services;

(j) PA must be obtained by the treating and performing practitioners;

(k) Refer to Table 130-0200-1 for all services/procedures requiring prior authorization.

(2) Prior Notification:

(a) Prior notification is required before performing the following radiology tests:

(A) MRIs;

(B) MRAs;

(C) CTs;

(D) CTAs; and

(E) SPECT scans.

(b) Prior notification is not required when these tests are performed during an emergency department visit or an inpatient stay;

(c) Providers ordering these tests must submit a prior notification form to DMAP prior to the performance of the tests;

(d) Refer to the Medical-Surgical Supplemental Information guide for instructions and forms;

(e) Refer to Table 130-0200-2 for radiology codes requiring prior notification.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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 461-014-0045; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0630; HR 25-1990(Temp), f. 8-31-90, cert. ef. 9-1-90; HR 44-1990, f. & cert. ef. 11-30-90; HR 17-1991(Temp), f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0220
Not Covered/BundledServices

(1) Refer to the Oregon Health Plan Administrative Rules (chapter 410, division 141) and General Rules (chapter 410, division 120) for coverage of services. Refer to Table 130-0220-1 for additional information regarding not covered services or for services that are considered by the Division of Medical Assistance Programs (DMAP) to be bundled.

(2) The following are examples of not covered services:

(a) Psychotherapy services (covered only through local Mental Health Clinics and Mental Health Organizations);

(b) Routine postoperative visits (included in the payment for the surgery) during 90 days following major surgery (global period) or 10 days following minor surgery;

(c) Services provided at the client's request in a location other than the practitioner's office that are normally provided in the office;

(d) Telephone calls for purposes other than tobacco cessation and maternity case management.

(3) This is not an inclusive list. Specific information is included in the DMAP General Rules, Medical Assistance Benefits: Excluded Services and Limitations (OAR 410-120-1200).

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

Stat. Auth.: ORS 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; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0640; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, cert. ef. 5-1-91; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 16-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 30-1998, f. & cert. ef. 9-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 37-1999, f. & cert. ef. 10-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0225
Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Division of Medical Assistance Programs (DMAP) on a CMS-1500 or 837P when serving as an employee of the hospital during the time the service was provided or when the hospital reports the service as a direct medical education cost on the Medicare and DMAP cost report.

(2) For requirements for the provision of services, including documentation requirements, follow Medicare guidelines for Teaching Physician Services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0370, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0230
Administrative Medical Examinations and Reports

(1) This rule does not apply to Managed Health Care plans.

(2) These services are covered only when requested by an CAF, SPD, AMH, OYA, SCF branch office or approved by the Division of Medical Assistance Programs (DMAP). The branch office may request an administrative medical examination or a medical report (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) See the Administrative Examination and Report Billing rule for complete billing instructions.

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

Stat. Auth.: ORS 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

Hist.: HR 36-1992, f. & cert. ef. 12-1-92; HR 6-1994, f. & cert. ef. 2-1-94; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0900, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03

410-130-0240
Medical Services

(1) All medical and surgical services requiring prior authorization (PA) are listed in OAR 410-130-0200 PA Table 130-0200-1, and services that are Not Covered/Bundled services are listed in OAR 410-130-0220 Table 130-0220-1. Table 130-0220-1 only contains clarification regarding some services that are not covered. Refer to the Health Services List of Prioritized Services for additional information regarding not covered services.

(2) Acupuncture may be performed by a physician, a physician's employee-acupuncturist under the physician's supervision, or a licensed acupuncturist, and billed using CPT 97810-97814.

(3) Chiropractic services must be billed using 99202 and 99212 for the diagnostic visits and 98940-98942 for manipulation. Use CPT lab and radiology codes which most accurately identify the services performed.

(4) Maternity Care and Delivery:

(a) Use Evaluation and Management codes when providing three or fewer antepartum visits;

(b) For births performed in a clinic or home setting, use CPT codes that most accurately describe the services provided. HCPCS supply code S8415 may be billed in addition to the CPT procedure code. Code S8415 includes all supplies, equipment, staff assistance, birthing suite, newborn screening cards, topical and local anesthetics. Bill medications (except topical and local anesthetics) with HCPCS codes that most accurately describe the medications;

(c) For labor management only, bill 59899 and attach a report;

(d) For multiple births, bill the highest level birth with the appropriate CPT code and the other births under the delivery only code. For example, for total OB with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.

(5) Mental Health and Psychiatric Services:

(a) For Administrative Exams and reports for psychiatric or psychological evaluations, refer to the Administrative Exam rules;

(b) Psychiatrists can be reimbursed by DMAP for symptomatic diagnosis and services, which are somatic (physical) in nature. Contact the local Mental Health Department for covered psychiatric and psychological services;

(c) Mental Health Services — Must be provided by local Mental Health Clinics or a client's Mental Health Organization (MHO). Not payable to private physicians, psychologists, and social workers.

(6) Neonatal Intensive Care Unit (NICU) procedure codes:

(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;

(b) Consultations by specialists other than neonatologists and pediatric intensivists are payable in addition to these codes;

(c) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use specific CPT ECMO codes.

(7) Neurology/Neuromuscular — Payment for polysomnographs and multiple sleep latency test (MSLT) are each limited to two in a 12-month period.

(8) Ophthalmology Services–Routine eye exams for the purpose of glasses or contacts are limited to one examination every 24 months for adults. All materials and supplies must be obtained from DMAP's contractor. Refer to the Vision Program Rules for more information.

(9) Speech & Hearing:

(a) HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists, and hearing aid dealers;

(b) Refer to the Speech and Hearing Program Rules for detailed information;

(c) Payment for hearing aids and speech therapy must be authorized before the service is delivered;

(d) CPT 92593 and 92595 are only covered for children under age 21.

(10) Massage therapy is covered only when provided with other modalities during the same physical therapy session. Refer to Physical and Occupational Therapy Services administrative rules (chapter 410 division 131) for other restrictions.

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

Stat. Auth.: ORS 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 461-014-0021 & 461-014-0056; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0650, 461-014-0690 & 461-014-0700; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 18-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 18-1992, f. & cert. ef. 7-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 16-1993, f. & cert. ef. 7-2-93; HR 6-1994, f. & cert. ef. 2-1-94, Renumbered from 410-130-0320, 410-130-0340, 410-130-0360 & 410-130-0740; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef.

6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 88-2004, f. 11-24-04, cert. ef. 12-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0245
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 appropriate comprehensive diagnosis and treatment for all children (birth through age 20) covered by the Basic Health Care benefit package.

(2) Screening Exams:

(a) Physicians (MD or DO), nurse practitioners, licensed physician assistants and other licensed health professionals may provide EPSDT services. Screening services are based on the definition of "Preventive Services" in OAR 410-141-0000;

(b) Periodic EPSDT screening exams must include:

(A) A comprehensive health and developmental history including assessment of both physical and mental health development;

(B) Assessment of nutritional status;

(C) Comprehensive unclothed physical exam including inspection of teeth and gums;

(D) Appropriate immunizations;

(E) Lead testing for children under age 6 as required. See the "Blood Lead Screening" section of this rule;

(F) Other appropriate laboratory tests (such as anemia test, sickle cell test, and others) based on age and client risk;

(G) Health education including anticipatory guidance;

(H) Appropriate hearing and vision screening.

(c) The provider may bill for both lab and non-lab services using the appropriate CPT and HCPCS codes. Immunizations must be billed according to the guidelines listed in OAR 410-130-0255;

(d) Inter-periodic EPSDT screening exams are any medically appropriate encounters with a physician (MD or DO), nurse practitioner, licensed physician assistant, or other licensed health professional within their scope of practice.

(3) Referrals:

(a) If, during the screening process (periodic or inter-periodic), a medical, mental health, substance abuse, or dental condition is discovered, the client may be referred to medical providers, Addictions and Mental Health Division (AMH) or dental providers for further diagnosis and/or treatment;

(b) The screening provider shall explain the need for the referral to the client, client's parent, or guardian;

(c) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate referral provider and making an appointment should be offered;

(d) The caseworker or local branch will assist in making other necessary arrangements.

(4) Blood Lead Screening: All children ages 12 months to 72 months are considered at risk for lead poisoning. Children ages 12 months to 72 months with Medical Assistance Program coverage must be screened for possible exposure to lead poisoning. Because the prevalence of lead poisoning peaks at age two, children screened or tested at age one should be re-screened or re-tested at age two. Screening consists of a Lead Risk Assessment Questionnaire (DMAP 9033) and/or blood lead tests as indicated.

(5) Lead Risk Assessment Questionnaire: Complete the Lead Risk Assessment Questionnaire (DMAP 9033) found in the Medical-Surgical Services Supplemental Information. The questionnaire must be used at each EPSDT exam beginning at one year of age to assess the potential for lead exposure. Retain this questionnaire in the client's medical record. Do not attach this form to the claim for reimbursement. DMAP does not stock this form; photocopy the form and the instructions from the Medical-Surgical Services Supplement Information.

(6) Blood Lead Testing: Any "yes" or "don't know" answer in Part B, questions 1-8 on the Lead Risk Assessment Questionnaire (DMAP 9033) means that the child should receive a screening blood lead test. An elevated blood lead level is defined as > = 10 µg/dL. Children with an elevated blood lead screening test should have a confirmatory blood lead test performed according to the schedule described in Table 130-0245-1 of this rule. If the confirmatory blood lead test is elevated, follow-up blood lead tests should be performed approximately every three months until two consecutive test results are less than 10 µg/dL. Comprehensive follow-up services based on the results of the confirmatory blood lead test are described in Table 130-0245-2 of this rule.

(7) Method of Blood Collection: Either venipuncture or capillary draw is acceptable for the screening blood lead test. All confirmatory blood lead tests must be obtained by venipuncture. Erythrocyte protoporphyrin (EP) testing is not a substitute for either a screening or a confirmation blood lead test.

(8) Additional Lead-Related Services: Families should be provided anticipatory guidance and lead education prenatally and at each well-child visit, as described in Tables 130-0245-3 and 130-0245-4 of this rule. Table 130-0245-1, Table 130-0245-2, Table 130-0245-3, Table 130-0245-4, Table 130-0245-5

[ED. NOTE: Tables referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 37-1999, f. & cert. ef. 10-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0080, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04

410-130-0255
Immunizations and Immune Globulins

(1) Use standard billing procedures for vaccines that are not part of the Vaccines for Children (VFC) Program.

(2) The Division of Medical Assistance Programs (DMAP) covers Synagis (palivizumab-rsv-igm) only for high-risk infants and children as defined by the American Academy of Pediatric guidelines. Bill 90378 for Synagis.

(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective.

(4) VFC Program:

(a) Under this federal program, vaccine serums are free for clients' ages 0 through 18. DMAP will not reimburse the cost of privately purchased vaccines that are provided through the VFC Program, but will reimburse for the administration of those vaccines;

(b) Only providers enrolled in the VFC Program can receive free vaccine serums. To enroll as a VFC provider, contact the Public Health Immunization Program. For contact information, see the Medical-Surgical Supplemental Information;

(c) DMAP will reimburse providers for the administration of any vaccine provided by the VFC Program. Whenever a new vaccine becomes available through the VFC Program, administration of that vaccine is also covered by DMAP;

(d) Refer to Table 130-0255-1 for immunization codes provided through the VFC Program. Recommendations as to who may receive influenza vaccines vary from season to season and may not be reflected in Table 130-0255-1;

(e) Use the following procedures when billing for the administration of a VFC vaccine:

(A) When the sole purpose of the visit is to administer a VFC vaccine, the provider should bill the appropriate vaccine procedure code with modifier -26 or -SL for each injection. Do not bill CPT code 90465-90474 or 99211;

(B) When the vaccine is administered as part of an Evaluation and Management service (e.g., well-child visit) the provider should bill the appropriate immunization code with modifier -26, or -SL for each injection in addition to the Evaluation and Management code.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0800, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0365
Ambulatory Surgical Center and Birthing Center Services

(1) Ambulatory Surgical Centers (ASC) and Birthing Centers (BC) must be licensed by the Oregon Health Division. ASC and BC services are items and services furnished by an ASC or BC in connection with a covered surgical procedure as specified in the Medical-Surgical Services

rule or in the Dental Services rule. Reimbursement is made at all-inclusive global rates based on the surgical procedure codes billed.

(2) If the client has Medicare and Medicare does not allow the specific surgery in an ASC or BC then the surgery may not be performed in an ASC or BC.

(3) Global Rates include:

(a) Nursing services, services of technical personnel, and other related services;

(b) Any support services provided by personnel employed by the ASC or BC facility;

(c) The use by the client of the ASC's or BC'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 procedure);

(f) Administrative, record-keeping, and housekeeping items and services;

(g) Blood, blood plasma, platelets;

(h) Materials for anesthesia;

(i) Items not separately identified in section (4) of this rule.

(4) Items and Services Not Included in ASC or BC Global Rate:

(a) Practitioner services such as those performed by physicians, licensed physician assistants, nurse practitioners, certified nurse anesthetists, dentists, and podiatrists;

(b) The sale, lease, or rentals of durable medical equipment to ASC or BC clients for use in their homes;

(c) Prosthetic devices;

(d) Ambulance services;

(e) Leg, arm, back and neck brace, or other orthopedic appliances;

(f) Artificial legs, arms, and eyes;

(g) Services furnished by a certified independent laboratory.

(5) ASCs and BCs will not be reimbursed for services that are normally provided in an office setting unless the practitioner has justified the medical appropriateness of using an ASC or BC through documentation submitted with the claim. Practitioner's justification is subject to review by the Division of Medical Assistance Programs (DMAP). If payment has been made and the practitioner fails to justify the medical appropriateness for using an ASC or BC facility, the amount paid is subject to recovery by DMAP.

(6) Procedure Coding:

(a) For reduced or discontinued procedures, use CPT instructions and add appropriate modifiers;

(b) Attach a report to the claim when billing an unlisted code;

(c) For billing instructions regarding multiple procedures, see rule 410-130-0380.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0940, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03

410-130-0368
Anesthesia Services

(1) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520).

(2) Reimbursement is based on the base units listed in the current American Society of Anesthesiology Relative Value Guide plus one unit per each 15 minutes of anesthesia time, except for anesthesia for neuraxial labor analgesia/anesthesia/anesthesia (code 01967). See item 3 below for reporting neuraxial labor analgesia/anesthesia.

(a) For anesthesia services billed (excluding OB code 01967), do not bill the "base units" plus "time units" as the total quantity of service units. (DMAP will automatically calculate the base units for the billed anesthesia code using current year ASA listing of base units.)

(b) Bill only, the total quantity of time units on one line. 1 unit of time equals one 15minute increment of anesthesia time: (For example, 1 hour (60 minutes) equals 4 units of anesthesia time.) DMAP will then add the billed time units to the anesthesia code base units to determine total units for payment.

(C) For the last fraction of time less than 15 minutes, bill one unit for 8–14 minutes. Do not bill a unit for 1–7 minutes of time.

(3) Anesthesia for neuraxial labor analgesia/anesthesia (01967) will be paid at a flat rate. DMAP will disregard the number of units in the unit field and pay a flat rate/unit of one. OB Services that do not include labor (i.e. 01958-10966) and code billed in conjunction with 01967 (i.e. 01968 and 01969) should be reported with the appropriate time units only (see item 2b above).

(4) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100-01999.

(5) A valid consent form is required for all hysterectomies and sterilizations.

(6) If prior authorization (PA) was not obtained on a procedure that requires PA, then the anesthesia services may not be paid. Refer to OAR 410-130-0200 PA Table 130-0200-1.

(7) Anesthesia services are not payable to the provider performing the surgical procedure except for conscious sedation.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0380
Surgery Guidelines

(1) The Division of Medical Assistance Programs (DMAP) reimburses all covered surgical procedures as global packages. Global payments do not include initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.

(2) Surgical procedures listed in the Medical-Surgical Services guide with prior authorization (PA) indicated require authorization unless they are emergent.

(3) Global payment for major surgery includes:

(a) Surgery;

(b) Pre-operative visits within 15 days of the surgery (except the initial consultation);

(c) Initial admission history and physical;

(d) Related follow-up visits within 90 days after the surgery;

(e) Treatment of complications not requiring a return trip to the operating room;

(f) Hospital discharge.

(4) Global payment for minor surgery includes:

(a) Surgery;

(b) Pre-operative visits within 15 days of the surgery;

(c) Initial admission history and physical;

(d) Related follow-up visits for 10 days after the surgery;

(e) Hospital discharge.

(5) Global payment for endoscopy includes:

(a) Surgery;

(b) Related visit on the same day as the endoscopy procedure;

(c) No follow-up days for this procedure;

(d) Pre-operative and post-operative care provided by the surgeon's associate(s) or by another physician "on call" for the surgeon are considered included in the reimbursement to the surgeon and will not be paid in addition to the payment to the surgeon;

(e) Do not bill separately for procedures which are considered to be bundled in another procedure. Payment for bundled services is included in the primary surgery payment.

(6) Co-surgeons — Two or more surgeons/same or different specialties/separate functions/one major or complex surgery:

(a) Add modifier -62 to procedure code(s);

(b) Payment will be determined by medical review.

(7) Team Surgeons — Two or more surgeons/different specialties performing/separate surgeries/same operative session:

(a) Add modifier -66 to procedure code(s);

(b) Payment will be determined by medical review.

(8) Multiple Surgical Procedures performed during the same operative session:

(a) Primary Procedure paid at 100% of the DMAP maximum fee for that procedure;

(b) Second and third procedure paid at 50% of the DMAP maximum fee;

(c) Fourth, fifth, etc. paid at 25% or less as determined by DMAP;

(d) Endoscopic procedures paid at 100% of the DMAP maximum fee for the primary level procedure. the DMAP fee for insertion will be deducted from the maximum allowable for each additional procedure performed at the same site;

(e) Bill each procedure on separate lines (even multiples of the same procedure) unless the code description specifies "each additional";

(f) Bilateral procedures must be billed on two lines unless a single code identifies a bilateral procedure. Use modifier -50 only on the second line;

(g) Reimbursement for laparotomy is included in the surgical procedure and should not be billed separately or in addition to the surgical procedure;

(h) For Integumentary System codes 10000 thru 17999, bill multiples of the same procedure on the same line with the appropriate quantity unless the code indicates the first in a series (i.e., code 11100) or the code is for multiple procedures (i.e., code 11900).

(9) Surgical Assistance — Payment is restricted to physicians, naturopaths, podiatrists, dentists, nurse practitioners, licensed physician assistants, and registered nurse first assistants:

(a) The assistance must be medically appropriate;

(b) No payment will be made for surgical assistant for minor surgical or diagnostic procedures, e.g., "scoping" procedures;

(c) Only one surgical assistant may receive payment (except when the need is clinically documented);

(d) Use an appropriate modifier to indicate assistance.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: PWC 868, f. 12-30-77, ef. 2-1-78; AFS 32-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 2-1983, f. 1-31-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 4-1984, f. & ef. 2-1-84; AFS 30-1984, f. 7-26-84, ef. 8-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-1984; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 30-1987, f. 7-15-87, ef. 8-1-87; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0048, 461-014-0049, 461-014-0053, 461-014-0055 & 461-014-0056; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0710; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02

410-130-0562
Abortion

For medically induced abortions by oral ingestion of medication use S0199 for all visits, counseling, lab tests, ultrasounds, and supplies. S0199 is a global package except for medication:

(1) Bill medications with codes S0190-S0191 and appropriate HCPCS codes.

(2) For surgical abortions use CPT codes 59840 through 59857:

(3) For services related to surgical abortion such as lab, ultrasound and pathology bill separately. Add modifier U4 (a Division of Medical Assistance Programs (DMAP) modifier) for surgical abortion related services.

(4) Use the most appropriate ICD-9 diagnosis code.

Stat. Auth.: ORS 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; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03

410-130-0580
Hysterectomies and Sterilization

(1) Refer to OAR 410-130-0200 Prior Authorization, Table 130-0200-1 and 410-130-0220 Not Covered/Bundled Services, Table 130-0220-1.

(2) Hysterectomies performed for the sole purpose of sterilization are not covered.

(3) All hysterectomies, except radical hysterectomies, require prior authorization (PA).

(4) A properly completed Hysterectomy Consent form (DMAP 741) or a statement signed by the performing physician, depending upon the following circumstances, is required for all hysterectomies:

(a) When a woman is capable of bearing children:

(A) Prior to the surgery, the person securing authorization to perform the hysterectomy must inform the woman and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing;

(B) The woman or her representative, if any, must sign the consent form to acknowledge she received that information.

(b) When a woman is sterile prior to the hysterectomy, the physician who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of the sterility;

(c) When there is a life-threatening emergency situation that requires a hysterectomy in which the physician determines that prior acknowledgment is not possible, the physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible and describe the nature of the emergency.

(5) In cases of retroactive eligibility: The physician who performs the hysterectomy must certify in writing one of the following:

(a) The woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;

(b) The woman was previously sterile and states the cause of the sterility;

(c) The hysterectomy was performed because of a life-threatening emergency situation in which prior acknowledgment was not possible and describes the nature of the emergency.

(6) Do not use the Consent to Sterilization form (DMAP 742) for hysterectomies.

(7) Submit a copy of the Hysterectomy consent form with the claim.

(8) Sterilization Male & Female: A copy of a properly completed Consent to Sterilization form (DMAP 742), the consent form in the federal brochure DHHS Publication No. (05) 79-50062 (Male), DHHS Publication No. (05) 79-50061 (Female) or another federally approved form must be submitted to DMAP for all sterilization. The original consent form must be retained in the clinical records. Prior authorization is not required.

(9) Voluntary Sterilization:

(a) Consent for sterilization must be an informed choice. The consent is not valid if signed when the client is:

(A) In labor;

(B) Seeking or obtaining an abortion; or

(C) Under the influence of alcohol or drugs.

(b) Ages 15 years or older who are mentally competent to give informed consent:

(A) At least 30 days, but not more than 180 days, must have passed between the date of the informed written consent (date of signature) and the date of the sterilization except:

(i) In the case of premature delivery by vaginal or cesarean section the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement;

(ii) In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before the sterilization was performed.

(B) The client must sign and date the consent form before it is signed and dated by the person obtaining the consent. The date of signature must meet the above criteria. The person obtaining the consent must sign the consent form anytime after the client has signed but before the date of the sterilization. If an interpreter is provided to assist the individual being sterilized, the interpreter must also sign the consent form on the same date as the client;

(C) The client must be legally competent to give informed consent. The physician performing the procedure, and the person obtaining the consent, if other than the physician, must review with the client the detailed information appearing on the Consent to Sterilization form regarding effects and permanence of the procedure, alternative birth control methods, and explain that withdrawal of consent at any time prior to the surgery will not result in any loss of other program benefits.

(10) Involuntary Sterilization — Clients who lack the ability to give informed consent and are 18 years of age or older:

(a) Only the Circuit Court of the county in which the client resides can determine that the client is unable to give informed consent;

(b) The Circuit Court must determine that the client requires sterilization;

(c) When the court orders sterilization, it issues a Sterilization Order. The order must be attached to the billing invoice. No waiting period or additional documentation is required.

(11) Submit the Consent to Sterilization Form (DMAP 742) along with the claim. The Consent to Sterilization form must be completed in full:

(a) Consent forms submitted to DMAP without signatures and/or dates of signature by the client or the person obtaining consent are invalid;

(b) The client and the person obtaining consent may not sign or date the consent retroactively;

(c) The performing physician must sign the consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 803(Temp), f. & ef. 7-1-76; PWC 813, f. & ef. 10-1-76; PWC 834, f. 3-31-77, ef. 5-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 4-1979(Temp), f. & ef. 3-8-79; AFS 11-1979, f. 6-18-79, ef. 7-1-79; AFS 50-1981(Temp), f. & ef. 8-5-81; AFS 79-1981, f. 11-24-81, ef. 12-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1985, f. & ef. 7-1-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; Renumbered from 461-014-0030, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0840; HR 43-1991, f. & cert. ef. 10-1-91; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0585
Family Planning Services

(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.

(2) The Division of Medical Assistance Programs (DMAP) covers family planning services for clients of childbearing age (including minors who are considered to be sexually active).

(3) Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Laboratory tests;

(d) Radiology services;

(e) Medical and surgical procedures, including tubal ligations and vasectomies;

(f) Pharmaceutical supplies and devices.

(4) Clients may seek family planning services from any provider enrolled with DMAP, even if the client is enrolled in a Prepaid Health Plan (PHP). Reimbursement for family planning services is made either by the client's PHP or DMAP. If the provider is:

(a) A participating provider with the client's PHP, bill the PHP;

(b) An enrolled DMAP provider, but is not a participating provider with the client's PHP, bill DMAP and mark the family planning box (24H) with a "Y" on the CMS-1500 claim form or 837P.

(5) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, sub-dermal implants, condoms, and diaphragms.

(6) Bill all family planning services with the most appropriate ICD-9-CM diagnosis code in the V25 series (Contraceptive Management), the most appropriate CPT or HCPCS code and add modifier –FP.

(7) For annual family planning visits use the appropriate CPT code in the Preventative Medicine series (9938X-9939X). These codes include comprehensive contraceptive counseling.

(8) When comprehensive contraceptive counseling is the only service provided at the encounter, use a CPT code from the Preventative Medicine, Individual Counseling series (99401-99404).

(9) Bill contraceptive supplies with the most appropriate HCPCS codes.

(10) Where there are no specific CPT or HCPCS codes, use an appropriate unlisted code and add modifier -FP. Bill supplies at acquisition cost.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0587
Family Planning Clinic Services

(1) This rule pertains only to Family Planning Clinics.

(2) To enroll with the Division of Medical Assistance Programs (DMAP) as a Family Planning Clinic, a provider must also be enrolled with the Office of Family Health as a Family Planning Expansion Project (FPEP) provider.

(3) Family Planning Clinics must follow all applicable FPEP and DMAP rules.

(4) DMAP will reimburse Family Planning Clinics an encounter rate only when the primary purpose of the visit is for family planning.

(5) Bill HCPCS code T1015 "Clinic visit/encounter, all-inclusive; family planning" for all encounters where the primary purpose of the visit is contraceptive in nature:

(a) This encounter code includes the visit and any procedure or service performed during that visit including:

(A) Annual family planning exams;

(B) Family planning counseling;

(C) Insertions and removals of implants and IUDs;

(D) Diaphragm fittings;

(E) Dispensing of contraceptive supplies and contraceptive medications;

(F) Contraceptive injections.

(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or HCPCS codes;

(c) Bill only one encounter per date of service;

(d) Reimbursement for educational materials is included in T1015. Educational materials are not billable separately.

(6) Reimbursement for T1015 does not include payment for family planning (FP) supplies and medications:

(a) Bill contraceptive supplies and contraceptive medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code:

(A) Bill spermicide code A4269 per tube;

(B) Bill contraceptive pills code S4993 per monthly packet;

(C) Bill emergency contraception with code S4993 and bill per packet.

(b) Bill all contraceptive supplies and contraceptive medications at acquisition cost;

(c) Add modifier -FP after all codes for contraceptive services, supplies and medications;

(d) Non-contraceptive medications are not billable under this program.

(7) Reimbursement for T1015 does not include payment for laboratory tests:

(a) Clinics and providers who perform lab tests in their clinics and are CLIA certified to perform those tests may bill CPT and HCPCS lab codes in addition to T1015;

(b) Add modifier -FP after lab codes to indicate that the lab was performed during an FP encounter;

(c) Labs sent to outside laboratories, such as PAP smears, can be billed only by the performing laboratory.

(8) Encounters where the primary purpose of the visit is not contraceptive in nature, use appropriate CPT codes and do not add modifier -FP.

(9) When billing for services provided to clients enrolled in a Prepaid Health Plan, mark the family planning Box 24 H on the CMS-1500 billing form or 837P.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 78-2003, f. & cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0595
Maternity Case Management (MCM)

(1) The primary purpose of the MCM program is to optimize pregnancy outcomes including reducing the incidence of low birth weight babies. MCM services are tailored to the individual client needs. These services are provided face-to-face, unless specifically indicated in this rule, throughout the client's pregnancy.

(2) This program:

(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month postpartum period;

(c) Must be initiated during the pregnancy and before delivery;

(d) Is an additional set of services over and above medical management of pregnant clients;

(e) Allows for billing for intensive nutritional counseling services.

(3) Any time there is a significant change in the health, economic, social, or nutritional factors of the client, the prenatal care provider must be notified.

(4) In situations where multiple providers are seeing one client for MCM services, the case manager must coordinate care to ensure duplicate claims are not submitted to the Division of Medical Assistance Programs (DMAP) if services are duplicated.

(5) Definitions:

(a) Case Management — An ongoing process to assist the individual client in obtaining access to and effective utilization of necessary health, social, economic, nutritional, and other services as defined in the Client Service Plan (CSP) or other documentation;

(b) Case Management Visit — A face-to-face encounter between a maternity case manager and the client that must include two or more specific training and education topics, addresses the CSP and provides on-going relationship development between the client and the case manager;

(c) Client Service Plan (CSP) — A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in the Initial Assessment and includes a client discharge plan/summary;

(d) High Risk Case Management — Intensive case management services provided to a client identified and documented by the maternity case manager or prenatal care provider as being high risk;

(e) High Risk Client — Includes clients who have current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who are 17 or under, or have other conditions identified in the initial assessment or during the course of service delivery;

(f) Home/Environmental Assessment — A visit to the client's primary place of residence to assess health and safety of the client's living conditions;

(g) Initial Assessment — Documented, systematic collection of data with planned interventions as outlined in a CSP to determine current status and identify needs and strengths, in physical, psychosocial, behavioral, developmental, educational, mobility, environmental, nutritional, and emotional areas;

(h) Nutritional Counseling — Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (14);

(i) Prenatal/Perinatal Care Provider — The physician, licensed physician assistant, nurse practitioner, certified nurse midwife, or licensed direct entry midwife providing prenatal or perinatal (including labor and delivery) and/or postnatal services to the client;

(j) Telephone Case Management Visit — A non-face-to-face encounter between a maternity case manager and the client providing identical services of a Case Management Visit (G9012).

(6) Maternity Case Manager Qualifications:

(a) Maternity case managers must be currently licensed as a.

(A) Physician;

(B) Physician Assistant;

(C) Nurse Practitioner;

(D) Certified Nurse Midwife;

(E) Direct Entry Midwife;

(F) Social Worker; or

(G) Registered Nurse

(b) The Maternity Case Manager must be an enrolled provider or deliver services under an appropriate enrolled provider. See DMAP General Rules 410-120-1260 for provider enrollment qualifications.

(c) All of the above must have a minimum of two years related and relevant work experience;

(d) Other paraprofessionals may provide specific services with the exclusion of the initial assessment (G9001) while working under the supervision of one of the practitioners listed in (6)(a)(A–G) of this rule;

(e) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

(7) Nutritional Counselor Qualifications — Nutritional counselors must:

(a) Be a registered dietician; or

(b) A Qualified Nutritionist. A qualified nutritionist is a nutrition profession who meets one or more of the following qualifications: a Masters Degree in nutrition; a Registered Dietician (RD) with the American Dietetic Association (ADA) or eligible for ADA registration; an Oregon Licensed Dietitian (LD).

(8) Documentation Requirements:

(a) Documentation is required for all MCM services in accordance with DMAP General Rules 410-120-1360; and

(b) A correctly completed DMAP form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for Maternity Case Management Services.

(9) G9001 — Initial Assessment must be performed by a licensed Maternity Case Manager as defined under (6)(a): above

(a) Services include:

(A) Client assessment as outlined in the "Definitions" section of this rule;

(B) Development of a CSP which addresses needs identified;

(C) Making and assisting with referrals as needed to:

(i) A prenatal care provider;

(ii) A dental health provider.

(D) Forwarding the initial assessment and other relevant information to the prenatal care provider;

(E) Communicating pertinent information to others participating in the client's medical and social care.

(b) Data sources relied upon may include:

(A) Initial assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client.

(c) The client's record must reflect the date and to whom the initial assessment was sent;

(d) Billable once per pregnancy per provider. No other MCM service can be performed until after an initial assessment has been completed. No other maternity management codes except a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be billed the same day as an initial assessment.

(10) G9002 — Case Management (Full Service) — Includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

(A) The client's records must include a CSP and written updates to the plan;

(B) The CSP activities involve determining the client's strengths and needs, setting specific goals and utilizing appropriate resources in a cooperative effort between the client and the maternity case manager.

(c) Referral to services included in the CSP:

(A) Make referrals, provide information and assist the client in self-referral;

(B) Maintain contact with resources to ensure service delivery, share information, and assist with coordination.

(d) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;

(e) Utilization and documentation of the "5 A's" brief intervention protocol for addressing tobacco use (US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2000). Routinely:

(A) Ask all MCM clients about smoking status;

(B) Advise all smoking clients to quit;

(C) Assess for readiness to try to quit;

(D) Assist all those wanting to quit by referring them to the Quitline and/or other appropriate tobacco cessation counseling and provide motivational information for those not ready to quit;

(E) Arrange follow-up for interventions.

(f) Provide training and education on all mandatory topics - Refer to Table 130-0595-2;

(g) Provide linkage to labor and delivery services;

(h) Provide linkage to family planning services as needed;

(i) CSP coordination as follows:

(A) Contact with Department of Human Services (DHS) worker, if assigned;

(B) Contact with prenatal care provider;

(C) Contact with other community resources/agencies to address needs.

(j) Client advocacy as necessary to facilitate access. The case manager serves as a client advocate and intervenes with agencies or persons to help the client receive appropriate benefits or services;

(k) Assist client in achieving the goals in the CSP. The case manager will advocate for the client when resources are inadequate or the service delivery system is non-responsive;

(l) Billable once per pregnancy.

(m) Billable after the delivery when more than three months of service were provided. Services must be initiated during the prenatal period and carried through the date of delivery.

(11) G9009 — Case Management (Partial Service):

(a) Can be billed when the CSP has been developed and case management services (G9002) were initiated during the prenatal period and partially completed;

(b) Provided case management services to the client for three months or less.

(12) G9005 -- High Risk Case Management (Full Service):

(a) Enhanced level of services which are more intensive and are provided in addition to G9002;

(b) Provided at least eight Case Management Visits;

(c) Provided high risk case management services to the client for more than three months;

(d) Billable after the delivery and only once per pregnancy;

(e) Can be billed in addition to G9002.

(13) G9010 — High Risk Case Management (Partial Service):

(a) Are the same enhanced level of services provided in G9005 but the client became "high risk" during the latter part of the pregnancy or intensive high risk MCM services were initiated and partially completed but not carried through to the date of delivery;

(b) Provided less than eight Case Management Visits;

(c) Provided high risk case management services to the client for three months or less;

(d) Billable after the delivery and once per pregnancy;

(e) Can be billed in addition to G9002 or G9009.

(14) S9470 — Nutritional Counseling:

(a) Available for clients who have at least one of the following conditions:

(A) Chronic disease such as diabetes or renal disease;

(B) Hematocrit (Hct) less than 34 or hemoglobin (Hb) less than 11 during the first trimester, or Hct less than 32 or Hb less than 10 during the second or third trimester;

(C) Pre-gravida weight under 100 pounds or over 200 pounds;

(D) Pregnancy weight gain outside the appropriate WIC guidelines;

(E) Eating disorder;

(F) Gestational diabetes;

(G) Hyperemesis;

(H) Pregnancy induced hypertension (pre-eclampsia); or

(I) Other conditions identified by the maternity case manager, physician or prenatal care provider for which adequate services are not accessible through another program.

(b) Documentation must include all of the following:

(A) Nutritional assessment;

(B) Nutritional care plan;

(C) Regular client follow-up.

(c) Can be billed in addition to other MCM services;

(d) Billable once per pregnancy.

(15) G9006 — Home/Environment Assessment:

(a) Includes an assessment of the health and safety of the client's living conditions with training and education of all topics as indicated in Table 130-0595-1;

(b) One Home/Environment Assessment may be billed per pregnancy. Additional Home/Environment Assessments may be billed with documentation of problems which necessitate a follow-up assessment or when a client moves. Documentation must be submitted with the claim to support the additional home/environment assessment.

(16) G9011 — Telephone Case Management Visit:

(a) A non-face-to-face encounter between a maternity case manager and the client, meeting all requirements of a Case Management Visit (G9012) and when a face-to-face Case Management Visit is not possible or practical;

(b) In lieu of a Case Management visit and counted towards the total number of Case Management Visits (see G9012 for limitations).

(17) G9012 — Case Management Visit:

(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and at least two training and education topics listed in Table 130-0595-2;

(b) Four Case Management Visits may be billed per pregnancy. Telephone contacts (G9011) are included in this limitation;

(c) Six additional Case Management Visits may be billed if the client is identified as High Risk. These additional visits may not be billed until after delivery. Bills for these additional six visits may only be submitted with or after High-Risk Full (G9005) or Partial (G9010) case management has been billed. Telephone contacts (G9011) are included in this limitation;

(d) May be provided in the client's home or other site.

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

Stat. Auth.: ORS 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 461-014-0200 & 461-014-0201; AFS 54-1989(Temp), f. 9-28-89, cert. ef. 10-1-89; AFS 71-1989, f. & cert. ef. 12-1-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0580; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 34-1998, f. & cert. ef. 10-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0100, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07

410-130-0610
Telemedicine

(1) For the purposes of this rule, telemedicine is the real time exchange of information for diagnosing and treating medical conditions. The telemedicine technology is an audio/video connection linking a medical practitioner in one locality with a client in another locality.

(2) Coverage for telemedicine:

(a) Telemedicine is covered only for synchronous (live two-way interactive) video transmission which permits real time communications between a medical practitioner located in a distant site and the client being evaluated and located in the originating site;

(b) The evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (DMAP) provider.

(3) Billing requirements:

(a) Only the transmission site (where the patient is located) may bill for the transmission:

(A) Bill the transmission with Q3014;

(B) The referring practitioner may bill an E/M code only if a separately identifiable visit is performed. The visit must meet all of the criteria of the E/M code billed.

(b) The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission (Q3014):

(A) Bill the most appropriate E/M code for the evaluation;

(B) Add modifier GT to the E/M code to designate that the evaluation was made by a synchronous (live and interactive) transmission.

(4) Services not covered:

(a) Asynchronous (store and forward later) telecommunications;

(b) Other forms of telecommunications, such as telephone calls, images transmitted via facsimile machines and electronic mail.

(5) The referring provider is not required to be present with the client at the originating site.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05

410-130-0670
Death With Dignity

(1) All Death with Dignity services must be billed directly to the Division of Medical Assistance Programs (DMAP), even if the client is in a managed care plan.

(2) Death with Dignity is a covered service, incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(3) The following physician visits and medical encounters are billable when performed by a licensed physician or psychologist:

(a) The medical confirmation of the terminal condition;

(b) The two visits in which the client makes the oral request;

(c) The visit in which the written request is made;

(d) The visit in which the prescription is written;

(e) Counseling consultation(s); and

(f) Medication and dispensing.

(4) More than one of the services listed in sections (3)(a) through (3)(f) may be provided during the same visit. Additional visits for discussion or counseling are also covered for payment.

(5) Billing:

(a) All claims for Death with Dignity services must be made on a paper CMS-1500 billing form;

(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;

(c) Claims must be submitted using appropriate CPT or HCPCS codes;

(d) DMAP unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;

(e) Claims must be submitted only on paper to: DMAP, PO Box 992, Salem, Oregon 97308-0992;

(f) Prescriptions must be billed only with DMAP unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS-1500. In addition, the actual NDC number of the drug dispensed and the dosage must be listed below the prescription code;

(g) DMAP may be billed for prescription services only when the pharmacy has been properly notified by the physician in accordance with OAR 847-015-0035. This OAR requires the physician to have the client's written consent to contact and inform the pharmacist of the purpose of the prescription.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 46-1998, f. & cert. ef.12-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 2-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0680

Laboratory and Radiology

(1) The following tables list the medical and surgical services that:

(a) Require prior authorization (PA) — OAR 410-130-0200 Table 130-0200-1 (PET scans require PA and are included in the table), and;

(b) Require prior notification (PN) — OAR 140-130-0200 Table 130-0200-2 (MRIs, MRAs, CTs, CTAs, and SPECT scans require PN and are included in the table), and;

(c) Are not covered/bundled — OAR 410-130-0220 Table 130-0220-1.

(2) Newborn screening (NBS) kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) are considered bundled into the delivery fee and, therefore, must not be billed separately. Replacement of lost NBS kits may be billed with code S3620 with modifier –TC. The loss must be documented in the client's medical record. NBS confirmation tests performed by reference laboratories at the request of the OSPHL shall be reimbursed only to the OSPHL.

(3) The Division of Medical Assistance Programs (DMAP) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the DMAP Transplant Services administrative rules (chapter 410, division 124).

(4) All lab tests must be specifically ordered by, or at the direction of a licensed medical practitioner within the scope of their license.

(5) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests performed by the referring lab.

(6) When billing for lab tests, use the date that the specimen was collected as the date of service (DOS) even if the tests were not performed on that date.

(7) Reimbursement for drawing/collecting or handling samples:

(a) DMAP will reimburse providers once per day regardless of the frequency performed for drawing/collecting the following samples:

(A) Blood — by venipuncture or capillary puncture, and;

(B) Urine — only by catheterization.

(b) DMAP will not reimburse for the collection and/or handling of other specimens, such as PAP or other smears, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to DMAP.

(9) Only the provider who performs the test(s) may bill DMAP.

(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:

(a) DMAP will only reimburse laboratory services to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS);

(b) CLIA requires all entities that perform even one test, including waived tests on... "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory;

(c) Providers must notify DMAP of the assigned ten-digit CLIA number;

(d) Payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.

(11) Organ Panels:

(a) DMAP will only reimburse panels as defined by the CPT codes for the year the laboratory service was provided. Tests within a panel may not be billed individually even when ordered separately. The same panel may be billed only once per day per client;

(b) DMAP will pay at the panel maximum allowable rate if two or more tests within the panel are billed separately and the total reimbursement rate of the combined codes exceeds the panel rate, even if all the tests listed in the panel are not ordered or performed.

(12) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, are payable only when given in conjunction with radiation oncology and nuclear medicine codes 77401-79999;

(b) HCPCS codes R0070 through R0076 are covered.

(13) Reimbursement of contrast and diagnostic-imaging agents is bundled in the radiology procedure except for low osmolar contrast materials (LOCM).

(14) Supply of LOCM may be billed in addition to the radiology procedure only when the following criteria are met:

(a) Prior adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting;

(b) History of asthma or significant allergies;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension;

(d) Decrease in renal function;

(e) Diabetes;

(f) Dysproteinemia;

(g) Severe dehydration;

(h) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage);

(i) Sickle cell disease, or;

(j) Generalized severe debilitation.

(15) X-ray and EKG interpretations in the emergency room:

(a) DMAP reimburses only for one interpretation of an emergency room patient's x-ray or EKG. The interpretation and report must have directly contributed to the diagnosis and treatment of the patient;

(b) DMAP considers a second interpretation of an x-ray or EKG to be for quality control purposes only and will not be reimbursed;

(c) Payment may be made for a second interpretation only under unusual circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0800; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0700
HCPCS Supplies and DME

(1) Use appropriate HCPCS codes to bill all supplies and DME.

(2) For items that do not have specific HCPCS codes:

(a) Use unlisted HCPCS code;

(b) Bill at acquisition cost, purchase price plus postage.

(3) CPT code 99070 is no longer billable for supplies and materials. Use HCPCS codes.

(4) Use S3620 with modifier TC for lost newborn screening (NBS) kits.

(5) The Division of Medical Assistance Programs (DMAP) bundles reimbursement for office surgical suites and office equipment in the reimbursement of surgical procedures.

(6) Contraceptive Supplies — Refer to OAR 410-130-0585.

(7) A4000-A9999:

(a) All "A" codes listed in Table 130-0700-1 are covered under this program;

(b) All "A" codes not listed in Table 130-0700-1 must be referred to a Durable Medical Equipment (DME) provider;

(c) Do not use A4570, A4580 and A4590 for splint and cast materials. Use codes Q4001-Q4051;

(d) A9150-A9999 (administrative, investigational, and miscellaneous) are not covered, except for A9500-A9699. Refer to OAR 410-130-0680.

(8) B4000-B9999:

(a) HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers;

(b) Refer these services to home enteral/parenteral providers.

(9) C1000-C9999 are not covered.

(10) E0100-E1799: DMAP covers only the following DME HCPCS codes for medical-surgical providers when provided in an office setting:

(a) E0100-E0116;

(b) E0602;

(c) E0191;

(d) E1399;

(e) Refer all other items with "E" series HCPCS codes to DME providers.

(11) J0000-J9999 HCPCS codes — Refer to OAR 410-130-0180 for coverage of drugs.

(12) K0000-K9999 HCPCS codes — Refer all items with "K" series to DME providers.

(13) L0000-L9999:

(a) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies program Administrative rules for coverage criteria for orthotics and prosthetics;

(b) Refer to Table 130-0220-1 for a list of "L" codes that are not covered;

(c) Reimbursement for orthotics is a global package, which includes:

(A) Measurements;

(B) Moldings;

(C) Orthotic items;

(D) Adjustments;

(E) Fittings;

(F) Casting and impression materials.

(d) Evaluation and Management codes are covered only for the diagnostic visit where the medical appropriateness for the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.

(14) Refer to Table 130-0700-1 for supplies and DME covered in the office setting.

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

Stat. Auth.: ORS 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 461-014-0056, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0810; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

DIVISION 131

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

410-131-0040
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 Plan of Care

(1) A therapy plan of care is required for payment authorization (PA).

(2) The therapy plan of care must include:

(a) Client's name, diagnosis, type, amount, frequency and duration of the proposed therapy;

(b) Individualized, measurably objective short-term and/or long-term functional goals;

(c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;

(d) Plan to address implementation of a home management program as appropriate, from the initiation of therapy forward;

(e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and

(f) Evidence of certification of the therapy plan of care by the prescribing practitioner.

(3) Recertification of the therapy plan of care:

(a) Is required every 30 days from the initiation of treatment;

(b) The need for continuing therapy should be clearly stated;

(c) The therapy plan of care, duration and frequency of intervention, and any changes to previous therapy plan of care must be documented, signed and dated by the prescribing practitioner.

(4) Therapy Expected Outcome:

(a) Therapy is based on a prescribing practitioner's written order and a therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation.

(b) When possible, the therapy regimen will be taught to the client, 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 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; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2006, f. 12-15-06, cert. ef. 1-1-07

410-131-0100
Maintenance

(1) Determination of when maintenance therapy is reached is made through comparison of written documentation of evaluation of the last several functional evaluations related to initial baseline measurements.

(2) Therapy becomes maintenance when any one of the following occur:

(a) The therapy plan of care goals and objectives are reached; or

(b) There is no progress toward the therapy plan of care goals and objectives; or

(c) The therapy plan of care does not require the skills of a therapist; or

(d) The client, family, foster parents, and/or caregiver have been taught and can carry out the therapy regimen and are responsible for the maintenance therapy.

(3) Maintenance therapy is not a reimbursable service.

(4) Re-evaluation to change the therapy plan of care and up to two treatments for brief retraining of the client, family, foster parents or caregiver are not considered maintenance therapy and are reimbursable.

Stat. Auth.: ORS 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; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01

410-131-0120
Limitations

(1) OARs 410-131-0020 through 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 are to be in accordance with the rules in their respective provider guides.

(2) Program Information — 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:

(a) Duration — Therapy treatments must not exceed one hour per day each for occupational and physical therapy;

(b) Maintenance Therapy — 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 client, family, foster parents, or caregiver have been taught and can carry out the therapy regimen. Maintenance therapy is not reimbursable;

(c) Modalities — Up to two modalities may be authorized per day of treatment;

(d) Massage therapy, CPT 97124, is limited to two (2) units per day of treatment, and will only be authorized in conjunction with another therapeutic procedure or modality;

(e) Physical Capacity Examinations — 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 office. See OAR 410 division 150 for information on Administrative examinations and report billing;

(f) Re-Evaluations — A re-evaluation to reassess or change the treatment plan and retrain the client, family, foster parents, or caregiver is reimbursable;

(g) Splint Fabrication — Supplies and materials for the fabrication of splints must be billed at the acquisition cost, not to exceed $62.40. Acquisition cost is purchase price plus shipping. Off-the-shelf splints are not included in this service;

(h) Therapy Records — Therapy records must include:

(A) A written order (including type, number and duration of services) and therapy treatment plan signed by the prescribing provider;

(B) Documents, evaluations, re-evaluations and progress notes to support the therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;

(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.

(i) Training — The therapy treatment plan and regimen will be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments will be authorized for teaching.

(3) Payment Authorization:

(a) The following services do not require payment authorization for occupational or physical therapy:

(A) Up to two initial evaluations in any 12-month period;

(B) Up to four re-evaluation services in any 12-month period.

(b) All other occupational and physical therapy treatments require payment authorization.

(4) Services Not Covered — The following services are not covered:

(a) Services that are not medically appropriate;

(b) Services that are not paired with a funded diagnosis on the Health Services Commission's Prioritized List of Health Services adopted under OAR 410-141-0520;

(c) Work hardening;

(d) Back school/back education classes;

(e) Hippotherapy;

(f) Durable medical equipment and medical supplies other than those listed in OAR 410-131-0280.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 64-2003, f. 9-8-03, cert. ef. 10-1-03; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 15-2005, f. 3-11-05, cert. ef. 4-1-05

410-131-0140
Prescription Required

(1) The prescription is the written referral by the prescribing practitioner.

(2) The provision of physical and occupational therapy services must be supported by a written referral and a therapy plan of care signed and dated by the prescribing practitioner. Evaluations and therapy services require a prescribing practitioner referral.

(3) A written referral must include:

(a) The client's name;

(b) The ICD-9-CM diagnosis code;

(c) The therapy referral must specify the services, amount, and duration required.

(4) A copy of the signed therapy plan of care must be on file in the provider's therapy record prior to billing for services. The therapy plan of care must be reviewed and signed by the prescribing practitioner every 30 days.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.645
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 461-023-0001; HR 19-1992, f. & cert. ef. 7-1-92; HR 28-1993, f. & cert. ef. 10-1-93; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01

410-131-0160
Payment Authorization

(1) Payment authorization is approval by the Division of Medical Assistance Programs (DMAP), the Medically Fragile Children's Unit (MFCU), the DMAP Case Management Contractor, or the Managed Care Organizations (MCOs) for services.

(2) Payment authorization is required for physical and occupational therapy services as indicated in the "Occupational and Physical Therapy Codes" section of the Physical and Occupational Therapy rules. For services requiring authorization from DMAP or MFCU, and for continuation of those services, providers must contact DMAP or MFCU for authorization within five working days following initiation of services. For services requiring payment authorization from the DMAP Case Management Contractor, authorization must be obtained prior to the initiation of services. For fee-for-service case management clients, DMAP will not reimburse for a service that requires payment authorization if provided prior to receiving authorization from the DMAP Case Management Contractor. Services for clients enrolled in a Managed Care Organization (MCO) will be authorized by the MCO. Contact the MCO to determine their procedures.

(3) If service is provided prior to receiving authorization, the provider may be at risk for denial of authorization. It is the provider's responsibility to obtain payment authorization. The FAX or postmark date is recognized by DMAP as the date of request.

(4) A payment authorization number must be present on all claims for occupational and physical therapy services that require payment authorization or the claim will be denied.

(5) Payment authorization does not guarantee eligibility or payment. It is the provider's responsibility to check for eligibility on the date of service.

(6) Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of services.

(7) Physical and occupational therapy services for DMAP fee-for-service clients with Medicare do not require payment authorization for Medicare covered services. For clients enrolled in a Managed Care Organization (MCO), contact the MCO for their procedures.

Stat. Auth.: ORS 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 geograph-

ical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 98-1982, f. 10-25-82, ef. 11-1-82; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 63-1987, f. 12-30-87, ef. 4-1-88; HR 8-1991, f. 1-25-91, cert. ef. 2-1-91, Renumbered from 461-023-0015; HR 19-1992, f. & cert. ef. 7-1-92; HR 28-1993, f. & cert. ef. 10-1-93; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 92-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04

410-131-0180
Billing

(1) Billings for physical and occupational therapy services listed in the Physical and Occupational Therapy Services guide must be submitted on a CMS-1500 or a DMAP 505.

(2) Physical Therapy Assistants and Certified Occupational Therapy Assistants may provide services and bill using the provider number of their licensed supervisor.

(3) CMS-1500 forms are not provided by the Division of Medical Assistance Programs (DMAP). They may be obtained from local forms suppliers.

(4) Send completed CMS-1500 claim forms to DMAP.

(5) Electronic Billing — Claims can be submitted electronically. For more information contact DMAP.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 53-2002, f. & cert. ef. 10-1-02

410-131-0200
Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medical Assistance Program coverage and has not met the current Medicare maximum, bill Medicare first. Medicare will automatically forward your bill to the Division of Medical Assistance Programs (DMAP) for you. If Medicare transmits incorrect information to DMAP or if an out-of-state Medicare carrier or intermediary was billed, bill DMAP using a DMAP 505 form.

(2) If an incorrect payment is made by DMAP, submit an Adjustment Request (DMAP 1036) to correct payment.

(3) See OAR 410-120-1210 (General Rules) for information on DMAP reimbursement.

(4) Supplies of DMAP 505 forms can be obtained from the Department of Human Services (DHS) Office of Forms and Document Management.

(5) Send all completed DMAP 505 forms to DMAP.

[ED. NOTE: Forms referenced are available from the agency.]
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; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04

410-131-0270
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 85-2002, f. 12-24-02, cert. ef. 1-1-03

410-131-0275
Standard Benefit Package

Physical and Occupational Therapy services are not covered under the Standard Benefit Package. See General Rules, 410-120-1210 for additional information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

410-131-0280
Occupational and Physical Therapy 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) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on covered services.

(3) Services that do not require payment authorization appear on Table 131-0280-1.

(4) Services that require payment authorization include the following:

(a) Modalities — need to be billed in conjunction with a therapeutic procedure code;

(b) Supervised — The application of a modality that does not require direct (one-on-one) client contact by the provider. Each individual code in this series may be reported only once for each client encounter. See Table 131-0280-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 3-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 16-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 64-2003, f. 9-8-03, cert. ef. 10-1-03; OMAP 14-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 15-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 19-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 7-2007, f. 6-14-07, cert. ef. 7-1-07

DIVISION 132

PRIVATE DUTY NURSING SERVICES

410-132-0020
Private Duty Nursing Services

(1) The practice of nursing is governed by the following: Oregon State Board of Nursing, ORS 678.010 to 678.410, and Oregon State Board of Nursing, chapter 851, divisions 31, 45, and 47.

(2) Private duty nursing is considered supportive to the care provided to a client by the client's family, foster parents, and/or delegated caregivers, as applicable. Nursing services must be medically appropriate. Medically appropriate for private duty nursing shift care is determined by qualifying for services based on the Private Duty Nursing Acuity Grid (DMAP 591). Increases or decreases in the level of care and number of hours or visits authorized shall be based on a change in the 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 appropriateness;
(d) Identified skilled nursing needs;
(e) Goals and objectives of care provided.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 6-1997, f. & cert. ef. 2-19-97; OMAP 6-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 54-2002, f. & cert. ef. 10-1-02

410-132-0030
Definitions

(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. See State Board of Nursing rules that govern the practice of nursing.

(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. See State Board of Nursing rules that govern the practice of nursing.

(6) Discharge — Client no longer meets the Division of Medical Assistance Programs (DMAP)' rules and criteria of the private duty nursing program.

(7) Home — A place of temporary or permanent residence, not including a hospital, ICF/MR, nursing facility, or licensed residential care facility.

(8) 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.

(9) Medically Fragile Children's Unit (MFCU) — A Department of Human Services 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.

(10) 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.

(11) 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 the "Documentation Requirements" section of the Private Duty Nursing Services Guide.

(12) 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.

(13) 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. See State Board of Nursing rules that govern the practice of nursing.

(14) 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.

(15) Respite — Short-term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

(16) Responsible Unit — The agency responsible for approving or denying prior authorization.

(17) Shift — Four to twelve hours of private duty nursing.

(18) 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.

(19) 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.

(20) 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. See State Board of Nursing rules that govern the practice of nursing.

(21) Teaching — The registered nurse instructs an unlicensed person in the correct method of performing a selected task of client/nursing care. See State Board of Nursing rules that govern the practice of nursing.

(22) Visit — Nursing service supplied on an intermittent basis in the home.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 6-1997, f. & cert. ef. 2-19-97; OMAP 6-1999, f. 3-4-99, cert. ef. 4-1-99

410-132-0050
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 86-2002, f. 12-24-02, cert. ef. 1-1-03

410-132-0055
OHP Standard Benefit Package

(1) Private duty nursing services are not covered for clients receiving the Standard Benefit Package. See General Rules, 410-120-1210 for additional information.

(2) The OHP Standard Benefit Package includes limited home enteral/parenteral services and intravenous services (see 410-148-0090).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

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 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

410-132-0070
Documentation Requirements

(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 Activities of Daily Living (ADL), 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, Registered Nurse (RN) case manager, Department of Human Services (DHS) 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 409
Stats. Implemented: ORS 414.065
Hist.: HR 6-1997, f. & cert. ef. 2-19-97; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00

410-132-0080
Limitations

(1) General; pertains to both shift care and visits:

(a) Private duty nursing is not covered if the client is:

(A) A resident of a nursing facility;

(B) A resident of a licensed intermediate care facility for people with developmental disabilities;

(C) In a hospital;

(D) In a licensed residential care facility.

(b) Private duty nursing is not covered solely to allow the client's family or caregiver to work or go to school;

(c) Private duty nursing is not covered solely to allow respite for caregivers or 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 program rules;

(f) Home nursing visits as defined in the Home Enteral/Parenteral Nutrition and IV Services Rules, are not covered in conjunction with private duty nursing services;

(g) 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 reimbursable;

(j) Travel time to reach the job site is not reimbursable;

(k) Maintenance care is not reimbursable.

(2) Private Duty Nursing Visit:

(a) The nursing care plan and documentation supporting the medical appropriateness 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:

(a) Medically appropriate private duty nursing shift care for clients up to18 years old, 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 skilled management by a licensed nurse is required;

(b) A client may be referred to the Medically Fragile Children's Unit (MFCU), to determine if they meet the criteria for MFCU admission 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.

(c) Private Duty Nursing shift care for clients age 18 and over will be referred to Seniors and People with Disabilities Division (SPD) for determination of their long-term care needs;

(d) The number of hours of private duty nursing services that a client may receive is determined by the score on the Private Duty Nursing Acuity Grid (DMAP 591):

(A) 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 (DMAP 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) The banking, saving, or accumulating unused prior authorized hours used for the convenience of the family or caregiver is not covered. Table 0080-1 (DMAP 590). Table 0080-2 (DMAP 591).

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 54-2002, f. & cert. ef. 10-1-02

410-132-0100
Prior Authorization

(1) Payment may be made only for private duty nursing services only 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 in order to obtain prior authorization:

(a) Client's name and recipient ID number;

(b) Performing provider name and Division of Medical Assistance Programs (DMAP) provider number;

(c) Physician's orders for service must be dated within seven days prior to the 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, the plan of care 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 (DMAP 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).
(7) Where to request prior authorization:
(a) Managed Health Care (MHC) Clients: Services for clients identified on their DMAP Medical Care Identification as having a "DMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;
(b) Adult and Family Services (AFS) and State Office for Services to Children and Families (SCF) Clients: Services for clients identified on the Medical Care Identification as AFS and SCF (shown on the Medical ID as CSD) will be authorized by DMAP;
(c) Seniors and People with Disabilities Division (SPD) Clients:
(A) Those services for clients identified on the Medical Care Identification as SDSD clients will be authorized by DMAP;
(d) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, authorization must be obtained from the MCM Contractor prior to the initiation of services. For FFS MCM clients, DMAP will not reimburse for a service that requires payment authorization if the service is provided prior to receiving authorization from the MCM Contractor.
(e) Medically Fragile Children's Unit Clients. Services for clients identified by the Department of Human Services (DHS) as Medically Fragile Children will be authorized by MFCU.

Stat. Auth.: ORS 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; OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 93-2003, f. 12-30-03 cert. ef. 1-1-04

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 Division of Medical Assistance Programs (DMAP) 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 DMAP.
(3) For information about electronic billing, contact the DMAP Electronic Billing Representative.
(4) When billing for clients with Medicare, bill on a HCFA-1500 and enter the appropriate TPR Explanation Code in Field 9.

Stat. Auth.: ORS 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; OMAP 54-2002, f. & cert. ef. 10-1-02

410-132-0180
Procedure Codes

(1) All private duty nursing services require prior authorization. (See definitions section of the guide).
(2) Private Duty Nursing Visit:
(a) T1030 — Nursing care, in the home, by registered nurse, per diem;
(b) T1031 — Nursing care, in the home, by licensed practical nurse, per diem.
(3) Private Duty Nursing Shift Care:
(a) S9123 — Nursing care, in the home, by registered nurse, per hour — 1 unit equals one hour;
(b) S9124 — Nursing care, in the home, by licensed practical nurse, per hour — 1 unit equals one hour.

Stat. Auth.: ORS 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; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 54-2002, f. & cert. ef. 10-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

410-132-0200
Provider Enrollment

In order for registered nurses or licensed practical nurses to be enrolled or continue enrollment as a Division of Medical Assistance Programs (DMAP) provider, a copy of licensure must be submitted every two years upon renewal by the Oregon State Board of Nursing.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00

DIVISION 133

SCHOOL-BASED HEALTH SERVICES

410-133-0000
Purpose

(1) School-Based Health Services (SBHS) rules describe the Medicaid covered services available to Medicaid-eligible students receiving Health Services on a fee-for-service basis when "Necessary and Appropriate" and within the limitations established by the Medical Assistance Program and these rules, consistent with the requirements of the Individuals with Disabilities Education Act (IDEA). These rules are to be used in conjunction with the General Rules governing the Division of Medical Assistance Programs (DMAP) (OAR 410 division 120) and the Oregon Health Plan (OHP) rules (OAR 410 division 141). The School-Based Health Services rules are also a user's manual designed to assist the Educational Agency (EA) in matching State and Federal Funds for Oregon's Medicaid-eligible students with disabilities.
(2) The Oregon Administrative Rules (OARs) in chapter 581, division 15 for the Oregon Department of Education (ODE) outline Oregon's program to meet the federal provisions of the IDEA. These SBHS rules define Oregon's fee-for-service program to reimburse publicly funded education agencies for the Health Services provided under the IDEA to Oregon's Medicaid-eligible children.
(3) The Department of Human Services (DHS) and ODE recognize the unique intent of Health Services provided for Medicaid-eligible students with disabilities in the special education setting. The School-Based Health Services rules address the health aspects of special education services that are covered by Medicaid or the Children's Health Insurance Program.
(4) DHS endeavors to furnish School Medical Providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements. DHS does so by providing information on it's website.
(5) Enrolled School-Based Health Services Providers are responsible to maintain current publications provided by DHS and DMAP, and to comply with the OARs in effect on the date of service the Health Service is provided.
(6) In order for DHS to reimburse for Health Services provided in the school, the Health Services must be included as a covered service under the Oregon Health Plan. There is no benefit category in the Medicaid statute titled "school health services" or "early intervention services." These rules do not create a new category of health benefits for this fee for service program.
(7) These rules describe Health Services that are covered services for Medicaid-eligible students, which are authorized and provided consistent with these rules.
(8) Medicaid-eligible students retain the ability to obtain services from any qualified Medicaid provider that undertakes to provide services to them. These rules do not require a Medicaid-eligible student to receive their Health Services solely from School Medical Providers.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0040
Definitions

(1) Adapted Vehicle — Vehicle specifically designed or modified to transport passengers with disabilities.

(2) Adequate Recordkeeping — In addition to General Rules OAR 410-120-0000, Definitions and 410-120-1360, Requirements for financial, clinical, and other records, documentation in the student's Educational Record and on the Individualized Education Plan or Individualized Family Service Plan (IEP/IFSP) showing the Necessary and Appropriate Health Services provided to the student detailed in DHS SBHS rules (See Definitions 26, 38, 39, 74, & 89 and OAR 410-133-0320).

(3) Assessment — A process of obtaining information to determine if a student qualifies for or continues to qualify for DMAP covered School-Based Health Services.

(4) Assistive Technology Service — Services provided by Medically Qualified Staff within the scope of practice under State law with training and expertise in the use of assistive technology (see 410-133-0080 Coverage and 410-133-0200 Not Covered Services in these rules).

(5) Audiologist — A person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology or holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA) and meet the requirements in 42 CFR 440.110.

(6) Audiology — Assessment of children with hearing loss; determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services.

(7) Automated Information System (AIS) — A computer system that provides information on Medicaid client current eligibility status under the Medical Assistance Program. (See General Rules OAR 410-120-0000 Definitions).

(8) Benefit Package — The "package" of covered health care services for which the Medicaid-eligible student is eligible. (See General Rules OAR 410-120-0000 Definitions and 410-120-1210 Medical Assistance Benefit Packages and Delivery System and OHP rules OAR 410-141-0480 and 410-141-0520). The benefit package is identified on the Medical ID card issued by DHS.

(9) Billing Provider (BP) — A person, agent, business, corporation, clinic, group, institution, or other entity that submits claims to and/or receives payment from the Medical Assistance Program on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider. (See General Rules OAR 410-120-1260 and SBHS Rules 410-133-0140.)

(10) Billing Time Limit — Refers to the rules concerning the period of time allowed to bill services to DMAP under "Timely Submission of Claims" (See OAR 410-120-1300). In general, those rules require initial submission within 12 months of the date of service or 18 months for resubmission.

(11) Centers for Medicare and Medicaid Services (CMS) — The federal regulatory agency for Medicaid programs.

(12) CMS-1500 — The standard federal billing form used to bill medical services.

(13) Certification — See "licensure."

(14) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by the Department of Human Services Division of Medical Assistance Programs (see Medical Assistance Program).

(15) COTA — Certified Occupational Therapy Assistant — A person who is licensed as an occupational therapy assistant assisting in the practice of occupational therapy under the supervision of a licensed occupational therapist.

(16) Clinical Social Work Associate (CSWA) — A person working toward LCSW licensure under the supervision of a LCSW for two years of post masters clinical experience and is licensed by the State Board of Clinical Social Workers to practice in Oregon.

(17) Coordinated care — Services directly related to SBHS covered Health Services specified in the IEP or IFSP, performed by Medically Qualified Staff, and allowed under 410-133-0080, Coverage to manage integration of those Health Services in an education setting. Coordinated Care includes the following activities:

(a) Conference — The portion of a conference in a scheduled meeting, between Medically Qualified Staff and interested parties, to develop, review, or revise components of School-Based Health Services provided to a Medicaid-eligible student for the purpose to establish, re-establish or terminate a Medicaid covered Health Service on a Medicaid-eligible student's IEP or IFSP; or to develop, review, or revise components of a covered Health Service currently provided to a Medicaid-eligible student to determine whether or not those covered Health Services will continue to be specified on an IEP or IFSP.

(b) Consultation — performed by Medically Qualified Staff within the scope of practice providing technical assistance to or conferring with, special education providers, physicians, and families to assist them in providing a covered Health Service for Medicaid-eligible students related to a specific Health Service in support of goals and objectives in the IEP or IFSP.

(c) Physician coordinated care — Meeting or communication with a physician in reference to oversight of care and treatment provided for a Health Service specified on a Medicaid-eligible student's IEP or IFSP.

(18) Cost Determination — The process of establishing an annual discipline fee (rate), based on the prior-year actual audited costs, used by an EA for the purpose of billing for covered school-based health services (see 410-133-0245 in these rules).

(19) Current Procedural Terminology (CPT) — The American Medical Association's 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. See General Rules (OAR 410-120-0000 Definitions).

(20) Delegated Health Care Aide — A non-licensed person trained and supervised by a licensed Registered Nurse (RN) or Nurse Practitioner (NP) to perform selected tasks of nursing care specific to the Medicaid-eligible student identified in the Nursing Plan of Care pursuant to the IEP/IFSP.

(21) Delegation of Nursing Task — A selected nursing task that is performed by an unlicensed person, trained and monitored by a licensed Registered Nurse (RN). Delegation and supervision of selected nursing tasks must comply with Oregon Administrative Rules, Board of Nursing, chapter 851 division 45 and 47. A School Medical Provider must maintain documentation of the actual delegation, training, supervision and provision of the nursing service billed to Medicaid.

(22) Direct Services — Face-to-face delivery of Health Services between the Medically Qualified Staff who is the service provider and a Medicaid-eligible student.

(23) Early Intervention/Early Childhood Special Education (EI/ECSE) — A program designed to address the unique needs of a child age 0–3 years (EI) and preschool children ages 3–5 years (ECSE) with a disability.

(24) EDI Submitter — is a person or entity authorized to conduct an Electronic Transaction between a Provider that is a Trading partner and DHS, as those terms are used in the DHS EDI rules. OAR 410-001-0100 to 410-001-0200.

(25) Educational Agency (EA) — For purposes of these rules, any public school, school district, Education Service District (ESD), state institution, or youth care center providing educational services to students, birth to age 21 through grade 12, that receives federal or state funds either directly or by contract or subcontract with the ODE.

(26) Education Records — Those records, files, documents and other materials which contain information directly related to a student and maintained by an EA or by a person acting for such EA as set forth in OAR 581-021-0220. (A SBHS provider is required to keep and maintain supporting documentation for Medicaid reimbursed Health Services for a period of seven (7) years; this documentation is part of the student's education record but may be filed and kept separately by school health professionals.) See 410-133-0320 Documentation and Recordkeeping Requirements in these rules.

(27) Education Service District (ESD) — An education agency established to offer a resource pool of cost-effective, education-related, physical or mental health-related, state-mandated services to multiple local school districts within a geographic area described in ORS 334.

(28) Eligibility for Special Education Services — A determination by a designated EA, through a team, that 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.

(29) Evaluation — Evaluations are procedures performed by Medically Qualified Staff to determine whether a Medicaid-eligible student is disabled and the nature and extent of the Health Services the student needs under IDEA and in accordance with OAR 581-015-0071 and 0072. DHS can only reimburse evaluations that establish, re-establish or terminate a SBHS covered Health Service on a Medicaid-eligible student's IEP or IFSP under IDEA.

(30) Federal Medical Assistance Percentage (FMAP) — The percentage of Federal matching dollars for qualified State Medical Assistance Program expenditures.

(31) Healthcare Common Procedure Coding System (HCPCS) — A method for reporting health care professional services, procedures, and supplies. See General Rules (OAR 410-120-0000 Definitions).

(32) Health Assessment Plan (nursing) — Systematic collection of data for the purpose of assessing a Medicaid-eligible student's health or illness status and actual or potential health care needs in the educational setting. Includes taking a nursing history, and an appraisal of the student's health status through interview, information from the family and information from the student's past health or medical record. A SBHS provider is required to keep and maintain the Health Assessment Plan and supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's IEP or IFSP for a period of seven (7) years, as part of the student's Education Record, which may be filed and kept separately by school health professionals. (See 410-133-0320 Documentation and Recordkeeping Requirements.)

(33) Health Care Practitioner — A person licensed pursuant to state law to engage in the provision of health care services within the scope of the health care practitioner's license and/or certification standards established by their health licensing agency. Medical Provider and Health Care Practitioner are interchangeable terms. See Definition 48 Medical Provider.

(34) Health Services — Medical evaluation services provided by a physician for diagnostic and evaluation purposes for a Medicaid-eligible student that is found eligible under IDEA and leads to an established IEP or IFSP, physical or mental health evaluations, and assessment or treatment performed by Medically Qualified staff to achieve the goals set forth in a Medicaid-eligible student's IEP or IFSP. A SBHS covered Health Service is one that is covered by the Medical Assistance program and is provided to enable the Medicaid-eligible student to benefit from a special education program (age 3–21) or to achieve developmental milestones in an early intervention program (age 0–3). "Health Services" are synonymous with "medical services" in these rules. To determine whether a Health Service specified on an IEP or IFSP is a covered SBHS (See 410-133-0080 Coverage and 410-133-0200 Not Covered Services).

(35) Health Services Commission (HSC) — 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 serviced.

(36) ID Number — A number issued by DHS used to identify Medicaid-eligible students. This number may also be referred to as Recipient Identification Number; Prime Number; Client Medical ID Number or Medical Assistance Program ID Number.

(37) Individuals with Disabilities Education Act (IDEA) — The federal law ensuring the rights of children with disabilities to a "free and appropriate education" (FAPE).

(38) Individualized Education Plan (IEP) — A written statement of an educational program for a child with a disability which is developed, reviewed, or revised in a meeting in accordance with OAR chapter 581, division 15. When an IEP is used as a prescription for Medicaid reimbursement for SBHS covered services, it must include: type of Health Service, amount, duration and frequency for the service provided. In order to bill Medicaid for covered Health Services they must be delivered by or under the supervision of Medically Qualified Staff and must be recommended by a physician or appropriate health care practitioner acting within the scope of practice. See definition (51) Medically Qualified Staff.

(39) Individualized Family Service Plan (IFSP) — A written plan of early childhood special education services, early intervention services, and other services developed in accordance with criteria established by ODE for each child (age's birth to 5 years) eligible for IFSP services. The plan is developed to meet the needs of a child with disabilities in accordance with requirements and definitions in OAR chapter 581, division 15. When an IFSP is used as a prescription for Medicaid reimbursement for SBHS covered services, it must include: type of health service, amount, duration and frequency for the service provided. In order to bill Medicaid for covered Health Services they must be delivered by or under the supervision of Medically Qualified Staff and must be recommended by a physician or appropriate health care practitioner acting within the scope of practice. See definition (51) Medically Qualified Staff.

(40) Individualized Education Plan/Individualized Family Service Plan (IEP/IFSP) Team — A group of teachers, specialists, and parents responsible for determining eligibility, developing, reviewing, and revising an IEP or IFSP in compliance with OAR chapter 581, division 15.

(41) Licensed Clinical Social Worker (LCSW) — A person licensed to practice clinical social work pursuant to State law.

(42) Licensed Physical Therapist Assistant (LPTA) — A person licensed to assist in the administration of physical therapy, solely under the supervision and direction of a physical therapist.

(43) Licensed Practical Nurse (LPN) — A person licensed to practice under the direction of a licensed professional within the scope of practice as defined by State law.

(44) Licensure — Documentation from state agencies demonstrating that licensed or certified individuals are qualified to perform specific duties and a scope of services within a legal standard recognized by the licensing agency. In the context of Health Services, licensure refers to the standards applicable to Health Service providers by health licensing authorities. For Health Services provided in the State of Oregon, licensure refers to the standards established by the appropriate State of Oregon licensing agency.

(45) Medicaid-eligible student — The child or student who has been determined to be eligible for Medicaid Health Services by the Department of Human Services. For purposes of this rule, Medicaid-eligible student is synonymous with "Recipient" or "Oregon Health Plan Client." For convenience, the term student used in these rules applies to both students covered by an IEP and children covered by an IFSP. Also for purposes of this rule, students or children whose eligibility is based on the Children's Health Insurance Program (CHIP) shall be referred to as Medicaid-eligible students.

(46) Medical Assistance Program — A program for payment of Health Services provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and the Children's Health Insurance Program (CHIP). The Medical Assistance Program is administered by DHS, DMAP.

(47) Medical Management Information System (MMIS) — A data collection system for processing paper and electronic claims for payment of Health Services provided to Medicaid-eligible recipients.

(48) Medical Provider — An individual licensed by the State to provide health services within their governing body's definitions and respective scope of practice. Medical provider and health care practitioner are interchangeable terms.

(49) Medical Services — The care and treatment provided by a licensed health care practitioner to prevent, diagnose, treat, correct or address a medical problem; whether physical, mental or emotional. For the purposes of these rules, this term shall be synonymous with Health Services or health-related services listed on an IEP or IFSP, as defined in OAR chapter 581, division 15. Not all health-related services listed on an IEP or IFSP are covered as SBHS. See 410-133-0080 Coverage and 410-133-0200 Not Covered Services.

(50) Medical Transportation — Specialized transportation in a vehicle adapted to meet the needs of passengers with disabilities transported to and from a SBHS covered service.

(51) Medically Qualified Staff:

(a) Staff employed by and/or through contract with an EA; and

(b) licensed by the State to provide Health Services in compliance with State law defining and governing the scope of practice, described further in OAR 410-133-0120.

(52) Medication Management — A task performed only by Medically Qualified Staff, pursuant to a student's IEP/IFSP, which involves administering medications, observing for side effects, and monitoring signs and symptoms for medication administration.

(53) "Necessary and Appropriate Health Services" — Those Health Services described in a Medicaid-eligible student's IEP or IFSP that are:

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

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

(c) not solely for the convenience of the Medicaid-eligible student or provider of the service; and

(d) the most cost-effective of the alternative levels of Health Services, which can safely be provided to a Medicaid-eligible student.

(54) Nursing Diagnosis and Management Plan — A written plan that describes a Medicaid-eligible student's actual and anticipated health conditions that are amenable to resolution by nursing intervention.

(55) Nursing Plan of Care — Written guidelines made a part of and attached to the IEP or IFSP that identify specific health conditions of the Medicaid-eligible student, and the nursing regimen that is "Necessary and Appropriate" for the student. Development and maintenance of this plan includes establishing student and nursing goals, and identifying nursing interventions (including location, frequency, duration and delegation of care) to meet the medical care objective identified in their IEP or IFSP. See Oregon State Board of Nursing Practice Act, division 47. The SBHS Provider is responsible for developing the Nursing Plan of Care and is required to keep and maintain a copy of the Nursing Plan of Care as supporting documentation for Medicaid reimbursed health services. (See definition #26 Education records.)

(56) 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.

(57) Nursing Services — Services provided by a nurse practitioner (NP), registered professional nurse (RN), a licensed practical nurse (LPN) or Delegated Health Care Aide, within the scope of practice as defined by State law. Nursing services include preparation and maintenance of the Health Assessment Plan, Nursing Diagnosis and Management Plan, Nursing Plan of Care, consultation, and coordination and integration of Health Service activities, as well as direct patient care and supervision.

(58) Observation — Surveillance or visual monitoring performed by Medically Qualified Staff as part of an evaluation, assessment, direct service, or care coordination for a Necessary and Appropriate Medicaid covered Health Service specified on a Medicaid-eligible student's IEP or IFSP to better understand the child's medical needs and progress in their natural environment. An observation by itself is not billable.

(59) Occupational Therapist (OT) — A person licensed by the State Board of Examiners for Occupational Therapy.

(60) Occupational Therapy — Assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation. To improve the ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function. Obtaining and interpreting information, coordinating care, and integrating Necessary and Appropriate occupational therapy services relative to the Medicaid-eligible student.

(61) Office of Medical Assistance Programs (DMAP) — An office of the Oregon Department of Human Services. DMAP is responsible for coordinating the Medical Assistance Program within the State of Oregon.

(62) Oregon Department of Education (ODE) — The state agency that provides oversight to public Educational Agencies for ensuring compliance with Federal and State laws relating to the provision of services required by the IDEA.

(63) Orientation and Mobility Training — Services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community. These services are not covered under the SBHS program.

(64) Performing Provider — A person, agent, business, corporation, clinic, group, institution, or other entity that is the provider of a service or item with the authority to delegate fiduciary responsibilities to a Billing Provider to obligate or act on the behalf of the Performing Provider regarding claim submissions, receivables, and payments relative to the Medical Assistance Program. For the purposes of these SBHS rules, the School Medical Provider is the Performing Provider.

(65) Physical Therapist — A person licensed by the relevant State licensing authority to practice physical therapy (See OAR chapter 848 division10).

(66) Physical Therapy — Assessing, preventing or alleviating movement dysfunction and related functional problems. Obtaining and interpreting information, coordinating care, and integrating Necessary and Appropriate physical therapy services relative to the student receiving treatments.

(67) Prime Number — See definition of ID Number.

(68) Prioritized List of Health Services — The listing of condition and treatment pairs developed by the Health Services (HSC) 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).

(69) Procedure Code — See definition of HCPC Healthcare Common Procedure Code.

(70) Provider — An individual, facility, institution, corporate entity, or other organization which supplies health care 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 DMAP-enrolled providers who have by signature on the provider enrollment form, agreed to provide services and to bill in accordance with the General Rules 410-120-1260 and the SBHS program rules 410-133-0140. If a Provider submits claims electronically, the Provider must become a Trading Partner with the Department of Human Services and comply with the requirements of the EDI rules pursuant to OAR 410-001-0100 et seq.

(71) Psychiatrist — A person licensed to practice medicine and surgery in the State of Oregon and possesses a valid license from the Oregon Licensing Board for the Healing Arts.

(72) Psychologist — A person with a doctoral degree in psychology and licensed by the State Board of Psychologist Examiners See 858-010-0015.

(73) Psychologist Associate — A person who does not possess a doctoral degree that is licensed by the Board of Psychologists Examiners, to perform certain functions within the practice of psychology under the supervision of a Psychologist. See 858-050-0100 through 858-050-0145. An exception would be Psychologist Associate with the authority to function without immediate supervision, see OAR 858-050-0150.

(74) Recordkeeping Requirements — A SBHS provider is required to keep and maintain the supporting documentation for Medicaid reimbursed Health Services described in a Medicaid-eligible student's IEP or IFSP for a period of seven (7) years, as part of the student's Education Record, which may be filed and kept separately by school health professionals (See 410-133-0320).

(75) Re-evaluation — Procedure used to measure a Medicaid-eligible student's health status compared to an initial or previous evaluation, or to determine whether the student continues to be eligible for Medicaid covered Health Services under the IDEA.

(76) Regional Program — Regional Program Services are provided on a multi-county basis, under contract from the Department of Education to eligible children (birth to 21) visually impaired, hearing impaired, deaf-blind, autistic, and/or severely orthopedically impaired. A Regional program may be reimbursed for covered Health Services it provides to Medicaid-eligible students through the School Medical Provider (e.g., school district or ESD) that administers the program.

(77) Registered Nurse (RN) — A person licensed and certified by the Board of Nursing to practice as a registered nurse pursuant to State law.

(78) Rehabilitative Services — For purposes of the SBHS program, any Health Service that is covered by the Medical Assistance Program and that is a medical, psychological or remedial Health Service recommended by a physician or other licensed health care practitioner within the scope of practice under State law, and provided to a Medicaid-eligible student pursuant to an IEP/IFSP under IDEA, for reduction, correction, stabilization or functioning improvement of physical or mental disability of a Medicaid-eligible student (See 410-133-0060).

(79) Related Services — For purposes of this rule, Related Services as listed on an IEP or IFSP may include: transportation and such developmental, corrective and other supportive services (e.g., speech language, audiology services, psychological services, physical therapy, occupational therapy, social work services in schools, and nursing services) as are required to assist a child or student with a disability to benefit from special education; and includes early identification and assessment of disabling conditions in children.

NOTE: Not all "Related Services" are covered for payment by Medicaid. To determine whether a particular Related Service is a covered Health Service for a Medicaid-eligible student (see OAR 410-133-0080, Coverage and OAR 410-133-0200, Not Covered Services).

(80) School-Based Health Services (SBHS) — Health Services provided in the educational setting, meeting the requirements of these rules, and applicable federal and state laws and rules.

(81) School Medical Provider — An enrolled provider type established by DMAP to designate the provider of School-Based Health Services eligible to receive reimbursement from DMAP. See OAR 410-133-0140 (School Medical Provider Enrollment Provisions).

(82) Screening — A limited examination to determine a Medicaid-eligible student's need for a diagnostic medical evaluation. See OAR 410-133-0200 (Not Covered Services).

(83) 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.

(84) Speech Language Pathology Assistant (SLPA) — A person who is licensed by the Oregon State Board of Examiners for Speech Pathology and Audiology and provides speech-language pathology services under the direction and supervision of a speech-language pathologist licensed under ORS 681.250.

(85) Speech-Language Pathologist — A person licensed by the Oregon Board of Examiners for Speech Pathology and Audiology or holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA).

(86) Speech-Language Pathology Services — Assessment of children with speech/language disorders, diagnosis and appraisal of specific speech/language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech/language disorders and provision of speech/language services for the prevention of communicative disorders. Obtaining and interpreting information, coordinating care, and integrating Necessary and Appropriate speech-language pathology services relative to the student receiving services.

(87) State Education Agency (SEA) — See "Oregon Department of Education (ODE)."

(88) State-Operated Schools — The Oregon School for the Blind or the Oregon School for the Deaf. See "Educational Agency."

(89) Student Health/Medical/Nursing Records — Education Records that document, for Medical Assistance Program purposes, the Medicaid-eligible student's diagnosis or the results of tests, screens or treatments, treatment plan, the IEP or IFSP, and the record of treatments or Health Services provided to the child or student.

(90) Teachers' Standards and Practices Commission (TSPC) — The Commission that governs licensing of teachers, personnel service specialists, and administrators as set forth in OAR chapter 584. In order for schools or school providers to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the Medicaid provider qualifications. It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered Health Services provided in an education setting.

(91) Testing — See "Assessment."

(92) Testing Technician — A person/technician adequately trained to administer and score specific tests, as delegated under the direction and supervision of a licensee, and maintains standards for the testing environment and testing administration as set forth in the American Psychological Association Standards for Educational and Psychological Tests (1999) and Ethical Principles for Psychologists (2002). See ORS 675.010(4), OAR 858-010-0001, and 858-010-0002.

(93) 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.

(94) Transportation Aide — An individual trained for health and safety issues to accompany a Medicaid-eligible student transported to and from a SBHS covered Health Service as specified in the IEP/IFSP. The School Medical Provider must maintain documentation of the training, supervision and provision of the services billed to Medicaid. For the purposes of these rules, individual transportation aides are included in the cost calculation for transportation costs and will not be billed separately. This computation will not include delegated health care aides for whom costs are direct costs.

(95) Transportation as a Related Service — Specialized Transportation adapted to serve the needs of a Medicaid-eligible student to and from a covered Health Service that is necessary and appropriate, and described in the IEP/IFSP as outlined in OAR 410-133-0080 (Coverage).

(96) Transportation Vehicle Trip Log — A record or log kept specifically for tracking each transportation trip a Medicaid-eligible student receives transportation to or from a covered Health Service. See OAR 410-136-0280 (Medical Transportation rules — Required Documentation and SBHS Rules Cost Determination and Payment 410-133-0245).

(97) Treatment Plan — A written plan of care services, including treatment with proposed location, frequency and duration of treatment as required by the health care practitioner's health licensing agency.

(98) Unit — A service measurement of time for billing and reimbursement efficiency. One (1) unit equals 15 minutes unless otherwise stated.

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Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 29-1993, f. & cert. ef. 10-1-93; HR 21-1995, f. & cert. ef. 12-1-95;OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0060
Health Services

(1) School-based Health Service is a Health Service for a Medicaid-eligible student that meets the coverage requirements in OAR 410-133-0080 and that:

(a) Addresses physical or mental disabilities of the child or student; and

(b) Is identified in a student's Individual Education Program/Plan (IEP), or the Individualized Family Service Plan (IFSP); and

(c) Is recommended by a physician or other licensed health care practitioner within the scope of practice under State law.

(2) School-based Health Services that meet the requirements of subsection (1) of this rule may include:

(a) Physical Therapy Evaluations and Treatments which include assessing, preventing or alleviating movement dysfunction and related functional problems, obtaining and interpreting information, and coordinating care and integrating services relative to the student receiving treatments such as:

(A) Neuromotor or neurodevelopmental assessment;

(B) Assessing and treating problems related to musculo-skeletal status;

(C) Gait, balance, and coordination skills;

(D) Oral motor assessment;

(E) Adaptive equipment assessment;

(F) Gross and fine motor development;

(G) Observation of orthotic devices; and

(H) Prosthetic training.

(b) Occupational Therapy Evaluations and Treatments which include assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function, obtaining and interpreting information, coordinating care, and integrating services relative to the student receiving services such as:

(A) Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);

(B) Gross and fine motor development;

(C) Feeding or oral motor function;

(D) Adaptive equipment assessment;

(E) Prosthetic or orthotic training;

(F) Neuromotor or neurodevelopmental assessment;

(G) Gait, balance, and coordination skills.

(c) Speech Evaluation and Therapy Treatments, which include assessment of children with speech and/or language disorders, diagnosis and appraisal of specific speech or language disorders, referral for medical and other professional attention, necessary for the rehabilitation of speech/language disorders, provision of speech/language services for the prevention of communicative disorders, obtaining and interpreting information, coordinating care and integrating services relative to the student receiving services such as:

(A) Expressive language;

(B) Receptive language;

(C) Auditory processing, discrimination, perception and memory;

(D) Vocal quality;

(E) Resonance patterns;

(F) Phonological;

(G) Pragmatic language;

(H) Rhythm or fluency; and

(I) Feeding and swallowing assessment.

(d) Audiological Evaluation and Services which include assessment of children with hearing loss, determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders, provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech con-

versation, and determination of the child's need for individual amplification, obtaining and interpreting information, coordinating care and integrating services relative to the student receiving services such as:

(A) Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;

(B) Auditory discrimination in quiet and noise;

(C) Impedance audiometry, including tympanometry and acoustic reflex;

(D) Central auditory function;

(E) Testing to determine the child's need for individual amplification;

(F) Auditory training; and

(G) Training for the use of augmentative communication devices.

(e) Nurse Evaluation and Treatment Services which include assessments, treatment services, and supervision of delegated health care services provided to prevent disease, disability, other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. This includes any medical or remedial services recommended by a physician or other licensed health care practitioner, within the scope of practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. The RN is responsible for periodic supervision for services provided to coordinating care and integrating nursing tasks and services that can be performed in the educational setting such as:

(A) Monitoring patient's seizure activity for breathing patterns, onset/duration of seizure, triggers/auras, level of consciousness, support after seizure, administering medication as ordered;

(B) Monitoring/providing treatment for high and low blood sugar, checking urine keytones, blood glucose testing, carbohydrate calculations, assisting with insulin administration;

(C) Ventilator Care, suctioning, and equipment management;

(D) Tracheotomy Care, changing dressings, emergency trach replacement, suctioning, changing "nose," and providing humidification as necessary;

(E) Catheterization, assisting with or performing procedure for catheterization, monitor urinary tract infections, and performing skin integrity checks;

(F) Gastrostomy Tube feeding, administering tube feedings per physician order, monitoring skin status around the tube, and emergency treatment for button dislodgement;

(G) Medication pumps, e.g., insulin pump, calculate carbohydrate amounts in food/snacks, provide insulin bolus per physician order, emergency disconnect procedure and monitoring blood sugar; and

(H) Medication management, e.g., monitoring signs and symptoms for medication administration, administering medications, observing for side effects.

(f) Mental Health Evaluation and Treatment Services — Assessment and treatment services provided by or under the supervision and direction of a Psychiatrist, Psychologist, a Mental Health Nurse Practitioner, or by a Social Worker qualified and licensed to deliver the service, and who may provide care coordination and integration for services relative to the student for out patient mental health services received in the educational setting to prevent disease, disability, other health conditions or their progression, to prolong life and promote physical and mental health and efficiency. This includes any medical or remedial services recommended by a physician or other licensed health care practitioner, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level, such as:

(A) Mental health assessment;

(B) Psychological testing (non-educational cognitive and adaptive testing);

(C) Assessment of motor language, social, adaptive, and/or cognitive functioning by standardized developmental instruments;

(D) Behavioral health counseling and therapy; and

(E) Psychotherapy (group/individual).

(3) Services for physical, occupational, and speech therapy, hearing, nursing, and mental health services must be recommended as set out, and provided by medically qualified individuals as defined in OAR 410-133-0120.

(4) Medicaid covered services and treatments are provided in accordance with the Oregon Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an IEP/IFSP eligible under IDEA in the educational setting. The above-listed therapy services and treatments are examples of services that may be provided to eligible recipients in an educational setting under the Oregon Medicaid program. The current Prioritized List of services can be found on the Health Services Commission web site.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0080
Coverage

The Department of Human Services may reimburse School Medical Providers for the SBHS covered Health Services that meet all of the following criteria:

(1) The Health Service(s) must be "Necessary and Appropriate" and covered under the Oregon Health Plan as a service that is above the funding line of the Prioritized List of Health Services and the Health Services must not be excluded under OAR 410-133-0200 (Not Covered Services).

(2) The Health Service(s) must be required by a Medicaid-eligible student's physical or mental condition(s) as specified on the IEP or IFSP and further described in the treatment plan and the evaluation of the student.

(a) The Health Service, individual or group, may include corrective Health Services treatments and Medicaid-covered Related Services as described in a student's IEP or IFSP.

(A) The payment rate for Health Services includes case management and necessary supplies for these services. Additional reimbursement for such services are not paid separately from the Health Service.

(B) These services must be provided by Medically Qualified Staff who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120 and comply with the respective medical provider's governing definitions, scope of practice, documentation requirements, and licensure or certification.

(3) Evaluation and Assessment for SBHS are reimbursed for the part of the Evaluation or Assessment regarding a Medicaid-eligible student's "Necessary and Appropriate" SBHS needs for the purpose of establishing, re-establishing, or terminating a Medicaid covered SBHS on a Medicaid-eligible student's IEP or IFSP; or to develop, review, or revise components of a covered Health Service currently provided to a Medicaid-eligible student for continuation of those covered services pursuant to an IEP or IFSP under IDEA.

(a) Evaluation services are procedures used to determine a covered SBHS health-related need, diagnosis, or eligibility under IDEA.

(b) Re-evaluation services are procedures used to determine whether or not a Medicaid-eligible student will continue to receive a covered SBHS pursuant to the IEP or IFSP under IDEA.

(4) Assistive Technology Services directly assist a Medicaid-eligible student with a disability, eligible under IDEA, to receive assistive technology covered SBHS as specified on the IEP or IFSP, in the selection, acquisition, or use of an assistive technology device, including:

(a) The Assistive technology assessment with one-to-one student contact time by Medically Qualified Staff within the scope of practice performing the assessment of the need, suitability, and benefits of the use of an assistive technology device or adaptive equipment that will help restore, augment, or compensate for existing functional ability in the Medicaid-eligible student or that will optimize functional tasks and/or maximize the Medicaid-eligible students environmental accessibility. This requires and includes the preparation of a written report;

(b) Care Coordination with the Medicaid-eligible student's physician, parent/guardian, and the Division of Medical Assistance Programs for the parent/guardian's acquisition of a personal assistive technology device for their Medicaid-eligible student through the student's Medicaid plan for the benefit of the Medicaid-eligible student to maximize his/her functional ability and environmental accessibility; and

(c) Training or technical assistance provided to or demonstrated with the Medicaid-eligible student by Medically Qualified staff, instructing the use of an assistive technology device or adaptive equipment in the educational setting with professionals (including individuals providing education and rehabilitation services) or where appropriate the family members, guardians, advocates, or authorized representative of the Medicaid-eligible student. In order to bill Medicaid for this service, the student must be present.

(5) DHS may reimburse Physical Therapy Services provided by:

(a) A physical therapist authorized to administer physical therapy to an individual, when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, and is being seen pursuant to the Medicaid-eligible student's individual education

plan or individual family service plan (see division 30 Practice Without Referral through OAR 848-030-0000, 848-030-0100 Scope of Practice);

(b) A physical therapist assistant providing treatment under the supervision of a physical therapist who is available and readily accessible for consultation with the assistant, at all times, either in person or by means of telecommunications (see scope of practice and supervision requirements for physical therapy assistant OAR 848-015-0010 through 848-015-0030). Physical therapy services must be provided by Medically Qualified Staff who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120.

(c) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report to establish Necessary and Appropriate physical therapy services on a Medicaid-eligible student's IEP or IFSP.

(B) Obtaining and interpreting medical information for the part of an evaluation or assessment performed by the Physical Therapist to establish Necessary and Appropriate physical therapy services on a Medicaid-eligible student's IEP or IFSP; or to determine whether or not Necessary and Appropriate physical therapy services will continue to be specified on the Medicaid-Eligible student's IEP or IFSP under IDEA (cannot be delegated).

(C) Care coordination and integrating services, within the scope of practice, for providing Necessary and Appropriate physical therapy services relative to the Medicaid-eligible student pursuant to an IEP or IFSP.

(D) Direct treatment and supervision of services provided to a Medicaid-eligible student by the Physical Therapist and defined in the individual plan; when

(E) Documentation by the supervising Physical Therapist supporting the appropriate supervision of the assistant is maintained and kept by the School Medical Provider for a period of seven years (See OAR 848-020-0030 Supervision; Delegation of Supervision; Professional Responsibility of Supervisors and Supervisees).

(F) Individual or group physical therapy services provided to a Medicaid-eligible student by or under the supervision and direction of a Licensed Physical Therapist pursuant to the Medicaid-eligible student's IEP or IFSP; when the documentation describing physical therapy services provided are signed by the Therapist providing the service in accordance with their Board licensing requirements and documentation for supervision of services performed by or under the supervision and direction of the Supervising Physical Therapist supporting the services provided is maintained and kept by the School Medical Provider for seven (7) years (See Minimum Standards for Physical Therapy Practice and Records OAR 848-040-0100 through 848-040-0170).

(G) Other covered physical therapy services within the scope of practice and subsections (1) and (2) of this rule.

(6) DHS may reimburse Occupational Therapy Services provided by:

(a) A Licensed Occupational Therapist authorized to administer occupational therapy to an individual, when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, and is being seen pursuant to the Medicaid-eligible student's individual education plan or individual family service plan; and

(b) A licensed occupational therapy assistant assisting in the practice of occupational therapy under the general supervision of a licensed Occupational Therapist. (General supervision requires the supervisor to have at least monthly direct contact in person with the supervisee at the work site with supervision available as needed by other methods); and

(c) Before an occupational therapy assistant assists in the practice of occupational therapy, he/she must file with the Board a signed, current statement of supervision of the licensed occupational therapist that will supervise the occupational therapy assistant. The signature of the supervising Occupational Therapist must be notarized (See OAR 339-010-0035 Statement of Supervision for Occupational Therapy Assistants). Occupational therapy services must be provided by Medically Qualified Staff who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120.

(d) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment reports that establish Necessary and Appropriate occupational therapy services on a Medicaid eligible students IEP or IFSP.

(B) Obtaining and interpreting medical information for the part of the evaluation or assessment performed by the Occupational Therapist (OT) to establish Necessary and Appropriate occupational therapy services on a Medicaid-eligible student's IEP or IFSP; or to determine whether or not Necessary and Appropriate occupational therapy services will continue to be specified on the Medicaid Eligible student's IEP or IFSP under IDEA (cannot be delegated).

(C) Development of the initial occupational therapy treatment plan by the OT (cannot be delegated).

(D) Coordinating care and integrating services, within the scope of practice, relative to the Medicaid-eligible student receiving Necessary and Appropriate occupational therapy services as specified on the IEP or IFSP.

(E) Individual or group occupational therapy services provided to a Medicaid-eligible student by or under the supervision and direction of a Licensed Occupational Therapist as specified on Medicaid-eligible student's IEP or IFSP,

(F) Direct treatment and supervision of services provided to a Medicaid-eligible student by the Occupational Therapist and defined in the individual plan; when documentation supporting the appropriate supervision of the assistant is kept and maintained by the School Medical Provider for a period of seven years;

(G) The occupational therapy services provided are consistent with OAR 339-010-0050 Occupational Therapy Services in an Educational Setting for Children with Handicap; and

(H) Documentation describing treatment provided are signed and initialed by the Occupational Therapy Assistant for review and co-signature by the supervising Occupational Therapist.

(I) Other covered occupational therapy services within the scope of practice and subsections (1) and (2) of this rule.

(7) DHS May Reimburse Speech Therapy Services Provided By:

(a) A Licensed Speech Pathologist licensed by the Oregon Board of Examiners for Speech Pathology and Audiology or holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA), authorized to administer speech therapy to an individual, when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, receiving speech therapy services pursuant to an individual education plan or individual family service plan; or

(b) A graduate speech pathologist in their Clinical Fellowship Year (CFY) practicing under the supervision of an ASHA licensed speech pathologist with CCC who meet the standards of licensing or certification for the Health Service provided as described in OAR 410-133-0120 Medically Qualified Staff; and when

(A) A standardized system for reviewing the clinical work of the clinical fellow is performed at regularly scheduled intervals, using the Skills Inventory Rating (CFSI) form addressing the fellow's attainment of skills for independent practice;

(B) The clincial fellow supervisor maintains and documents the supervision of the clinical fellow to be kept by the School Medical Provider for a period of seven years.

(C) Documentation describing the treatment provided are signed and initialed by the Clinical Fellow for review and co-signature by the supervising Clinical Fellow.

(c) Speech-language pathology assistants (SLPA), licensed by the Oregon State Board of Examiners for Speech Pathology and Audiology, under the supervision of a supervising speech-language pathologist and who meet the standards of licensing or certification for the Health Service provided as described in OAR 410-133-0120 Medically Qualified Staff, when the following conditions are met:

(A) The supervising speech-language pathologist must have at least two years of full-time professional speech-language pathology experience (see OAR 335-095-0050 Supervision Guidelines for the Speech-Language Pathology Assistant);

(B) The supervising speech therapist does not supervise more than two full-time or three part-time speech-language pathology assistants;

(C) The supervising speech-language pathologist maintains documentation supporting the appropriate supervision of the assistant(s) to be kept by the School Medical Provider for a period of seven (7) years;

(D) The caseload of the supervising clinician allows for administration, including assistant supervision, evaluation of students and meeting times. (All students assigned to an assistant are considered part of the caseload of the supervising clinician);

(E) The supervising speech-language pathologist must be able to be reached at all times (A temporary supervisor may be designated as necessary);

(F) The services provided by the assistants are consistent with the Scope of Duties for the Speech-Language Pathology Assistant (SLPA) pursuant to OAR 335-095-0060;

(G) Documentation describing the treatment provided are signed and initialed by the SLPA for review and co-signature by the supervising speech-language pathologist to be kept by the School Medical Provider for a period of seven (7) years.

(d) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the Speech Pathologist to establish Necessary and Appropriate speech therapy services on a Medicaid-eligible student's IEP or IFSP; or determine whether or not Necessary and Appropriate speech therapy services will continue to be specified on the Medicaid-Eligible student's IEP or IFSP under IDEA (cannot be delegated);

(B) Development of the initial speech therapy treatment plan by the Speech Pathologist (cannot be delegated);

(C) Care coordination and integrating services, within the scope of practice, relative to the Medicaid-eligible student receiving Necessary and Appropriate speech therapy services specified on the IEP or IFSP;

(D) Direct individual or group speech therapy services provided to a Medicaid-eligible student for speech services specified on the IEP or IFSP delivered by or under the supervision and direction of a Speech Pathologist who is medically qualified to deliver the service see 410-133-0120 Medically Qualified Staff;

(E) Direct training and supervision of services provided to a Medicaid-eligible student by the Medically Qualified Supervising Speech Pathologist to be kept by the School Medical Provider for a period of seven (7) years; and

(F) Other covered speech therapy services within the scope of practice and subsections (1) and (2) of this rule.

(8) DHS May Reimburse Audiology Services Provided By:

(a) A Licensed Audiologist within the scope of practice as defined by state or federal law who meet the standards of licensing or certification for the Health Service provided as described in OAR 410-133-0120 Medically Qualified Staff.

(b) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the Audiologist within the scope of practice, to establish Necessary and Appropriate hearing services on a Medicaid-eligible student's IEP or IFSP; or determine whether or not Necessary and Appropriate hearing impairment services will continue to be specified on the Medicaid-Eligible student's IEP or IFSP under IDEA.

(B) Periodic hearing evaluations and assessments of a Medicaid-eligible student with hearing loss found eligible under IDEA pursuant to services as specified on the IEP or IFSP, for determination of the range, nature and degree of hearing loss.

(C) Care coordination and integration of services for medical or other professional attention relative to Medicaid-eligible student receiving services for restoration or rehabilitation due to hearing and communication disorders as specified on the IEP or IFSP.

(D) Provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the Medicaid-eligible student's need for individual amplification in accordance with the student's IEP or IFSP.

(9) DHS May Reimburse Nurse Services Provided By:

(a) A Nurse Practitioner (NP), Registered Nurse (RN, Licensed Practical Nurse (LPN) or Delegated Health Care Aid under the supervision of an RN or NP who meet the standards of licensing or certification for the Health Service provided as described in OAR 410-133-0120 Medically Qualified Staff.

(b) Nursing services under this program are not intended to reimburse nursing activities of a Private Duty RN or LPN that is otherwise billing Medicaid directly for those services.

(c) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report to establish nursing services including obtaining and interpreting medical information for the part of the evaluation or assessment performed to establish Necessary and Appropriate nursing services on the Medicaid-Eligible student's IEP or IFSP; or determine whether or not Necessary and Appropriate nursing services will continue to be specified on the Medicaid-eligible students IEP or IFSP under IDEA.

(B) Coordinated care for other specified care management for a chronic medical condition that is not addressed on the current IEP or IFSP that will result in amending nursing services specified in the IEP or IFSP and requires an updated nursing plan of care. This may results in an increase in supervision, monitoring and training of DHC staff to provide new nursing tasks related to the change in condition. For example: a child with seizure disorder that develops diabetes.

(C) Care coordination and integration of Necessary and Appropriate nursing services relative to the Medicaid-eligible student's covered Health Service specified on the IEP or IFSP.

(D) Nurse to student interactive services that are covered Health Services provided to a Medicaid-eligible student with a chronic medical condition receiving nursing services pursuant to an IEP or IFSP.

(E) Oversight of delegated health care aides performing delegated nursing services directly with the student as specified on the IEP or IFSP.

(F) Student observation by Medically Qualified Staff for medical reasons of a Medicaid-eligible student with a chronic medical condition as part of an evaluation/assessment or care coordination. An observation by itself is not a billable activity.

(G) Other covered nursing care services within the scope of practice and subsections (1) and (2) of this rule.

(10) DHS May Reimburse Mental Health Services Provided By:

(a) A Psychiatrist who meets the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(2)(f)(A), or a Psychologist who meets the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(2)(f)(B), or a Mental Health Nurse Practitioner who meets the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(2)(e)(A); or

(b) A Psychologist Associate with authority to function without immediate supervision, performing functions that may include but are not restricted to administering tests of mental abilities, conducting personality assessments and counseling (see OAR 858-050-0150 Application for Functioning Without Immediate Supervision). These services must be provided by Medically Qualified Staff who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(2)(f)(C); or

(c) A Psychologist Associate under the supervision of a Psychologist as specified by the Board of Psychologists Examiners, chapter 858 division 50, Psychologist Associates OAR 858-050-0100 through 858-050-0145. These services must be provided by Medically Qualified Staff who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(2)(f)(D); or

(d) A testing technician under the supervision of a Psychologist as specified by the Board of Psychologists Examiners, chapter 858, division 10, OAR 858-010-0002 Guidelines for Supervising Technicians and who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(f)(E); or

(e) A Licensed (LCSW) qualified and licensed to deliver the service, or a Clinical Social Work Associate (CSWA) under the supervision of an LCSW specified by the Board of Clinical Social Workers, chapter 877 division 20, OAR 877-020-000 through 877-020-0050 and who meet the standards of licensing or certification for the Health Service being provided as described in OAR 410-133-0120(f)(F).

(f) Reimbursable time may include:

(A) Preparation of the written initial evaluation or initial assessment report for a suspected disability per the referral process for determining IDEA eligibility, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the mental health care practitioner within the scope of practice, to establish Necessary and Appropriate mental health services on the Medicaid-Eligible student's IEP or IFSP; or to determine whether or not Necessary and Appropriate mental health services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA.

(B) Care coordination and integrating services, within the scope of practice, relative to the Medicaid-eligible student receiving mental health services as specified on the IEP or IFSP;

(C) Direct individual therapy services provided within the scope of practice under state law and covered under subsections (1) and (2) of this rule to a Medicaid-eligible student by or under the supervision and direction of a Psychologist, a Psychiatrist, or Mental Health Nurse Practitioner, or a Licensed Clinical Social Worker qualified and licensed to deliver the service pursuant to the Medicaid-eligible student's IEP or IFSP.

(11) Medicaid Reimbursed Transportation:

(a) Transportation to a covered Health Service as documented in the child's IEP/IFSP and defined in these rules (see 410-133-0245 Cost Determination and Payment).

(b) Ongoing transportation specified, as a related service, on the Medicaid-eligible student's IEP or IFSP may be claimed as a Medicaid service on the days a Medicaid-eligible student receives a covered Health Service that is also specified on the IEP or IFSP;

(c) DHS may only reimburse for transportation as a related service to and from a Medicaid-covered service for a Medicaid-eligible student when the student receives a Medicaid covered Health Service other than transportation on that day when either of the following situations exist:

(A) The Medicaid-eligible student requires specialized transportation adapted to serve the needs of the disabled student, there is documentation to support specialized transportation is "Necessary and Appropriate," and transportation is listed as a related service on the student's IEP or IFSP; or

(B) The Medicaid-eligible student has a medical need for transportation that is documented in the IEP or IFSP, and resides in an area that does not have regular school bus transportation such as those areas in close proximity to a school.

(d) If a Medicaid-eligible student is able to ride on a regular school bus, but requires the assistance of a delegated health care aide, trained by an RN to provide a delegated nursing task specific to the student, who cannot be transported safely without the delegated health care aide, the service provided by the delegated healthcare aide is reimbursed under the delegated healthcare code. See the standards for delegation of a Nursing Care Task as outlined in the Nurse Practice Act, division 47, OAR 851-047-000

(e) If a Medicaid-eligible student requires the assistance of a delegated health care aide and transportation adapted to serve the needs of the disabled student, both the necessary and appropriate transportation and the service provided by the delegated healthcare aide may be reimbursed when both are specified on the Medicaid-eligible student's current IEP or IFSP.

(f) If an education agency provides special transportation to a Medicaid-eligible student to a covered service outside the district or the Medicaid-eligible student's resident school and the student cannot be transported safely without a transportation aide as specified on the IEP or IFSP, the transportation is billable. However, a transportation aide who is not a delegated healthcare aide trained by an RN cannot be billed as a separate cost because the cost of the transportation aide is included in the cost of the transportation.

(g) Transportation is not reimbursable by DMAP when provided by the parent or relative of the child.

(h) Transportation to an Evaluation service is covered as long as:

(A) Medically necessary transportation is listed and included in the Medicaid-eligible student's current IEP or IFSP and the evaluation is to establish, re-establish, or terminate a SBHS covered service under IDEA;

(B) The Evaluation is a SBHS covered Health Service;

(C) The medical provider conducting the Evaluation, if not employed or contracted by the School Medical Provider, is an enrolled provider with DMAP and meets applicable medical licensing standards necessary to conduct the evaluation.

(12) Medicaid may reimburse for Contracted Consultation Health Services for furnishing consultations regarding a Medicaid-eligible student's covered Health Service(s) specified on the IEP or IFSP for an evaluation or assessment to establish, re-establish, or terminate a covered SBHS on an IEP or IFSP. Contracted consultation services must be provided by a licensed medical professional other than School Medical Provider staff.

(a) This service may be on a contracted basis for a number of students;

(b) Allowable services must be furnished through a personal service contract between the School Medical Provider and the licensed health care practitioner;

(c) This service would only be a SBHS covered Health Service by the School Medical Provider when the licensed health care practitioner did not bill Medicaid directly under other programs for the same services.

(13) Reimbursed Coordinated care, performed by Medically Qualified Staff as described in OAR 410-133-0120 directly related to Health Services required by a Medicaid-eligible student's physical or mental condition as described in the IEP or IFSP; and must be one of the following:

(a) Managing integration of those Medicaid covered Health Services for treatment provided in the education setting;

(b) The portion of a Conference, between interested parties and Medically Qualified Staff for developing, reviewing, or revising a Medicaid covered Health Service, or therapy treatment plan, for services provided pursuant to a Medicaid-eligible student's IEP or IFSP, or to establish, re-establish, or terminate a covered Health Service under IDEA for eligibility purposes;

(c) Consultation from Medically Qualified Staff providing technical assistance to or conferring with special education providers, physician, or families to assist them in providing covered Health Services to Medicaid-eligible students for treatment provided in the educational setting related to specific Health Services in support of the goals and objectives in the student's IEP or IFSP. Consultation services must be completed by a licensed health care practitioner within the scope of practice under their licensure.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 31-2003, f. & cert ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0090
School Medical Provider Payment

(1) Payment will be made to the enrolled Educational Agency as the School Medical Provider for those covered Health Services provided by the employed Medically Qualified Staff working within the scope of their practice. While the Educational Agency shall hold primary responsibility for providing these services with its own qualified staff, it may also contract, on a supplemental basis only, for covered Health Services with individuals or organizations that meet qualifications for Medically Qualified Staff as outlined in OAR 410-133-0120.

(2) Signing the School Medical Provider Enrollment Agreement sets forth the relationship between the State of Oregon, DHS, and the School Medical Provider and constitutes agreement by the School Medical Provider to comply with all applicable rules of DHS, the Medical Assistance Program, federal and state laws or regulations.

(3) The public School Medical Provider will bill for Health Services provided to Medicaid-eligible students according to these SBHS rules. Payments will be made through the Medical Management Information System (MMIS).

(4) SBHS for public School Medical Providers is a cost-sharing (Federal Financial Participation) program. In addition to the requirements set forth in subsections (1)–(3) of this rule, and pursuant to 42 CFR 433.10, DHS may monthly, but will no less than quarterly, invoice the public School Medical Provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The public School Medical Provider shall pay the amount stated in the invoice within 30 days of the date of the invoice.

(a) The public School Medical Provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42 CFR 433.51, public funds may be considered as the State's share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies and are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(b) The public School Medical Provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's expenditure to the public School Medical Provider.

(c) The public School Medical Provider shall submit to DHS an original signed document certifying that the public funds transferred to DHS (for the non-federal matching share) by the public School Medical Provider under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to remit the non-federal share described in subsection (4) of this rule within the time stated on the DHS invoice will constitute an overpayment, and will make the School Medical Provider subject to overpayment recoupment or other remedy pursuant to DMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(6) DHS shall not be financially responsible for payment of any claim that CMS disallows under the Medicaid program. If DHS has previously paid the School Medical Provider for any claim which CMS disallows, the School Medical Provider shall reimburse DHS the amount of the claim that DHS has paid to the School Medical Provider, less any amount previously paid by the School Medical Provider to DHS for purposes of reimbursing DHS for the non-federal match portion of that claim.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 41-1992, f. 12-31-92, cert. ef. 1-1-93; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 88-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 4-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0100
School Medical Provider Requirements

The School Medical Provider is responsible to:

(1) Enroll with DMAP to provide Health Services, and comply with all the requirements in OAR 410-120-1260 (Provider Enrollment) applicable to enrollment as a provider (see 410-133-0140 in these rules).

(2) Provide Health Services pursuant to the Medicaid-eligible student's IEP or IFSP for special education under OAR chapter 581, division 15;

(3) Provide Health Services using Medically Qualified Staff;

(4) Provide appropriate medical supervision by licensed Medically Qualified Staff consistent with their licensing board requirements;

(5) Document Health Services in writing as required in OAR 410-133-0320;

(6) Maintain adequate medical and financial records as part of the Medicaid-eligible student's Education Record;

(7) Make the records required by these rules and specifically OAR 410-133-0320 available for a period of seven years;

(8) Document costs and establish a schedule of rates per discipline in accordance with OAR 410-133-0245;

(9) Provide access for on-site review of Medicaid-eligible students' medical records that are part of the Education Record;

(10) Document any changes in the IEP/IFSP related to SBHS covered Health Services;

(11) Assure that services billed reflect covered Health Services and do not reimburse for non-covered education services or administrative activities;

(12) Utilize procedures to confirm that all individuals providing Health Services to Medicaid-eligible students, whether as employees or under contract with the School Medical Provider, are eligible to provide Medicaid services and are not excluded from providing Medicaid services (see 410-133-0120 Medically Qualified Staff (1) and 410-133-0200 Not Covered Services (6)(m); and

(13) Comply with all applicable provisions of the DMAP General Rules, including rules related to the use of billing providers and if the School Medical Provider seeks to submit claims to DHS electronically, comply with the applicable provisions of the DHS Electronic Data Interchange rules, OAR 410-001-0000 et seq. (See 410-133-0090).

Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0120
Medically Qualified Staff

(1) The School Medical Provider shall furnish covered Health Services through the medically qualified staff who provide Health Services within the scope of their licensure. The School Medical Provider shall document the credentials and qualifications, updated periodically, of all Medically Qualified Staff. The School Medical Provider credential file shall document the manner in which the provider checked, and periodically re-checked, the Medicaid provider exclusion list to confirm that the Medically Qualified Staff are eligible to provide Health Services to Medicaid-eligible students. Special education teachers are not recognized as medically qualified staff for these services. See http://oig.hhs.gov/fraud/exclusions.html

(2) School-based services, are delivered by providers who meet the federal requirements listed below and who operate within the scope of their health care practitioner's license or certification pursuant to state law as follows:

(a) Evaluation and physical therapy treatments shall be provided by licensed physical therapists, that meet the federal requirements of 42 CFR 440.110, and are licensed by the State Physical Therapist Licensing Board. Licensed physical therapists assistants who's function is to assist the physical therapist in patient-related activities and to perform delegated procedures that are commensurate with the licensed therapist assistant's education and training may provide therapy treatments under the supervision and direction of a State licensed physical therapist within the scope of the health care practitioner's license and accreditation pursuant to State law.

(b) Occupational therapy evaluation and treatments shall be provided by licensed occupational therapists, that meet the federal requirements of 42 CFR 440.110, and are licensed by the State Occupational Therapist Licensing Board. Licensed occupational therapist assistants who's function is to assist the occupational therapist in patient-related activities and to perform delegated procedures that are commensurate with the licensed therapist assistant's education and training may provide therapy treatments under the supervision and direction of a State licensed occupational therapist within the scope of the health care practitioner's license and accreditation pursuant to State law.

(c) Speech therapy evaluation and treatments shall be provided by Speech Pathologists that meet the federal requirements at 42 CFR 440.110, and are licensed by the State Board of Examiners for Speech Pathology and Audiology or hold a Certificate of Clinical Competency from the American Speech and Hearing Association.

(A) Speech therapy services may be provided by a graduate speech pathologist being supervised in the Clinical Fellowship Year (CFY) under the supervision of an ASHA licensed speech-language pathologist; or

(B) A Certified Speech-language Pathology Assistant (SLPA) performing within the scope of practice may provide therapy under the supervision of a State licensed speech-language pathologist within the scope of the health care practitioner's license and accreditation pursuant to State law.

(d) Audiology evaluation and services shall be provided by Audiologists that meet the federal requirements at 42 CFR 440.110.

(e) Nurse evaluation and treatments shall be provided by Registered Nurses (RN) and Licensed Practical Nurses (LPN) licensed to practice in Oregon by the Oregon State Board of Nursing. A Licensed Practical Nurse (LPN) may participate in the implementation of the plan of care for providing care to clients under the supervision of a licensed Registered Nurse, Nurse Practitioner, or Physician pursuant to the Oregon State Board of Nursing Practice Act Divisions 45 and 47. Treatment may also be provided by a delegated health care aide that is a non-licensed person trained and supervised by a licensed Registered Nurse (RN) or Nurse Practitioner (NP) to perform selected tasks of nursing care pursuant to The Oregon State Board of Nursing Division 47 of the Nurse Practice Act.

(A) Nurse Practitioners that meet the federal requirements at 42 CFR 440.166, and are licensed by the Oregon State Board of Nursing to practice in Oregon as a Nurse Practitioner (See Oregon State Board of Nursing Nurse Practice Act, Division 50, Nurse Practitioners OAR 851-050-000 through 851-050-0170).

(f) Psychological/mental health evaluations, testing, psychological services and treatments shall be provided by individuals who meet the relevant requirements of their respective professional state licensure as follows:

(A) Psychiatrists must be licensed to practice medicine and surgery in the State of Oregon; and possess a valid license from the Oregon Licensing Board for the Healing Arts.

(B) Psychologists must have one of the following: a doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the State Board of Psychologist Examiners by rule; and have two years of supervised employment under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the board to have equivalent supervisory competence.

(C) Psychologists Associates meeting the requirements to function without immediate supervision pursuant to Oregon Board of Psychologist Examiners division 50, OAR 858-050-0150 may apply to the Board for authority to function without immediate and direct supervision. Until the psychologist associate successfully completes the oral examination for independent practice, the associate must not practice without immediate supervision, but must at all times be under the direct supervision of a licensed psychologist who shall continue to be responsible for the practice of the associate.

(D) Psychologists Associates who do not possess a doctoral degree, and are deemed competent to perform certain functions within the practice of psychology under the periodic direct supervision of a psychologist licensed by the board:

(i) Has complied with all the applicable provisions of ORS 675.010 to 675.150;

(ii) Has received a master's degree in psychology from a psychology program approved by the board by rule;

(iii) Has completed an internship in an approved educational institution or one year of other training experience acceptable to the board, such as supervised professional experience under the direction of a psychologist licensed in Oregon, or under the direction of a person considered by the board to have equivalent supervisory competence; and

(iv) Furnishes proof acceptable to the board of at least 36 months, exclusive of internship, of full-time experience satisfactory to the board under the direct supervision of a licensed psychologist in Oregon, or under the direct supervision of a person considered by the board to have equivalent supervisory competence. (1973 c.777 §5; 1987 c.158 §137; 1991 c.490 §3; 1993 c.585 §5; 1999 c.443 §2.)

(E) Testing Technicians under the supervision of Psychologist. A licensee may delegate administration and scoring of tests to technicians as provided in ORS 675.010(4) and OAR 858-010-0001, if the licensee ensures the technicians are adequately trained to administer and score the specific test being used; and ensures that the technicians maintain standards for the testing environment and testing administration as set forth in the American Psychological Association Standards for Educational and Psychological Tests (1999) and Ethical Principles for Psychologists (2002). See OAR 858-010-0002 Guidelines for Supervising Technicians.

(F) Services provided by Clinical Social Work Associate (CSWA) or Licensed Clinical Social Worker (LCSW): must possess a master's degree from an accredited college or university accredited by the Council on Social Work Education and have completed the equivalent of two years of full-time experience in the field of clinical social work in accordance with rules of the Oregon State Board of Clinical Social Workers for a LCSW or whose plan of practice and supervision has been approved by the board, for a CSWA working toward LCSW licensure under the supervision of a LCSW for two years of post masters clinical experience and is licensed by the State Board of Clinical Social Workers to practice in Oregon. See Board of Clinical Social Workers, chapter 877 division 20, OAR 877-020-000 through 877-020-0050.

Stat. Auth.: ORS 409
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; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 31-2003, f. & cert ef. 4-1-03 ; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0140
School Medical Provider Enrollment Provisions

(1) This rule applies only to providers seeking reimbursement from DMAP, except as otherwise provided in OAR 410-120-1295.

(2) Providers of SBHS will be enrolled with DMAP as School Medical Providers and registered with the Oregon Department of Education as qualified public educational entities.

(3) The provider enrollment process will consist of:

(a) Documentation of registration with ODE as a qualified special education provider (see OAR 581-015-0035 Criteria for Approving School District Special Education Programs); and

(b) Completion of the School Medical Provider enrollment application with the Division of Medical Assistance Programs.

(4) An approved enrollment application is a contractual agreement that binds the provider to comply with DMAP General Rules and DHS SBHS rules.

(5) 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.

(6) A Performing Provider or Billing Provider may utilize an EDI Submitter for the purpose of submitting the Performing Provider's claims to DHS electronically. A School Medical Provider that intends to use an EDI Submitter shall register with DHS as a Trading Partner and shall comply with the Trading Partner requirements of identifying the authority of the EDI Submitter to submit claims on its behalf. The EDI Submitter must sign the EDI Certification and meet other DHS EDI submission requirements pursuant to the EDI rules, before DHS may accept an electronic submission from the EDI Submitter on behalf of the Performing Provider. Information about the EDI transaction requirements is available on the DHS web site.

(7) An individual or organization must meet applicable licensing and 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.

(8) An individual or organization that is currently subject to sanction(s) by the Medical Assistance Program or Federal government is not eligible for enrollment (see Provider Sanctions).

(9) 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 dis-enrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Approval of the application by DMAP or the Division responsible for enrolling the provider.

(10) 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.

(11) 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.

(12) If a provider changes address, business affiliation, licensure, ownership, certification, billing agents or Federal Tax Identification Number (TIN), the Division of Medical Assistance Programs must be notified in writing within 30 days of the change. Failure to notify DMAP of a change of Federal Tax Identification Number may result in the imposing of a $50 fine. Changes in business affiliation, ownership, and Federal Tax Identification Number may require the submission of a new application. Payments made to providers who have not furnished such notification may be recovered.

(13) Enrollment of Billing Providers:

(a) A person or business entity who submits claims to the Medical Assistance Program and/or receives payments from the Medical Assistance Program on behalf of a professional provider (e.g., physician, physical therapist, and speech therapist). The person or business entity must be enrolled with DMAP and meet all applicable federal regulations;

(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 delegated the authority to act on behalf of the performing provider and 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) 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 DMAP;

(e) The billing provider fee must not be based on a percentage of the amount collected or whether or not they collect the subject's payment (42 CFR 447 subpart A).

(14) Provider termination:

(a) The provider may terminate enrollment at any time. The request must be in writing, via certified mail, return receipt requested. The notice shall specify the provider number to be terminated and the effective date of termination. Termination of the provider enrollment does not terminate any obligations of the provider for dates of services during which the enrollment was in effect;

(b) DMAP provider terminations or suspensions may be for, but are not limited to the following:

(A) Breaches of provider agreement;

(B) Failure to comply with the statutes, regulations and policies of the Department of Human Services, Federal and State regulations that are applicable to the provider.

(C) When no claims have been submitted in an 18-month period. The provider must reapply for enrollment.

(15) 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.

Stat. Auth.: ORS 184
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0160
Licensed Practitioner Recommendation

Requests for payment of Health Services required by a Medicaid-eligible student's IEP or IFSP must be supported by written recommendation from a physician or a licensed health care practitioner acting within the scope of their practice for the treatment provided. The recommendation must be current for the treatment provided as specified on the IEP or IFSP.

Stat.Auth.: ORS 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; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0180
Duplication of Service

(1) The School Medical Provider that utilizes a contractor to provide Health Services may only bill DHS or DMAP for Health Services when the School Medical provider and the contracted provider have previously agreed that the contractor will not also bill for the same service.

(2) Duplicate billings are not allowed and payments will be recovered. Billings for Health Services to Medicaid-eligible students will be considered as duplicate if the same services are billed by more than one Educational Agency to address the same need. For example: 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 409
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

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 DHS;

(2) Health Services and treatment not documented on the Medicaid-eligible student's IEP or IFSP is not covered for payment by DHS under the School-Based Health Services rules;

(3) Reviewing records (exception: reviewing records as part of an evaluation to establish, re-establish, or terminate a SBHS covered Health Service on a Medicaid-eligible student's IEP or IFSP);

(4) Meeting preparation;

(5) Health Services preparation including materials preparation;

(6) Report writing (exception: report writing as part of preparation of initial evaluation and initial treatment plan to establish a covered Health Service on a Medicaid-eligible student's IEP or IFSP);

(7) Correspondence;

(8) Treatment and care coordination for an acute medical condition;

(9) Medication management not specific to mental health related services listed in the IEP/IFSP;

(10) Purchase of an Assistive Technology device is not covered through SBHS;

(11) Activities related to researching student names, determining Medical Assistance Program eligibility status, administrative activities such as data entry of billing claim forms, and travel time by service providers;

(12) Family therapy where the focus of treatment is the family;

(13) Routine health nursing services provided to all students by school nurses; nursing intervention for acute medical issues in the school setting, e.g. students who become ill or are injured;

(14) Educational workshops, training classes, and parent training workshops;

(15) Regular transportation services to and from school;

(16) Vocational services;

(17) Screening services;

(18) Evaluation services that are not performed by Medically Qualified Staff within the scope of practice to establish, re-establish or terminate a covered SBHS under IDEA;

(19) Service provided to non-Medicaid students in a group, class, or school free of charge. If only Medicaid-eligible students are charged for the service, the care is free and Medicaid will not reimburse for the service. The free care limitation does not apply to Health Services provided as a result of an Educational Agency's obligation to provide FAPE services and the Health Service is identified on the Medicaid-eligible student's IEP/IFSP. This means that School Medical Providers may bill for covered Health Services provided to Medicaid-eligible students under IDEA even though they may be provided to non-Medicaid-eligible students for free as a part of FAPE;

(20) Any non-medical unit of time spent on Evaluations;

(21) Recreational services;

(22) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) comprehensive examinations described in OAR 410-130-0245 are not authorized to be provided by School Medical Providers;

(23) Services provided by an entity that employs an excluded provider. It is the obligation of the education agency to utilize the excluded provider web site to check for providers who have been excluded from receiving any monies affiliated with Medicaid and Medicare service reimbursements;

(24) Covered Health Service(s) listed on an IEP or IFSP for those dates of service when the IEP/IFSP has lapsed;

(25) Covered Health Service(s) that do not have a current recommendation by Medically Qualified Staff within the scope of practice for the treatment provided as specified on the IEP or IFSP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0220
Billing and Payment

(1) The School Medical Provider must bill DHS at a rate no greater than the education agency's rate for the applicable discipline approved by DHS based on the cost determination process described in OAR 410-133-0245.

(2) Services must be billed on a CMS-1500 or by electronic media claims (EMC) submission using only those procedure codes specified for the School-Based Health Services program. If the School Medical Provider submits their claims electronically, the provider must become a Trading Partner with the Department of Human Services and comply with the requirements for Electronic Data Interchange pursuant to OAR 410-001-0000 et seq.

(3) DHS will accept a claim up to 12 months from the date of service. See General Rules OAR 410-120-1300, Timely Submission of Claims.

(4) Third party liability. In general, the Medicaid program is the payor of last resort and a provider is required to bill other resources before submitting the claim to Medicaid. This requirement means that other payment sources, including other federal or state funding sources, must be used first before DHS can be billed for covered Health Services. However, the following exceptions apply to the requirement to pursue third party resources:

(a) For Health Services provided under the IDEA, Medicaid pays before ODE or the Educational Agency, to the extent the Health Service is a covered service provided to a Medicaid-eligible student documented as required under these rules, and subject to the applicable reimbursement rate;

(b) If School-Based Health Services are provided under Title V of the Social Security Act (Maternal and Child Health Services Block Grant), Medicaid-covered Health Services provided by a Title V grantee are paid by Medicaid before the Title V funds;

(c) Oregon has obtained an exemption from CMS that does not require School Based Providers to pursue possible third party resources from private insurance companies.

Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-

2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0245
Cost Determination and Payment

(1) DHS will make rate determinations for the purposes of payment under OAR 410-133-0220 based on annual cost determinations submitted by local education agencies (EA's).

(a) Cost determinations will:

(A) Be based on the EA's prior year's annual audited costs;

(B) Establish an hourly and 15-minute increment rate for the current school year;

(C) Use the current year ODE-approved indirect rate for the EA;

(b) An EA shall not bill for more than its prior year's annual audited cost incurred during the previous year. There will be no required annual cost settlement for each EA, although DHS may conduct reviews or audits of cost reports.

(c) Data for cost determinations shall be submitted in a format prescribed by DHS and in accordance with Oregon's State Plan approved by the Centers for Medicare and Medicaid Services (CMS).

(d) Cost determinations shall be completed for each service discipline eligible for Medicaid billing. If an EA does not receive a confirmation from DHS indicating costs have been received and accepted, the EA may not submit payment requests for those services. Costs for services include: Nursing, Occupational Therapy, Physical Therapy, Speech Language Pathology, Audiology, Psychological, Delegated Health Care, and Clinical Social Work. DHS' acceptance of the cost calculations submitted by the SBHS provider for rates per discipline based upon the SBHS provider's previous year's audited costs and, if applicable, the current years indirect rates does not imply or validate the accuracy of the data submitted.

(e) Transportation costs for Medicaid-eligible children will be reimbursed when the IEP or IFSP for the Medicaid eligible child documents the need for Necessary and Appropriate transportation. Transportation cost reimbursement rates are based on the EA's prior year's audited costs for special education transportation and will be submitted in a format prescribed by DHS and in accordance to Oregon's State Plan approved by the Centers for Medicare and Medicaid Services (CMS).

Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0280
Rebilling

In order to correct a claim provided to a Medicaid-eligible student, the School Medical Provider must request an adjustment. The paid claim must be corrected on the Individual Adjustment Request Form (DMAP 1036) to allow revision of the original claim. Rebilling additional units of service on a CMS-1500 for the same timeframe would be denied as duplicate services.

[ED. NOTE: Forms referenced available from the agency.]
Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0300
Procedure Codes

(1) The provider must use the procedure code from the School-Based Health Services table that best describes the specific service provided and a modifier that describes the discipline providing the service. Refer to 410-133-0080 Coverage for service requirements and limitations.

(2) Unit values equal 15 minutes of service unless otherwise stated. These time units must be documented in the Medicaid-eligible student's records under the services billed and accounted for under one code only.

Stat. Auth.: ORS 409
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; OMAP 1-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0320
Documentation and Record keeping Requirements

(1) Record keeping must conform and adhere to Federal, state, and local laws and regulations.

(2) Records must record — history taken, procedures performed, tests administered, results obtained, and conclusions and recommendations made. Documentation may be in the form of a "SOAP" (subjective Objective Assessment Plan) note, or equivalent.

(3) Providers will retain information necessary to support claims submitted to DHS including: documentation and supervision of the specific Health Services provided, the extent of the Health Service provided, the dates and the name of Medically Qualified Staff who provided the service to the Medicaid-eligible student for seven (7) years. This documentation must meet the requirements of and must be made available pursuant to the requirements in the General Rules, OAR 410-120-1360 (Requirements of Financial, Clinical and Other Records). These requirements may be met if the information is included in the IEP or IFSP and the School Medical Provider maintains adequate supporting documentation at the time the service is rendered, consistent with the requirements of OAR 410-120-1360.

(a) Supporting documentation should:

(A) Be accurate, complete and legible;

(B) Be typed or recorded using ink;

(C) Be signed by the individual performing the service including their credentials or position;

(D) Be signed and/or initialed in accordance with Licensing Board requirements for each clinical entry by the individual performing the service;

(E) Be reviewed and authenticated by the supervising therapist in compliance with their Licensing Board requirements.

(F) Be for covered Health Services provided as specified for the service period indicated on the Medicaid-eligible student's current IEP or IFSP.

(b) Corrections to entries must be recorded by:

(A) Striking out the entry with a single line which does not obliterate the original entry, or amend the electronic record preserving the original entry; and

(B) Dating and initialing the correction.

(c) Late entries or additions to entries shall be documented when the omission is discovered with the following written at the beginning of the entry: "late entry for (date)" or "addendum for (date)."

(2) Supporting documentation for Medicaid reimbursed Health Services described in a Medicaid-eligible student's IEP or IFSP must be kept for a period of seven (7) years, as part of the student's Education Record, which may be filed and kept separately by school health professionals and must include:

(a) A copy of the Medicaid-eligible student's IEP or IFSP as well as any addendum to the plan that correlates with the covered Health Service(s) provided and reimbursed by Medicaid;

(b) A notation of the diagnosis or condition being treated or evaluated, using specific medical or mental health diagnostic codes;

(c) Results of analysis of any mental health or medical analysis, testing, evaluations, or assessments for which reimbursement is requested;

(d) Documentation of the location, duration, and extent of each Health Service provided, by the date of service, signed and/or initialed by Medically Qualified Staff in accordance with their Licensing Board requirements (electronic records can be printed);

(e) The record of who performed the service and their credentials or position;

(f) The medical recommendation to support the service;

(g) Periodic evaluation of therapeutic value and progress of the Medicaid-eligible student to whom a Health Service is being provided;

(h) Record of medical need for Necessary and Appropriate transportation to a covered Health Service, specific date transported, consistent with the record-keeping requirements in the Transportation rules, OAR 410-136-0280 (Required Documentation); and

(i) Date specific attendance records for Medicaid-eligible students for all dates of service billed.

(j) In supervisory situations, the licensed health care practitioner who supervises and monitors the assessment, care, or treatment rendered by licensed or certified therapy assistants, shall meet the minimum standards required by their Licensing Board (documentation may not be delegated except in emergency situations).

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; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

410-133-0340
Client Rights and Record Confidentiality

(1) School Medical Providers are required to provide DHS, the Division of Medical Assistance Programs (DMAP), the Department of Justice Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services, or their authorized representatives, access to Medicaid-eligible student medical records when requested as a condition of accepting Medicaid reimbursement from DHS.

(2) Medicaid client rights of confidentiality must be respected in accordance with the provisions of 42 CFR Part 431, Subpart F and ORS 411.320.

(3) School Medical Providers are also subject to the confidentiality laws applicable to student records, including student medical records maintained as part of the Education Record.

Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 411.320
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05

DIVISION 136

MEDICAL TRANSPORTATION SERVICES

410-136-0030
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 the Division of Medical Assistance Programs (DMAP);

(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 DMAP;

(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 409
Stats. Implemented: ORS 414.085
Hist.: HR 28-1994, f. & cert. ef. 9-1-94

410-136-0040
Reimbursement

(1) The Division of Medical Assistance Programs (DMAP) will reimburse according to the 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) Aid Call — service or care is provided at the scene by the responding emergency ambulance provider and no transport of client was required;

(c) Taxi;

(d) Secured Transport;

(e) Fixed Route Bus Service.

(2) The provider cannot bill DMAP if:

(a) County or city ordinance prohibits any provider from charging for services identified in the Medical

(b) Transportation Services Administrative Rules;

(c) The provider does not charge the general public for such services;

(d) The provider did not provide transport, medical services, or treatment; or

(e) The provider is providing the transport through a transportation brokerage.

(3) DMAP will make payment for medical transportation when those services have been authorized by either the client's local branch office or DMAP. DMAP may recoup such payments if, on subsequent review, it is found that the provider did not comply with DMAP Administrative Rules. Non-compliance includes, but is not limited to, failure to adequately document the service and the need for the service.

(4) Reimbursement 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 Medical Assistance Programs and that the service billed is adequately documented in the provider's records prior to billing.

(5) DMAP will reimburse at the lesser of the amount charged the general public (public billing rate), the amount billed or DMAP's maximum allowed, less any amount paid or payable by another party.

(6) DMAP will base reimbursement for transportation services covered by Medicare on the lesser of Medicare's allowed amount or DMAP's maximum allowed, less any amount paid or payable by another party.

(7) DMAP will only reimburse for the mode of transportation authorized by the local branch office or DMAP.

(8) DMAP will only reimburse when a transport of the client has occurred or in the case of aid calls where service or care was provided at the scene by an ambulance provider and no transport of the client occurred.

(9) DMAP reimbursement is considered to be payment in full.

Stat. Auth.: ORS 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 461-020-0025 & 461-020-0026; 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 55-2002, f. & cert. ef. 10-1-02; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04

410-136-0045
Copayment for Standard Benefit Package

A client receiving the Standard Benefit Package may be subject to copayments for Medical Transportation services. See General Rules, 410-120-1235 for additional information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03

410-136-0050
Out-of-State Transportation

(1) Division of Medical Assistance Programs (DMAP) may authorize and make payment for out-of-state transportation when each of the following three conditions are met:

(a) The medical 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 DMAP Out-of-State Coordinator.

(2) DMAP may also authorize out-of-state transportation when DMAP 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 transportation out-of-state to obtain medical 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 (PHP) and the Plan has authorized the service, DMAP may authorize and make payment for out-of-state transportation if 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 409
Stats. Implemented: ORS 414.065
Hist.: HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00

410-136-0060
Taxi Services

(1) The Division of Medical Assistance Programs (DMAP) 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. The DMAP definition of meter charge includes:

(a) A flag rate that does not exceed 110% of the usual and customary charges for the services within the area;

(b) Actual patient miles traveled at a rate that does not exceed 110% of the usual and customary charges for the services within the area;

(c) "In route" waiting time, e.g., 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 DMAP 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 events such as:

(a) Nausea, vomiting after dialysis or chemotherapy; or

(b) Pharmacy stop to obtain prescription; or

(c) Other medically appropriate 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 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00

410-136-0070
Wheelchair Car/Van Service

(1) The Division of Medical Assistance Programs (DMAP) will make payment for wheelchair car/van services, when those services have been authorized by the branch office.

(2) Payment for wheelchair services will not be made for transportation of ambulatory (capable of walking) clients.

(3) Wheelchair car/vans may also provide stretcher car services if allowed by local ordinance and when those services have been authorized by the local branch office.

(4) A stretcher car/van must be capable of loading a stretcher (gurney) into the vehicle.

(5) Reclining wheelchairs are not considered stretchers (gurneys) and must not be billed as stretcher car/van services.

(6) Payment for stretcher car/van services will not be made for transporting wheelchair clients.

Stat. Auth.: ORS 409
Stats.Implemented: ORS 414.065
Hist.: OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00

410-136-0080
Additional Client Transport

Ambulance, Wheelchair Car/Van, Stretcher Car, Taxi, and Contract Services (Ambulatory). If two or more Medicaid clients are transported by the same mode (e.g. Wheelchair Van) at the same time, the Division of Medical Assistance Programs (DMAP) will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more Medicaid clients are transported by mixed mode (e.g. Wheelchair Van and Ambulatory) at the same time, DMAP will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client.

NOTE: Reimbursement will not be made for duplicated miles traveled.

Stat. Auth.: ORS 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 461-020-0032; HR 30-1993, f. & cert. ef. 10-1-93; OMAP 55-2002, f. & cert. ef. 10-1-02

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 the Division of Medical Assistance Programs (DMAP).

(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 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 461-020-0050; 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

The Division of Medical Assistance Programs (DMAP) 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

(1) To qualify for reimbursement by the Division of Medical Assistance Programs (DMAP), a provider of ambulance, air ambulance, wheelchair car, stretcher car, taxi, secured transport or other medical transportation services must meet the following conditions:

(a) 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 unless prohibited by federal rules and/or regulations from charging for services. Any volunteer, community resource or other transportation service that operates without charge or provides services without charge to the community will not be reimbursed by DMAP when those same services are provided to DMAP clients;

(b) If providing ground or air ambulance services, be in compliance with Oregon Revised Statutes 682.015 through 682.991 (and any rules and regulations pertinent thereto) and must be licensed by the Oregon Health Division of the Department of Human Services (DHS) to operate as ground or air ambulance;

(c) An ambulance service provider located in a contiguous state which regularly provides transports for DMAP clients must be licensed by the Oregon Health Division (DHS) as well as by the state in which it is located;

(d) Be in compliance with all statutes, required certifications or regulations promulgated by any local or state government entity.

(2) In the absence of any local regulatory body, a provider must be enrolled with DMAP 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 DMAP using the specific codes defined in the Procedure Codes Section of the Medical Transportation Services Provider Guide.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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 461-020-0060; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; OMAP 26-1998(Temp), f. 8-14-98, cert. ef. 8-17-98 thru 1-1-99; OMAP 36-1998, f. & cert. ef. 10-1-98; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00

410-136-0160
Non-Emergency Medical Transportation

(1) The Division of Medical Assistance Programs (DMAP) 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 or DMAP has determined the transport is medically appropriate.

(2) DMAP will not make payment for transportation to a specific provider based solely on client preference or convenience. For purposes of authorizing non-emergency medical transportation, the medical service or practitioner must be within the 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 DMAP to be cost-effective.

(3) A Branch may not authorize and DMAP 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's refusing to provide further service or treatment to the client. In the event supporting documentation demonstrates inadequate or inappropri-

ate services are being (or have been) provided by the local treatment facility or practitioner, DMAP may authorize transportation outside of the client's local area on a case-by case basis.

(4) For a client who is threatening harm to providers or others in the vehicle, or whose health conditions create health or safety concerns to the provider or others in the vehicle, or whose other conduct or circumstances place the provider and others at risk of harm, the State may impose certain reasonable restrictions on transportation services to that client, including but not limited to the following:

(a) Restricting the client to a single transportation provider, or

(b) Requiring the individual to travel with an escort.

(5) If a managed care client selects a Primary Care Physician (PCP) or Primary Care Manager (PCM) outside of the client's local area when a PCP or PCM is available in the client's local area the client is responsible for the transportation to the PCP or PCM and this is not a covered service.

(6) 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. When more than one Medical Assistance client ride-shares to medical appointments, DMAP will reimburse mileage to only one client. The written documentation will be made available for review upon request by DMAP.

(7) The provider must submit billings for non-emergency ambulance transports provided to clients enrolled in Fully Capitated Health Plans (FCHP) to the FCHP. The Plan will review for medical appropriateness prior to payment. Depending on the individual FCHP the FCHP may or may not require authorization in advance of services.

Stat. Auth.: ORS 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 461-020-0020; 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; OMAP 27-1998(Temp), f. & cert. ef. 8-26-98 thru 2-1-99; OMAP 37-1998, f. & cert. ef. 10-1-98; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 7-2007, f. 6-14-07, cert. ef. 7-1-07

410-136-0180
Base Rate

(1) Ambulance — All Inclusive. The Division of Medical Assistance Programs (DMAP) 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 (including stretcher car services provided by an ambulance). DMAP reimbursement of the first ten miles of a transport is included in the payment for the base rate. A service from point of origin to point of destination (one-way) is considered a "transport."

Stat. Auth.: ORS 409.010
Stats. Implemented: ORS 414.065
Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00

410-136-0200
Emergency Medical Transportation (With Need for an Emergency Medical Technician)

(1) A service will qualify for Division of Medical Assistance Programs (DMAP) reimbursement as an emergency ambulance transport when a sudden, unexpected medical condition creates a medical crisis requiring immediate transportation (with need for an Emergency Medical Technician) to a site, usually a hospital, where appropriate Emergency Medical Service is available.

(a) An Emergency Medical Service, including the prudent layperson standard, is defined under OAR 410-120-0000. For purposes of this rule, emergency medical transportation is treated as an Emergency Medical Service if the DMAP Member's medical condition that requires transport meets the prudent layperson standard.

(b) Notwithstanding the other provisions of this rule, DMAP Clients with the CAWEM benefit package are governed by OAR 410-120-1210(3)(e)(B) that does not apply the prudent layperson standard.

(2) When transport occurs, the client must be transported to the nearest appropriate facility able to meet the client's medical needs.

(3) Authorizations of, and 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 Emergency Medical Condition using the prudent layperson standard as defined in OAR 410-141-0000(42) (Emergency Medical Condition) prior to payment.

Stat. Auth.: ORS 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 461-020-0032; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 42-2005, f. 9-2-05, cert. ef. 10-1-05

410-136-0220
Air Ambulance Transport

The Division of Medical Assistance Programs (DMAP) 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 non-emergent service has been authorized by the client's branch office or DMAP, after a written recommendation has been obtained by the attending physician indicating medical appropriateness.

Stat. Auth.: ORS 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; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01

410-136-0240
Secured Transports

(1) The Division of Medical Assistance Programs (DMAP) will reimburse 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) DMAP must recognize the provider as a provider of secured transports. This requires written advance notice to DMAP (prior to or at the time of enrollment) that the provider has met the requirements of the secure transport provider protocol as established in OARs 309-033-0200 through 309-033-0970;

(c) When medically appropriate (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), one additional person will be allowed to escort at no additional charge to DMAP. The DMAP reimbursement is considered to be payment in full for the transport.

(2) The provider must submit a copy of all rates charged to the general public to DMAP, Provider Enrollment, at the time of enrollment. The provider must submit any changes to those rates to DMAP in writing within 30 days of the change. The notification must indicate the rate changes and effective date. If subsequent review by DMAP discloses that the written notice is not accurate, DMAP may recoup payments.

(3) DMAP will authorize reimbursement on an individual client basis in keeping with the DMAP rules regarding level of transport needed, eligibility, cost effectiveness and medical appropriateness. In the event the provider gave transport on an emergent basis, DMAP will authorize when appropriate after provision of service.

(4) DMAP will not reimburse for any secured transport provided to a client in the custody of or under the legal jurisdiction of any law enforcement agency or institution. DMAP will not reimburse for any transport resulting from a court ordered placement, any transport to/from a court hearing, or to/from a commitment hearing.

(5) The provider must transport the client to a Title XIX eligible or enrolled facility recognized by DMAP as having the ability to treat the immediate medical, mental and/or emotional needs of a client in crisis.

(6) DMAP 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 appropriate to return a client to place of residence, the branch must obtain written documentation stating the circumstances and the treating physician must sign the documenta-

tion. The branch must retain the documentation in the branch record (along with a copy of the order) for DMAP review.

Stat. Auth.: ORS 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04

410-136-0260
Neonatal Intensive Care Transport

(1) The Division of Medical Assistance Programs (DMAP) will make reimbursement for a neonatal intensive care transport when the conditions listed below are met and the transport has been prior authorized by the Department of Human Services (DHS) branch/DMAP and meets all other eligibility requirements.

(2) The provider must be recognized by DMAP as a provider of neonatal intensive care transports. This requires advance written notice to DMAP that the provider 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 DMAP as a tertiary neonatal intensive care hospital unit.

(3) If subsequent review by DMAP discloses that the written notice is not accurate, payments may be recouped.

Stat. Auth.: ORS 409.010 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 54-1981, f. 8-19-81, cert. ef. 10-1-81; AFS 5-1984, f. & cert. ef. 2-3-84; AFS 30-1985, f. 5-30-85, cert. ef. 7-1-85; AFS 64-1986, f. 9-8-86, cert. ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93, Renumbered from 461-020-0032; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01

410-136-0280
Required Documentation

(1) For all claims submitted to the Division of Medical Assistance Programs (DMAP), 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, e.g., client address, Nursing Home name and address, location of accident, etc.;

(e) Destination point, e.g., 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 DMAP 405T (or DMAP 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 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00

410-136-0300
Authorization

(1) 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.

(2) Retroactive authorization for medical transportation will be made only under the following circumstances:

(a) "After hours" transports to obtain urgent medical care. Medical appropriateness will be determined by branch or The Division of Medical Assistance Programs (DMAP) review;

(b) Secured transports provided to clients in crisis on weekends, holidays or after normal branch office hours. Medical appropriateness for secured transports will be determined by branch/DMAP review to ensure authorization is given and/or reimbursement made only for those transports that meet criteria set forth in 410-136-0240.

(3) 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) Secured transport (including those arranged for and/or provided outside of normal branch office hours);

(g) Client reimbursed transportation (including medically appropriate meals, lodging, attendant);

(h) Fixed route public bus systems;

(i) All special/bid transports.

(4) Authorization will be made for the services identified above when:

(a) The transport is medically appropriate considering the medical condition of the client;

(b) The destination is to a medical service covered under the Medical Assistance 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 DMAP;

(d) The transport is the least expensive medically appropriate mode of conveyance available considering the medical condition of the client.

(5) Authorization must be obtained in advance of service provision. Branch telephone numbers can be found in the DMAP General Rules. The client's branch office is printed on the Medical Care Identification. A provider authorized to provide transportation will receive a completed Medical Transportation Order (DMAP 405T or DMAP 406). All transportation orders, including any equivalent, must contain the following:

(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, e.g., special client requirements;

(h) Mode of transportation, e.g., taxi;

(i) 1 way, round trip, 3 way;

(j) Current date;

(k) Branch number;

(l) Worker/clerk ID;

(m) Dollar amount authorized (if special/secured transport).

(6) If the Medical Transportation Order indicates 'on-going' transports have been authorized, the following information is also required:

(a) Begin and end dates;

(b) Appointment time(s);

(c) Days of week.

(7) Additional information identifying any special needs of the individual client should 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.

(8) 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. Only in this case, is it appropriate for the provider to initiate the Medical Transportation Order. All required information (except the branch number, worker/clerk ID and dollars authorized) must be completed by the provider before submitting the order to the branch for authorization. The provider must also indicate on the order the time and day of week the client called. The partially completed authorization order must be received at the appropriate branch office within 30 calendar days following provision of the service;

(b) 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 return the order to the provider within 30 calendar days. The provider may not bill DMAP until the final approved order is received;

(c) 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 covered under the Medical Assistance Programs.

(9) For client reimbursed transportation and fixed route public bus systems, the client must contact the branch office in advance of the travel. Once the transportation has been authorized, money for bus tickets/passes or the actual bus tickets/passes will be disbursed at the branch level. If a client is requesting mileage reimbursement, the branch is to provide assistance using the current guidelines and methodologies as indicated in the DHS Worker Guide.

(10) Authorization will not be made nor reimbursement provided:

(a) To 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) To return a client to Oregon from another state or provide mileage, meals or lodging to the client, unless the client was in the other state for the purpose of obtaining services or treatment approved by DMAP or approved by the client's Prepaid Health Plan with subsequent DMAP approval for the travel;

(c) To or from court ordered services.

(11) Authorization does not guarantee reimbursement:

(a) Check eligibility on the date of service by calling Automated Information System (AIS) or requesting a copy of the client's Medical Care Identification;

(b) Ensure the service to be provided is currently a medical service covered under the Medical Assistance program;

(c) Ensure the claim is for the actual services and/or number of services provided.

(d) Per OAR 410-136-0280, for all claims submitted to DMAP, the provider record must contain completed documentation pertinent to the service provided.

(12) DMAP may not be billed for services and/or dollars in excess of the number of services and/or dollars authorized.

Stat. Auth.: ORS 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 461-020-0021; 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 55-2002, f. & cert. ef. 10-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

410-136-0320
Billing

(1) Medical transportation services must be billed on the CMS-1500 or the 837P using the billing instructions and procedure codes found in the **Medical Transportation Services Provider Guide**.

(2) Completed CMS-1500s or 837Ps should be submitted to the Division of Medical Assistance Programs (DMAP).

[Publications: Publications referenced are available from the agency.]
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; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0340
Billing for Clients Who Have Both Medicare and Medicaid Coverage

(1) For services provided to clients with both Medicare and coverage through the Division of Medical Assistance Programs (DMAP), bill Medicare first, except when the items are not covered by Medicare.

(2) DMAP services not covered by Medicare should be billed directly to DMAP on either the DMAP-505, CMS-1500 or the 837P.

(3) DMAP may be billed directly (on an DMAP-505 or the 837P) for Aid Call.

(4) DMAP may be billed directly (on a CMS-1500 or the 837P) for the following medical transportation services:

(a) Taxi;

(b) Secured Transport;

(c) Wheelchair Car/Van;

(d) Stretcher Car (including stretcher car services provided by an ambulance).

(5) Except for Aid Call, all services listed above require authorization by the appropriate Department of Human Services office.

Stat. Auth.: ORS 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 66-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0350
Billing for Base Rate — Each Additional Client

(1) Billings must be submitted to the Division of Medical Assistance Programs (DMAP) on a separate CMS-1500 or the 837P.

(2) Bill using the appropriate procedure code found in the Procedure Code Section of the Medical Transportation Services 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: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 30-1993, f. & cert. ef. 10-1-93; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0360
Billing — Ambulance

The CMS-1500 or the 837P and the Division of Medical Assistance Programs (DMAP)-505 or the 837P forms are the required billing forms for medical transportation. Refer to the appropriate Department of Human Services (DHS) website for information on completion of both forms.

Stat. Auth.: ORS 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; OMAP 66-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0420
Emergency Medical Transportation Procedure Codes

Ambulance Service — Bill the following codes using Type of Service "E":

(1) Basic Life Support (BLS) — Bill using the following procedure codes:

(a) A0429 — Ambulance service, BLS, emergency transport (BLS-emergency);

(b) A0425 — Ground mileage, per statute mile;

(c) A0424 — Extra ambulance attendant, ALS or BLS (requires medical review).

(2) Advanced Life Support (ALS) — Bill using the following procedure codes:

(a) A0427 — Ambulance service, ALS, emergency transport, level 1 (ALS1-emergency);

(b) A0433 — Ambulance service, ALS, emergency transport, level 2 (ALS2-emergency);

(c) A0425 — Ground mileage, per statute mile;

(d) A0424 — Extra ambulance attendant, ALS or BLS (requires medical review).

(3) Neonatal Intensive Care — Bill using the following procedure codes:

(a) A0225 — Ambulance service, neonatal transport, base rate, emergency transport, one-way;

(b) A0425 — Ground mileage, per statute mile.

(4) Air Ambulance — Bill using the following procedure codes:

(a) A0430 — Ambulance service, conventional air services, transport, one-way (fixed wing);

(b) A0431 — Ambulance service, conventional air services, transport, one-way (rotary wing).

(5) Aid Call (Ambulance Response and Treatment, No Transport) — Bill procedure code A0998 for aid call.

Stat. Auth.: ORS 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 14-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 55-2002, f. & cert. ef. 10-1-02; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0440
Non-Emergency Medical Transportation Procedure Codes

(1) Ambulance Service — Bill the following codes using Type of Service "D."

(a) Basic Life Support (BLS) — Bill using the following procedure codes:

(A) A0428 — Ambulance service, BLS, non-emergency transport (BLS);

(B) S0215 — Ground mileage, per statute mile;

(C) A0424 — Extra ambulance attendant, ALS or BLS (requires medical review).

(b) Advanced Life Support (ALS) — Bill using the following procedure codes:

(A) A0426 — Ambulance Service, ALS, non-emergency transport, level 1 (ALS1);

(B) A0433 — Ambulance Service, ALS, non-emergency transport, level 2 (ALS2);

(C) S0215 — Ground mileage, per statute mile;

(D) A0424 — Extra ambulance attendant, ALS or BLS (requires medical review).

(c) Air Ambulance — Bill using the following procedure codes:

(A) A0430 — Ambulance service, conventional air services, transport, one-way (fixed wing);

(B) A0431 — Ambulance service, conventional air services, transport, one-way (rotary wing).

(d) Wheelchair Car/Van — Bill using the following procedure codes:

(A) A0130 — Non-emergency transportation, wheelchair car/van base rate;

(B) S0209 — Ground mileage, per statute mile;

(C) T2001 — Extra Attendant (each).

(e) Stretcher Car/Van — Bill using the following procedure codes:

(A) T2005 — Non-emergency transportation, stretcher car/van base rate;

(B) T2002 — Ground mileage, per statute mile, stretcher car/van

(C) T2001 — Extra Attendant (each);

(D) T2003 — Non-emergency transportation, stretcher car service provided by ambulance base rate;

(E) T2049 — Ground mileage, per statute mile, stretcher car/van by ambulance.

(f) Taxi — Bill using A0100 (all inclusive);

(g) Secured Transport (all inclusive) — Bill using A0434. Attach a copy of the Medical Transportation Order to all billings submitted for secured transports.

(2) All non-emergency Medical Transportation requires authorization in advance of service provision.

Stat. Auth.: ORS 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; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 14-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 55-2002, f. & cert. ef. 10-1-02; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04

410-136-0800
Prior Authorization of Client Reimbursed Mileage, Meals and Lodging

(1) The regional transportation brokerage or the client's local branch office must authorize all reimbursement for client mileage, meals and lodging in advance of the client's travel in order to qualify for reimbursement. A client may request reimbursement up to 30 days after their medical appointment(s) provided the expenditure was authorized in advance of the travel and provided that the requested amount is $10 or greater. Reimbursement under the amount of $10 shall be accumulated until the minimum of $10 is reached.

(2) A client must demonstrate medical necessity before the Division of Medical Assistance Programs (DMAP) authorizes reimbursement for mileage, meals and/or lodging. DMAP will only reimburse to access medical services covered under the Oregon Health Plan.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 9-1998, f. & cert. ef. 4-1-98; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04

410-136-0820
Qualifying Criteria for Meals/Lodging/Attendant

(1) Payment for meals may be made when a client (with or without attendant) is required to travel a minimum of four hours out of their geographic area, but only if the course of travel spans the recognized "normal meal time." The following criteria will be used:

(a) Breakfast allowance — travel must begin before 6 am;

(b) Lunch allowance — travel must span the entire period from 11:30 am through 1:30 pm;

(c) Dinner allowance — travel must end after 6:30 pm.

(2) Payment for lodging for the night previous to a next-day appointment may be made when a client would otherwise be required to begin travel prior to 5 am in order to reach a scheduled appointment, or when travel from a scheduled appointment would end after 9 pm. If lodging is available below the Division of Medical Assistance Program (DMAP)'s current allowable rate, payment will be made for only the actual cost of the lodging.

(3) When medically necessary, payment for meals and/or lodging may be made for one attendant to accompany the client. At least one of the following conditions/circumstances must be met:

(a) The client is a minor child and, therefore, unable to travel without an attendant; or

(b) The client's attending physician has forwarded to the client's branch office a signed statement indicating the reason an attendant must travel with the client; or

(c) The client is mentally/physically unable to reach his/her medical appointment without assistance; or

(d) The client is or would be unable to return home without assistance after the treatment or service.

(4) No reimbursement will be made for the attendant's time or services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 9-1998, f. & cert. ef. 4-1-98

410-136-0840
Common Carrier Transportation

When deemed cost effective and providing the client can safely travel by common carrier transportation, (e.g., inter/intracity bus, train, commercial airline) reimbursement can be made either directly to the client for purchase of fare or the branch may purchase the fare directly and disburse the ticket (and other appropriate documents) directly to the client.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 9-1998, f. & cert. ef. 4-1-98

410-136-0860
Overpayments — Client Mileage/Per Diem

(1) The following situations are considered to be overpayments:

(a) Client mileage and/or per diem monies were paid to the client directly for the purpose of traveling to medical appointments and reimbursement for the same travel was provided by another resource;

(b) Monies paid directly to the client for the purpose of traveling to medical appointments and the monies were subsequently not used by the client for the intended purpose;

(c) Monies were paid directly to the client for the purpose of traveling to medical appointments but the client ride-shared with another client who had also received mileage reimbursement;

(d) Monies were paid directly to the client for the purpose of traveling to medical appointments but the client subsequently failed to keep the appointment;

(e) Bus tickets/passes were provided to the client for the purpose of traveling to medical appointments but were sold or otherwise transferred to another person for use.

(2) All overpayments for client reimbursed travel relating to medical appointments will be recovered from the client by the Children, Adults and Families (CAF) Division's Overpayment Recovery Unit (ORU).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 9-1998, f. & cert. ef. 4-1-98

DIVISION 137

AMBULATORY SURGICAL SERVICES

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) DMAP 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) DMAP 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, 411 & 414
Stats. Implemented:
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 461-014-0320; HR 44-1991, f. & cert. ef. 10-1-91, Renumbered from 461-014-0290

DIVISION 138

TARGETED CASE MANAGEMENT — BABIES FIRST

410-138-0000
Babies First/Cocoon Program

(1) Babies First/Cocoon Targeted Case Management (TCM) Services is a medical program operated by public health authorities, which matches public funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the General Rules governing the Division of Medical Assistance Programs (DMAP) (OAR 410 division 120). The TCM Services rules are a user's manual designed to assist the TCM Provider Organization in matching State and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC (1396n)(g).

(2) The rules of the Babies First/Cocoon — Targeted Case Management Plan define Oregon Medicaid's program to reimburse the services provided under Babies First/Cocoon. 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, provided by an enrolled Babies First/Cocoon — TCM provider consistent with these rules.

(3) 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; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0020
Definitions — Babies First/Cocoon Program

(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 documentation of client authorization and 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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0040
Risk Criteria — Babies First/Cocoon Program

(1) Medical Risk Factors for infants and preschool children:

(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 evidence-based social risk factors.

(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 evidence-based developmental risk.

Stat. Auth.: ORS 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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0060
Provider Requirements — Babies First/Cocoon Program

(1) Babies First/Cocoon — Targeted Case Management (TCM) organizations must be a public health authority and must meet 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 development;

(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, including HIPAA Privacy requirements applicable to Case Management Services, ORS 192.518–192.524, 179.505, and 411.320;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.

(i) Enrolled as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(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 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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0080
Billing Policy and Codes — Babies First/Cocoon Program

(1) Payment will be made to the enrolled Targeted Case Management Provider as the performing provider for those Case Management services provided by the employed staff person:

(2) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations;

(3) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS). The TCM provider must have a trading partner agreement with DHS prior to submission of electronic transactions;

(4) Targeted Case Management authorized under these rules is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in this rule, and pursuant to 42 CFR 433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice;

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42 CFR 433.51, public funds may be considered as the State's share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies, and the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's payment to the TCM provider;

(c) The TCM provider shall submit to the Division of Medical Assistance Programs (DMAP) an original signed document certifying that the public funds transferred to DMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to timely remit the non-federal share described in subsection (4) will constitute an overpayment and will make the provider subject to overpayment recoupment or other remedy pursuant to DMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(6) DMAP shall not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If DMAP has previously paid the TCM provider for any claim which CMS disallows, the TCM provider shall reimburse DMAP the amount of the claim that DMAP has paid to the TCM provider, less any amount previously paid by the TCM provider to DMAP for purposes of reimbursing DMAP the non-federal match portion for that claim.

(7) Billing criteria for this program is as follows:

(a) The procedure code to be used is "T1016" for Babies First/Cocoon — Targeted Case Management. Maximum billing for the T1016 code is one time per day per client. One of the three activities listed below must occur in order to bill:

(A) Screening;

(B) Assessment;

(C) Intervention.

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) The provider must use Diagnosis Code "V201."

(8) Duplicate billings are not allowed and duplicate payments will be recovered. Services will be considered as duplicate if the same services are billed by more than one entity to meet the same need. Medical services must be provided and billed separately from Case Management Services.

(9) A unit of service can only be billed once under one procedure code, under one provider number.

Stat. Auth.: ORS 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; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0300
HIV Program

(1) HIV — Targeted Case Management (TCM) Services is a medical program operated by public health authorities, which matches public funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the General Rules governing the Division of Medical Assistance Programs (DMAP) (OAR 410 division 120). The TCM Services rules are a user's manual designed to assist the TCM Provider Organization in matching State and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC (1396n)(g).

(2) 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).

(3) 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, provided by an enrolled HIV — TCM provider consistent with these rules.

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; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0320
Definitions — HIV Program

(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 non-responsive.

(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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0340
Risk Criteria — HIV Program

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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0360
Provider Requirements — HIV Program

(1) HIV — Targeted Case Management (TCM) organizations must be a public health authority and must meet 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, including HIPAA Privacy requirements applicable to Case Management Services, ORS 192.518–192.524, 179.505, and 411.320;

(h) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.

(i) Enrolled as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(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 enrolled HIV — TCM provider 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; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0380
Billing Policy and Codes — HIV Program

(1) Payment will be made to the enrolled Targeted Case Management Provider as the performing provider for those Case Management services provided by the employed staff person:

(2) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services (Department) and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations;

(3) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Infor-

mation System (MMIS). The TCM provider must have a trading partner agreement with DHS prior to submission of electronic transactions;

(4) Targeted Case Management authorized under these rules is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in this rule, and pursuant to 42 CFR 433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice;

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42 CFR 433.51, public funds may be considered as the State's share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies, and the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's payment to the TCM provider;

(c) The TCM provider shall submit to the Division of Medical Assistance Programs (DMAP) an original signed document certifying that the public funds transferred to DMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to timely remit the non-federal share described in subsection (4) will constitute an overpayment and will make the provider subject to overpayment recoupment or other remedy pursuant to DMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(6) DMAP shall not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If DMAP has previously paid the TCM provider for any claim which CMS disallows, the TCM provider shall reimburse DMAP the amount of the claim that DMAP has paid to the TCM provider, less any amount previously paid by the TCM provider to DMAP for purposes of reimbursing DMAP the non-federal match portion for that claim.

(7) Billing criteria for this program is as follows:

(a) Use Procedure Code "T2023" for HIV — Targeted Case Management. Maximum billing for the T2023 code is one time per calendar month per client. At least one of the five activities listed below must occur during the month in order to bill:

(A) Assessment;

(B) Comprehensive Care/Services Plan Development;

(C) Intervention/Implementation;

(D) Coordination/Linking of Services;

(E) Evaluation.

(b) Any Place of Service (POS) is valid;

(c) Prior Authorization is not required;

(d) Provider must use Diagnosis Code "V08" or "042."

(8) Duplicate billings are not allowed and duplicate payments will be recovered. Services will be considered as duplicate if the same services are billed by more than one entity to meet the same need. Medical services must be provided and billed separately from Case Management Services.

(9) A unit of service can only be billed once under one procedure code, under one provider number.

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; OAR 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0500
Pregnant Substance Abusing Women and Women with Young Children Program

(1) Pregnant Substance Abusing Women and Women with Young Children (PWWC) — Targeted Case Management (TCM) Services is a medical program operated by public health authorities, which matches public funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the General Rules governing the Division of Medical Assistance Programs (DMAP) (OAR 410 division 120). The TCM Services rules are a user's manual designed to assist the TCM Provider Organization in matching State and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC (1396n)(g).

(2) 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, Jackson, and Yamhill Counties, provided by an enrolled PWWC — TCM provider consistent with these rules.

(3) 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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 19-1993, f. & cert. ef. 8-13-93; OMAP 41-1999, f. 10-15-99, cert. ef. 10-20-99; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0520
Definitions — Pregnant Substance Abusing Women and Women with Young Children Program

(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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0530
Risk Criteria — Pregnant Substance Abusing Women and Women with Young Children

(1) Pregnant or have children under the age of five; and

(2) Are in need of treatment for the abuse of alcohol and other drugs.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0540
Provider Requirements — Pregnant Substance Abusing Women and Women with Young Children Program

(1) (PWWC) — Targeted Case Management (TCM) organizations must be a public health authority and must meet 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, including HIPAA Privacy requirements applicable to Case Management Services, ORS 192.518–192.524, 179.505, and 411.320;

(h) Enrolled as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(i) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid Program; and

(j) 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; OMAP 50-2004, f. 9-9-04, cert. ef. 10-1-04

410-138-0560
Billing Policy and Codes — Pregnant Substance Abusing Women and Women with Young Children

(1) Payment will be made to the enrolled Targeted Case Management Provider as the performing provider for those Case Management services provided by the employed staff person:

(2) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services (DHS) and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations;

(3) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS). The TCM provider must have a trading partner agreement with DHS prior to submission of electronic transactions;

(4) Targeted Case Management authorized under these rules is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in this rule, and pursuant to 42 CFR 433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice;

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42 CFR 433.51, public funds may be considered as the State's share in claiming federal financial participation if the public funds meet the following conditions: The public funds are transferred to DHS from public agencies, and the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's payment to the TCM provider;

(c) The TCM provider shall submit to the Division of Medical Assistance Programs (DMAP) an original signed document certifying that the public funds transferred to DMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

(5) Failure to timely remit the non-federal share described in subsection (4) will constitute an overpayment and will make the provider subject to overpayment recoupment or other remedy pursuant to DMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(6) DMAP shall not be financially responsible for payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid program. If DMAP has previously paid the TCM provider for any claim which CMS disallows, the TCM provider shall reimburse DMAP the amount of the claim that DMAP has paid to the TCM provider, less any amount previously paid by the TCM provider to DMAP for purposes of reimbursing DMAP the non-federal match portion for that claim.

(7) Billing criteria for this program is as follows:

(a) The procedure code to be used is "T2023" for Pregnant Substance Abusing Women with Young Children — Targeted Case Management. Maximum billing for the T2023 code is one time per calendar month per client. One of the three activities listed below must occur in order to bill:

(A) Screening;

(B) Assessment;

(C) Intervention.

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) Provider must use Modifier Code "HF" and Diagnosis Code "V6141."

(8) Duplicate billings are not allowed and duplicate payments will be recovered. Services will be considered as duplicate if the same services are billed by more than one entity to meet the same need. Medical services must be provided and billed separately from Case Management Services.

(9) A unit of service can only be billed once under one procedure code, under one provider number.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 19-1993, f. & cert. ef. 8-13-93; OMAP 61-2004, f. 9-10-04, cert. ef. 10-1-04

410-138-0600
Purpose — Federally Recognized Tribal Governments in Oregon

(1) The Targeted Case Management (TCM) Services program is a medical assistance program, that leverages Division of Medical Assistance Programs (DMAP) certified Case Management Provider Organization allowable tribal funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the DMAP (OAR 410 division 120). The TCM Services program rules are designed to assist the Case Management Provider Organization in matching allowable tribal and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(2) The rules of the Federally Recognized Tribal Government Targeted Case Management program define Oregon Medicaid's program to reimburse the TCM services provided by a federally recognized tribal government located in the State of Oregon.

(3) TCM services include case management of non-medical services, which address health, psychosocial, economic, nutritional and other services.

(4) Provision of tribal TCM services may not restrict an eligible Client's choice of providers. Clients must have free choice of available tribal TCM service providers or other TCM service providers available to the eligible Client, subject to 42 USC 1396n. Eligible Clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.085
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0610
Targeted Group — Federally Recognized Tribal Governments in Oregon

(1) The target group consists of Oregon Health Plan (OHP) Medicaid eligible individuals served by tribal programs within the State of Oregon, or receiving services from a Federally recognized Indian tribal government located in the State of Oregon, and not receiving case management services under other Title XIX programs. The target group includes elder care; individuals with diabetes; children and adults with health and social service care needs; and pregnant women. These services will be referred to as Tribal Targeted Case Management Services.

(2) An Oregon Health Plan (OHP) Medicaid-eligible individual means an individual who has been determined to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Department of Human Services (DHS). For purposes of these rules, an eligible individual will be referred to as a Client.

(3) This does not include TCM services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0620
Definitions — Federally Recognized Tribal Governments in Oregon

(1) "Assessment" — After the need for tribal targeted case management services has been determined, the tribal case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary decisions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

(2) "Case Planning" — The tribal case manager develops a case plan, in conjunction with the Client and family (where applicable), to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the tribal case manager, the family and Client. This activity will include accessing medical, social, educational, and other services to meet the Clients' needs.

(3) "Case Plan Implementation" — The tribal case manager will link the Client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The tribal case manager will facilitate implementation of agreed-upon services through assisting the Client and family to access them and through assuring the Clients and providers fully understand how these services support the agreed-upon case plan.

(4) "Case Plan Coordination" — After these linkages have been completed, the tribal case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the Client and family. Coordination activities include, personal, mail and telephone contacts with providers and others identified by the case plan, and well as meetings with the Client and family to assure that services are being provided and used as agreed.

(5) "Case Plan Reassessment" — In conjunction with the Client, the tribal case manager will determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. Reassessment will also determine whether the case plan itself requires revision. This may include assisting Clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, staffing and mail, personal, and telephone contacts with involved parties.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0640
Provider Organizations — Federally Recognized Tribal Governments in Oregon

A Tribal Targeted Case Management (TCM) Provider must be an organization certified as meeting the following criteria:

(1) A minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including: Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment;

(2) A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population;

(3) Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements;

(4) Maintain a sufficient number of case managers to ensure access to targeted case management services;

(5) A financial management capacity and system that provides documentation of services and costs;

(6) Capacity to document and maintain Client case records in accordance with state and federal requirements, including requirements for recordkeeping in OAR 410-120-1360, and confidentiality requirements in ORS 192.519–192.524, ORS 179.505, and 411.320, and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable;

(7) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program;

(8) Evidence that the TCM organization is a federally recognized tribe located in the State of Oregon;

(9) Enrollment as a TCM provider with the Division of Medical Assistance Programs (DMAP).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0660
Qualifications of Case Managers within Provider Organizations — Federally Recognized Tribal Governments in Oregon

The following are qualifications of Case Managers within Provider Organizations:

(1) Completion of training in a case management curriculum;

(2) Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, and issues around aging;

(3) Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication;

(4) Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources;

(5) Knowledge and understanding of these rules and the applicable State Medicaid Plan Amendment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0680
Payment, Methodology, and Billing Instructions and Codes — Federally Recognized Tribal Governments in Oregon

(1) Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Targeted Case Management (TCM) services may not be reimbursed under this rule if the services are case management services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

(2) Payment Methodology for Tribal Targeted Case Management: For the purposes of these TCM rules, "Unit" is defined as a month. A unit consists of at least one documented contact with the Client (or other person acting on behalf of the Client) and any number of documented contacts with other individuals or agencies identified through the case planning process.

(3) Payment for tribal TCM services will be made using a monthly rate based on the total average monthly cost per Client served by the TCM Provider during the last fiscal year for which audited financial statements have been filed with the Department of Human Services (Department). The costs used to derive the monthly tribal TCM rate will be limited to the identified costs divided by the number of Clients served. Tribal TCM provider costs for direct and related indirect costs that are paid by other Federal or State programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of Clients served. For subsequent years, the rate will be based on actual eligible TCM costs from the previous year. A cost report must be submitted to the Department at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the following fiscal year.

(4) Payment will be made to the enrolled tribal TCM organization as the performing provider for those services provided by the employed staff person.

(5) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations.

(6) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS).

(7) Targeted Case Management for the Division of Medical Assistance Programs (DMAP) certified case management providers, is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in subsections (1) through (6) of this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP)

rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice:

(a) The TCM provider's share means the tribal funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, tribal funds may be considered as the State's share in claiming federal financial participation if the tribal funds meet the following conditions: The tribal funds are transferred to DHS from a tribal government; and, the tribal funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's expenditure to the TCM provider;

(c) The TCM provider shall submit to DMAP an original signed document certifying that the allowable tribal funds transferred to DMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

(8) Failure to timely remit the non-federal share described in subsections (1) will constitute an overpayment, and will make the provider subject to overpayment recoupment or other remedy pursuant to the DMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(9) Billing criteria for this program is as follows:

(a) The procedure code to be used for Federally Recognized Tribal Government — Targeted Case Management is "T1017." One of the activities listed below must occur in order to bill. Maximum billing code is one time per month per client:

(A) Assessment;

(B) Case Planning;

(C) Case Plan Implementation;

(D) Case Plan Coordination;

(E) Case Plan Reassessment.

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) Appropriate Diagnosis Code and Modifier must be used.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0700
Purpose — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) The Targeted Case Management (TCM) Services Program is a medical assistance program, that leverages Division of Medical Assistance Programs (DMAP) certified Case Management Provider Organization General Funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the DMAP General Rules Program (OAR 410 division 120). The TCM Services rules are designed to assist the Targeted Case Management Provider Organization in matching State and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(2) The rules of the Early Intervention/Early Childhood Special Education Targeted Case Management program define Oregon Medicaid's program to reimburse the TCM services provided under Early Intervention/Early Childhood Special Education. This TCM program provides services to eligible preschool children with disabilities, birth until eligible for public school.

(3) EI/ECSE TCM program services include management of non-medical services, which address health, psychosocial, economic, nutritional and other services.

(4) Provision of EI/ECSE TCM program services may not restrict an eligible child's choice of providers. Eligible children must have free choice of available EI/ECSE TCM service providers or other TCM service providers available to the eligible child, subject to 42 USC 1396n. Eligible children must have free choice of the available providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.085
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0710
Target Group — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) These rules apply to the population of Oregon Health Plan (OHP) Medicaid eligible clients who are preschool children with disabilities, beginning from birth until eligibility for public school, and who are either eligible for Early Intervention services under OAR 581-015-0946(3); or Early Childhood Special Education services under OAR 581-015-0943(4), (EI/ECSE). For the purpose of these rules, children in this target group shall be referred to as "eligible children."

(2) An Oregon Health Plan (OHP) Medicaid-eligible child means a child who has been determined to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Department of Human Services (DHS).

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0720
Definitions — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) "Case management" is provided to eligible children in the target group to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services. The case manager (aka service coordinator) is responsible for assisting the child and family in gaining access to and coordinating all services across agency lines and serving as the single point of contact in helping the child and family obtain the services and assistance they need. Case management may be delivered in person, electronically, or by telephone for the purpose of enabling the child and family to gain access to and obtain the needed services. Case management services include:

(a) "Intake and Needs Assessment" — The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, social, behavioral, emotional, and mobility areas. Data sources include family interview, existing available records, and needs assessment;

(b) "Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individualized Family Service Plan (IFSP)" — The case manager (service coordinator) develops a targeted case management plan coordinated with the IFSP, in conjunction with the family and other IFSP team members to identify goals, objectives and issues identified through the targeted case management assessment process. Targeted case management case planning includes determining activities to be completed by the case manager, in support of the eligible child and family. These activities include accessing appropriate health and mental health, social, educational, vocational, and transportation services to meet the eligible child's needs.

(2) "Service Coordination and Monitoring":

(a) Linkages — establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to the eligible child and family;

(b) Planning — Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion with the family and other IFSP team members;

(c) Implementation — Putting the targeted case management plan into action and monitoring its status;

(d) Support — Support is provided to assist the family to reach the goals of the plan, especially if resources are inadequate or the service delivery system is non-responsive;

(3) "Reassessment and Transitioning Planning": The case manager (service coordinator), in consultation with the family and other IFSP team members, determines whether or not the linked services continue to meet the eligible child and family's needs, and if not, adjustments are made and new or additional referrals are made to adequately meet the defined child and family needs. These services:

(a) Assist families of eligible children in gaining access to EI/ECSE services and other medical or social services identified in the targeted case management plan;

(b) Permit coordinating of EI/ECSE services and other medical or social services (such as medical services for other than diagnostic and evaluation purposes) that the eligible child needs or is being provided;

(c) Assist families in identifying available medical and social service providers;

(d) Permit coordination and monitoring the delivery of available medical or social services;

(e) Inform families of the availability of medical/social services;

(f) Maintain a record of targeted case management activities in each eligible child's record.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0740
Provider Organizations — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Qualifications of EI/ECSE TCM Provider Organizations: TCM Provider organizations must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be a sub-contractor with such a contractor, and must meet the following criteria:

(a) Demonstrated capacity (including sufficient number of staff) to provide TCM services;

(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) Capacity to document and maintain individual case records in accordance with state and federal requirements, including requirements for recordkeeping in OAR 410-120-1360, and confidentiality requirements in the Individuals with Disabilities Education and Improvement Act, ORS 192.518–192.524, 179.505, and 411.320, and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable;

(g) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program; and

(h) Enrollment as a TCM provider with the Division of Medical Assistance Programs (DMAP).

(2) In addition to the requirements in subsection (1) of this rule, the EI/ECSE TCM Provider must either be a governmental entity or a subcontractor of a government entity. The TCM Provider must submit written documentation that a governmental entity is solely responsible for providing the TCM provider's share from public funds for purposes of OAR 410-138-0780 of this rule. If the TCM provider is a subcontractor of a governmental entity, the documentation shall include a copy of the subcontract that expressly identifies the State of Oregon Department of Human Services (DHS) as a named third party beneficiary of the governmental entity's obligation to make the public fund payments. Such documentation is subject to approval by DHS.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0760
Provider Requirements — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Qualification of Case Managers (Service Coordinators).

(2) Case Managers (Service Coordinators) must:

(a) Be employees of the EI/ECSE contracting or subcontracting agency and meet the personnel standards requirements in OAR 581-015-1100;

(b) Have demonstrated knowledge and understanding about:

(A) The Oregon EI/ECSE program, including these rules and the applicable State Medicaid Plan Amendment.

(B) The Individuals with Disabilities Education Improvement Act;

(C) The nature and scope of services available under the Oregon EI/ECSE program, including the TCM services, and the system of payments for services and other pertinent information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0780
Payment, Payment Methodology, and Billing Instructions and Codes — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Payment for EI/ECSE TCM services, under these rules, will not duplicate payments made to public or private entities under other program authorities for this same purpose.

(2) Payment Methodology for EI/ECSE Targeted Case Management: Payment for Targeted Case Management will be based on a monthly encounter rate.

(a) The rate for reimbursement of the case management services is computed as follows. Compute the annual case manager salary and fringe benefits, plus other operating cost including travel, supplies, telephone, and occupancy cost, plus direct supervisory cost, plus average indirect administrative cost of provider organization; that will equal the total annual cost per case manager. Then divide by 12; that will equal the monthly cost per case manager. Then divide by the number of children to be served during the month, that will equal the total monthly cost per child;

(b) The total cost, per case manager, is the sum of the case manager's salary, direct supervisory costs, indirect administrative costs of the provider organization and other operating costs such as travel, supplies, occupancy, and telephone usage. Dividing the statewide average cost, per case manager, by twelve (12) months yields the average monthly cost per case manager. Dividing the monthly cost, per case manager, by the number of children to be served during the month results in the total monthly costs per child. This is the encounter rate to be used for the monthly billing whenever a Medicaid eligible client receives a TCM service during that month.

(3) Payment will be made to the enrolled Targeted Case Management Organization as the performing provider for those services provided by the employed staff person.

(4) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services (DHS) and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations.

(5) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS).

(6) Targeted Case Management for TCM Provider organizations certified as eligible to enroll under OAR 410-138-0740 is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in subsections (1) through (5) of this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the governmental TCM provider or the TCM Provider's responsible governmental entity for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The governmental TCM provider or its responsible governmental entity shall pay the amount stated in the invoice within 30 days of the date of the invoice.

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, public funds may be considered as the State's share in claiming federal financial participation, if the public funds meet the following conditions:

(A) The public funds are transferred to DHS from public agencies; and, the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(B) The public funds transferred to DHS may not be derived by the governmental entity from donations or taxes that would not otherwise be recognized as the non-federal share under 42 CFR 433 Subpart B;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's expenditure to the TCM provider;

(c) The governmental TCM provider or its responsible governmental entity shall submit to the Division of Medical Assistance Programs (DMAP) an original signed document certifying that the public funds transferred to DMAP (for the non-federal matching share) under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds, and that the transferred funds are not derived from donations or taxes that would not otherwise be recognized as the non-federal share under 42 CFR 433 Subpart B.

(7) Failure to timely remit the non-federal share described in subsection (6) or failure to comply with the public funds requirements of subsection (6) will constitute an overpayment, and will make the provider subject to overpayment recoupment or other remedy pursuant to DMAP General Rules, OAR 410-120-1400 through 410-120-1685. Failure to comply with the public funds requirements in this rule may result in termination of the TCM provider enrollment agreement.

(8) Billing criteria for this program is as follows:

(a) The procedure code to be used is "T2023" for Early Intervention/Early Childhood Special Education — Targeted Case Management. One of the activities listed below must occur in order to bill. Maximum billing code is one time per month per client:

(A) Intake and Needs Assessment;

(B) Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individual Family Service Plan (IFSP);

(C) Service Coordination and Monitoring;

(D) Reassessment and Transitioning Planning.

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) Diagnosis Code "V62.3" must be used.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

DIVISION 140

VISUAL SERVICES

410-140-0020
Managed Health Care Organizations

(1) Division of Medical Assistance Programs (DMAP) has contracted with Managed Care Organizations (MCO) and Primary Care Case Managers (PCCM) for medical services provided for Oregon's Medical Assistance Programs clients (Title XIX and Title XXI). MCOs include Fully Capitated Health Plans (FCHP), Mental Health Organizations (MHO), Dental Care Organizations (DCO) and Chemical Dependency Care Organizations (CDO).

(2) FCHPs are responsible for all vision services. When a client is enrolled with an FCHP, the FCHP 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 FCHP. When providing visual services for a client enrolled with an FCHP you must contact that FCHP for program limitations, criteria and prior authorization (PA). Failure to follow the rules established by the FCHP for visual services may result in the denial of payment. If the provider has been denied payment for failure to follow the rules established by the FCHP neither DMAP, the FCHP, nor the client are responsible for payment.

(3) Services covered by an FCHP will not be reimbursed by DMAP; reimbursement is a matter between the FCHP and the provider. If the FCHP utilizes the DMAP Visual Materials Contractor or another Visual Materials Contractor for visual materials and supplies, all issues must be resolved between the FCHP and the contractor.

(4) When a client is assigned to a PCCM all services by an ophthalmologist and optometrist require referrals from the PCCM except for routine vision exams, fittings, repairs, and materials. Bill DMAP for all services referred by the PCCM and for routine vision exams, fittings, repair, and materials.

(5) Vision therapy is not a routine vision service and does require PA from the client's PCCM, and may require PA from the FCHP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0160; HR 37-1992, f. & cert. ef. 12-18-92; HR 15-1994, f. & cert. ef. 3-1-94; HR 38-1994, f. 12-30-94, cert. ef. 1-1-95; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99

410-140-0040
Prior Authorization

(1) Prior Authorization (PA) requirements for services or supplies listed in the Visual Services guide are intended for clients that are not enrolled in a Fully Capitated Health Plan (FCHP). Contact the client's FCHP for their policy governing PA requirements.

(2) PA is approved by the Division of Medical Assistance Programs (DMAP) prior to the provision of services to make payment for medically appropriate services for clients that are not enrolled in an FCHP. To obtain a PA for vision services for clients that are enrolled in an FCHP, call the FCHP.

(3) If a claim has been denied because PA was not obtained prior to the service, or the rules as established by DMAP or the FCHP were not followed, neither DMAP, the FCHP, nor the client are responsible for payment.

(4) A PA number must be present on the billing claim for any visual service with a "PA" indicator in this guide, or the claim will be denied.

(5) All dispensing of ophthalmic materials by a provider other than a physician or optometrist require a written prescription signed by a physician or optometrist.

(6) PA does not guarantee payment.

(7) PA does not guarantee eligibility. Always check for eligibility on the date of service. After eligibility has been verified, (see General Rule 410-120-1140, that covers eligibility), it is the responsibility of the provider to determine if the service requires PA If a PA is required and the client is:

(a) Fee-for-service (not enrolled in an FCHP) — Obtain PA from DMAP as outlined below;

(b) Enrolled with an FCHP — Contact the FCHP for their policy governing PAs.

(8) DMAP will review documentation submitted to determine if a PA will be made. PA requests which do not meet the rule criteria will be denied. If a PA is requested after the service has been rendered, it will be denied.

(9) DMAP will not accept phone calls for PA.

(10) To determine client eligibility, check the client's Medical Care ID for eligibility information or call AIS.

(11) The request for PA must be submitted and signed by the provider with the following information:

(a) The client's name and recipient number from the Medical Care ID;

(b) The provider's name and DMAP provider number;

(c) A description of the needed item or service. Use the appropriate procedure code from this guide and acquisition cost of the item, if applicable;

(d) A Statement of medical appropriateness 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 clinical data or evidence, including medical history, which provides additional information or may simplify the review process.

(12) Once DMAP receives the PA request from the provider SWEEP Optical will receive a Notice of Prior Authorization (DMAP 1072). The DMAP 1072 will specify the services authorized and show the nine-digit PA number. This number must be entered in Field 23 of the HCFA-1500, or in Field 23 of the DMAP 505, when appropriate. SWEEP Optical will then contact the provider. The provider will then fax or mail the prescription to SWEEP Optical.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 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 461-018-0010; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0170; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00

410-140-0050
Eligibility

(1) The Vision Program requires the following types of eligibility conditions to be verified:

(a) The provider must verify if the client is eligible for Medical Assistance Program coverage (Title XIX or Title XXI) and if the client is enrolled in an MCO or assigned to a PCCM;

(b) The provider must verify if the client is eligible to receive vision services. For example, some vision services such as an intermediate or comprehensive eye exam for the purpose of prescribing glasses or contacts are limited to once every 24 months for adults. The provider must verify if the client has received these services within the limitation period from Division of Medical Assistance Programs (DMAP) and/or the client's FCHP.

(2) To Verify Service Eligibility:

(a) The provider must check the service being provided for any limitations;

(b) It is the responsibility of the provider to maintain accurate and complete client records. If a client is an established client, incomplete information on AIS does not dissolve the provider's responsibilities of informing the client that their benefit of an eye exam for the purpose of

prescribing glasses/contacts and the supply of glasses/contacts, has been exhausted;

(c) Some FCHP's may decide to allow more frequent exams for the purpose of prescribing glasses/contacts and the supply of glasses/contacts. If the client is enrolled in an FCHP, call the FCHP to find out what their policy is and if the client is eligible for these services. When calling the FCHP, the provider must inform the FCHP of the last date of service;

(d) AIS contains the last date of service for glasses/contacts. DMAP and several FCHPs contract with SWEEP Optical to provide vision materials. Regardless of the message on AIS, SWEEP Optical will not fill orders for clients that have received services in the past 24 months. When this happens:

(A) If the client is currently a fee-for-service client (not enrolled in an FCHP), DMAP will not pay for another pair of glasses/contacts (except when client has had cataract surgery within the last 120 days). If the client is not an established client of the provider and the client is currently a fee-for-service client, DMAP will reimburse the provider for the exam only;

(B) If the client is currently enrolled in an FCHP that has a contract with SWEEP Optical and the client received glasses/contacts through DMAP fee-for-service or through a previous FCHP who had a contract with SWEEP Optical, SWEEP Optical will refuse to fill the order. It is the responsibility of the provider to contact the client's FCHP and give them the last date of service and the current FCHP will determine if they want to allow for an additional supply of glasses/contacts. If the client is an established client, regardless of incomplete information from AIS or SWEEP Optical it is the responsibility of the provider to inform the FCHP the last date of service.

(e) 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 the "Contracted Services" section of this guide). SWEEP Optical is prohibited by contract to sell materials and supplies for non-eligible clients at the State Contracted Price.

(f) AIS can verify client eligibility for Oregon's Medical Assistance Programs for past and present dates. AIS can only verify vision service history for a client for the day the provider accesses AIS (see the AIS User's guide). AIS does not verify future dates.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 11-2002, f. & cert. ef. 4-1-02

410-140-0060
Health Insurance Claim Form (CMS-1500)

(1) Opticians, optometrists and ophthalmologists bill using the CMS-1500.

(2) Optometrists and ophthalmologists use the DMAP 505 form for those clients who have Medicare/Medical Assistance Program coverage, if Medicare transmits incorrect information to Division of Medical Assistance Programs (DMAP). Opticians cannot bill Medicare.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 12-1992, f. & cert. ef. 4-1-92; Renumbered from 461-018-0180, 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; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 87-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04

410-140-0080
Medicare/Medicaid Assistance Program Claims

(1) When a client has both Medicare and coverage through the Division of Medical Assistance Programs (DMAP), optometrists and ophthalmologists must bill Medicare first for Medicare covered services.

(2) Refer to OAR 410-120-1210 (General Rules) for information on DMAP reimbursement.

(3) Medicare will automatically forward your claim to DMAP.

(4) In all of the following situations, bill DMAP on the DMAP 505 or 837P:

(a) If Medicare sends incorrect claim information to DMAP and no payment is made on the entire claim;

(b) If an out-of-state Medicare carrier or intermediary was billed;

(c) If Medicare does not cover the service:

(A) If submitting a paper claim, enter any Medicare payment received in the "Amount Paid" field (Field 28) or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" (Field 9) portion on the DMAP 505. Be sure to enter the Medicare Maximum Allowable in Field 24H.

(B) If any billing corrections are needed and DMAP made payment, the provider must submit an Adjustment Request (DMAP 1036) to correct payment;

(d) If Medicare crosses the claim over incorrectly or it does not cross-over.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0190; HR 37-1992, f. & cert. ef. 12-18-92; HR 15-1994, f. & cert. ef. 3-1-94; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04; OMAP 22-2006, f. 6-12-06, cert. ef. 7-1-06

410-140-0110
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 87-2002, f. 12-24-02, cert. ef. 1-1-03

410-140-0115
Standard Benefit Package

Visual services for the purpose of vision correction, including routine eye examinations, frames, lenses, contacts, vision aids, and orthoptic and/or pleoptic training (vision therapy) are not covered under the OHP Standard Benefit Package.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04

410-140-0120
Procedure Codes

(1) Providers billing CPT/HCPCS codes must use the CPT or HCPCS codes that are effective for the current Calendar Year. The CPT/HCPCS codes most commonly used by optometrists and opticians are listed in the Visual Services guide. Ophthalmologists should refer to the Medical-Surgical Services guide for additional coverage information:

(a) Always use the most applicable CPT/HCPCS code. Do not "unbundle" coding when services can be included in a single code;

(b) Always read the definition at the beginning of each section of CPT/HCPCS to verify the level of service.

(2) Evaluation and Management codes from CPT cannot be used in lieu of the intermediate, comprehensive 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) Modifiers can be used with any code. The Division of Medical Assistance Programs (DMAP) will recognize modifiers from CPT, HCPCS and Oregon Medicare.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0210; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 44-2001, f. 9-24-01 cert. ef. 10-1-01; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 11-2002, f. & cert. ef. 4-1-02

410-140-0140
Ophthalmological Diagnostic and Treatment Services Coverage

(1) Ophthalmological diagnostic and treatment services are not limited except as directed by the rules contained in the Visual Services guide, General Rules — Medical Assistance Benefits: Excluded Services and Limitations, and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows:

(a) Coverage for diagnostic services and treatment for those services funded on the HSC List; and

(b) Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HSC List; (The date of service determines the appropriate version of the General Rules and HSC List to determine coverage).

(2) Adults (age 21 and over): Reimbursement for ophthalmological examinations for the purpose of prescribing glasses/contacts 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.

(3) Ophthalmological intermediate and comprehensive exam services are not limited for medical diagnosis.

(4) If the client is assigned to a Primary Care Case Manager (PCCM) the provider must get a referral for a medical eye exam prior to the service being rendered.

(5) Frames and lenses for adults age 21 and over are limited to once every 24 months. No coverage for glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes.

(6) Children (birth through age 20): All ophthalmological examinations are covered when documentation in the clinical record justifies the medical need.

(7) If the client is assigned to a PCCM the provider must get a referral for a medical eye exam prior to the service being rendered.

(8) Refractions: Determination of the refractive State is included in an ophthalmological examination and may not be billed as a separate service. The determination of the refractive state is limited to once every 24 months for adults age 21 and over for the purpose of prescribing glasses/contacts. The refraction can be billed as a separate sole service, if the refraction is done as a stand alone service to follow a medical condition such as, but not limited to, multiple sclerosis and is not limited for medical diagnosis.

(9) General Ophthalmological Services: See Definitions under Ophthalmology section in the current CPT/HCPCS code book for definitions and examples of levels of service.

(10) New Client: A new client 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:

(a) 92002 Ophthalmological services: Medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new client;

(b) 92004 Comprehensive, new client, one or more visits.

(11) Established Client: An established client 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:

(a) 92012 Ophthalmological services: Medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established client;

(b) 92014 Comprehensive, established client, one or more visits. Table 0140-1.

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 24-1984(Temp), f. & ef. 5-29-84; AFS 31-1984(Temp), f. 7-26-84, ef. 8-1-84; AFS 5-1985, f. & ef. 1-25-85; AFS 22-1987, f. 5-29-87, ef. 7-1-87; AFS 75-1989, f. & cert. ef. 12-15-89, Renumbered from 461-018-0012; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0220; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00

410-140-0160
Coverage for Contact Lenses

(1) Coverage for Adults (age 21 or older):

(a) Prior Authorization is required for contact lenses for adults, except for the medical condition of Keratoconus. See OAR 410-140-0040, Prior Authorization, for information on requesting prior authorization. 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-contacts for Keratoconus does not require PA;

(C) Anisometropia when the difference in power between two eyes is 3 diopters or greater;

(D) Nystagmus;

(E) Irregular astigmatism;

(F) Aphakia.

(b) Prescription and fitting of either contact lenses or glasses is limited to once every 24 months. Replacement of contact lenses is limited to a total of two contacts every 12 months, and does not require PA;

(c) Corneoscleral lenses are not covered.

(2) Coverage for 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-contacts for Keratoconus does not require PA;

(C) Anisometropia when the difference in power between two eyes is 3 diopters or greater;

(D) Nystagmus;

(E) Irregular astigmatism;

(F) Aphakia.

(b) Replacement of contact lenses is covered when documented as medically appropriate in the clinical record, and does not require PA;

(c) Corneoscleral lenses are not covered.

(3) General Information regarding contact lens coverage:

(a) Contact lenses may be obtained through SWEEP Optical. Include brand names with prescription information when ordering contact lenses. Contact lenses not obtained through SWEEP Optical must be billed to the Division of Medical Assistance Programs (DMAP) at the provider's Acquisition Cost. Acquisition cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item. Payment for contact lenses not obtained through SWEEP Optical will be the lesser of DMAP fee schedule or acquisition cost.

(b) The prescription for contact lenses includes specifying the optical and physical characteristics (such as power, size, curvature, flexibility, gas permeability).

(c) Fitting contact lenses includes instruction and training of the wearer and incidental revision of the lens during the training period.

(d) Follow-up of successfully fitted extended wear lenses is part of the general opthalmological service (such as office visits). Adaptation of contacts due to trauma or disease is not included as part of the general service. The client's record must show clear documentation of the trauma or disease to support additional reimbursement for follow-up visits.

(4) 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; for Keratoconus use 92070;

(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;

(e) V2510-Contact lens, gas permeable, spherical, per lens;

(f) V2511-Contact lens, gas permeable, toric or prism ballast, per lens;

(g) V2520-Contact lens, hydrophilic, spherical, per lens;

(h) V2521-Contact lens, hydrophilic, toric or prism ballast, per lens.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0230; HR 37-1992, f. & cert. ef. 12-18-92; HR 5-1995, f. & cert. ef. 3-1-95; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04

410-140-0180
Ocular Prosthetics, Artificial Eye

(1) Ocular prosthesis and related services are covered for clients 20 years or younger with documentation of medical necessity in the client's medical record.

(2) The following CPT codes apply:

(a) V2623 Prosthetic Eye, Plastic custom after removal. Limited to one prosthesis every five years after age 20. Supplier must keep on file an order for the prosthesis that is signed and dated by the ordering physician;

(b) V2624 Polishing /resurfacing of ocular prosthesis. Limited to once a year after age 20;

(c) V2625 Enlargement of ocular prosthesis. One enlargement or reduction of the prosthesis is covered every five years after age 20;

(d) V2626 Reduction of ocular prosthesis. One enlargement or reduction of the prosthesis is covered every five years after age 20.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0240; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 22-2006, f. 6-12-06, cert. ef. 7-1-06

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 either glasses or contact lenses is limited to once every 24 months for adults (age 21 years and older), except when dispensing glasses within one year following corneal transplantation or 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. When billing for fitting within one year of corneal transplantation document the date of surgery on the claim. (See OAR 410-140-0160 for information on coverage of contact lenses.) 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 the Division of Medical Assistance Programs (DMAP). 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 140-0200.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0250; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 56-2002, f. & cert. ef. 10-1-02; OMAP 60-2003, f. 9-5-03, cert. ef. 10-1-03

410-140-0210
Buy-Ups

(1) When a client wants to pay the difference for a frame, lens type, or supply that is not on contract.

(2) Buy-ups are prohibited. Please refer to OAR 410-120-1350 for specific language on buy-ups.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 20-1999, f. & cert. ef. 4-1-99

410-140-0220
Other Procedures

CPT Code 92499 By Report — Requires prior authorization.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0260; 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; Notation on Prescriptions — Follow criteria outlined in OAR 410-121-0144.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 9-1978, f. & ef. 2-1-78; AFS 75-1989, f. & cert. ef. 12-15-89, Renumbered from 461-018-0005; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0270; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02

410-140-0260
Purchase of Ophthalmic Materials

(1) The Division of Medical Assistance Programs (DMAP) buys materials (i.e., frames, lenses, specialty frames, contact lenses and miscellaneous items) through SWEEP Optical. Rates for materials are negotiated by the Oregon Department of Administrative Services. All frames listed in the DMAP Visual Services guide and the lenses and miscellaneous items filled 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 either one complete pair of glasses (frame and lenses) or contact lenses every 24 months. See OAR 410-140-0160 for information on coverage of contact lenses.

(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 (birth through age 20) are covered for glasses when it is documented in the physician/optometrist's clinical record as medically appropriate.

(5) Ophthalmic materials that are not covered include, but are not limited to the following:

(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, nearvision telescopes, and compound microscopic lens systems;

(f) Extra or spare pairs of glasses or contacts;

(g) Anti-reflective lens coating;

(h) U-V lens;

(i) Progressive and blended lenses;

(j) Bifocals and trifocals segments over 28mm including executive;

(k) Aniseikonia lenses;

(l) Sunglasses.

(6) Contractor Services: All materials and supplies must be provided by SWEEP Optical including any frames purchased "off" contract.

(7) Frames not "on" contract with Sweep Optical may be purchased through Sweep Optical if there is an unusual circumstance or medical need that prevents the client from using any of the existing frames or lenses. For example: A client has an unusually large head size that requires a larger frame than provided on the contract or a custom frame. This does not imply that a client can select an "off" contract frame because your office does not carry the full selection of contract frames or that the client does not approve of the selection.

(8) Frames purchased "off" contract require prior authorization. The provider working with the client should make every attempt to determine what frame will work and provide that information in writing to DMAP.

(9) If you need assistance with locating a frame to meet the client's need, you may also contact Sweep Optical's optician. Once the approval is granted, Sweep Optical will order and process the glasses. Frames "off" contract may exceed the limit of the required 7-10 calendar-day turn-around time frame.

(10) Scratch Coating is included in the lens service. Scratch coating cannot be charged to DMAP, the Fully Capitated Health Plan or the client as a separate service.

(11) Prior Authorization (PA):

(a) Materials provided by SWEEP Optical which require PA must be medically necessary and will be subject to the following limitations:

(A) Frames not listed in the Visual Services provider guide;

(B) Contact lenses — adults only (except for the treatment of injury or disease including Keratoconus);

(C) Polycarb lenses.

(b) PA will be sent to SWEEP Optical who then must forward a copy of the PA approval and number to the requesting provider.

(12) Limitations: The following services no longer require PA but are subject to strict limitations. The provider is responsible for providing SWEEP Optical with the specific documentation in writing as indicated under each service. It is the responsibility of the provider to maintain proper documentation of services provided to a client. Sweep Optical will not be responsible if DMAP determines the documentation in the client's record does not allow for the service as directed by the limitations indicated in the rules in this guide:

(a) Frames and lenses for adults age 21 and over are limited to once every 24 months. No coverage for glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes;

(b) Replacement frame fronts and temples for frames not listed in the Visual Services provider guide. Limited to frames purchased "off" contract with proper prior approval or when a client has a medical condition that requires the use of a specialty temple;

(c) Tints and Photochromic lenses: Limited to clients with documented albinism and pupillary defects. Documentation can only be provided by a physician or an optometrist. The physician or optometrist must select the most appropriate ICD-9-CM code and supply the code to SWEEP Optical;

(d) Other medically necessary items for a contract frame (i.e., cable temples, head-strap frame): When a client has a medical condition that requires the use of a specialty temple, nose pieces, head strap frame. Documentation can only be provided by a physician or an optometrist. Provide appropriate documentation for the add-on to SWEEP Optical;

(e) Nonprescription glasses: Limited to clients that do not require any correction in one eye and where there is blindness in one eye. The purpose of this exception is to offer maximum protection for the remaining functional eye. Documentation can only be provided by a physician or an optometrist. Provide appropriate documentation to Sweep Optical;

(f) High Index Lenses:

(A) Power is +/- 10 or greater in any meridian in either eye; or

(B) Prism diopters are 10 or more diopters in either lens.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 55-1983, f. 11-15-83, ef. 12-1-83; AFS 75-1989, f. & cert. ef. 12-15-89, Renumbered from 461-018-0011; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0280; HR 37-1992, f. & cert. ef. 12-18-92; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; HR 15-1996(Temp), f. & cert. ef. 7-1-96; HR 26-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 11-2002, f. & cert. ef. 4-1-02; OMAP 56-2002, f. & cert. ef. 10-1-02

410-140-0280
Vision Therapy Services

(1) Vision therapy is not covered for adults (age 21 and older).

(2) Vision therapy is only covered for children (birth through age 20) for treatment of strabismus and other disorders of binocular eye movements (See the Health Services Commission's Prioritized List of Health Services). It is limited to a total of six sessions per calendar year without prior authorization (additional therapy sessions require prior authorization):

(a) The therapy treatment plan and regimen will be taught to the client, 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 client, family, foster parents, and/or caregiver is not a reimbursable service;

(b) Include the following additional information on the DMAP 3071 (Request for Prior Authorization):

(A) Client's name;

(B) Medical Assistance Program recipient number;

(C) Date of birth;

(D) Provider number;

(E) Procedure code;

(F) Medical justification;

(G) Diagnosis and ICD-9-CM code (to the highest specificity);

(H) Development diagnostic exam result;

(I) Goals and objectives.

(3) Evaluation and Management CPT codes, or any unlisted CPT or HCPC procedure code, cannot be used to bill the Division of Medical Assistance Programs (DMAP) for vision therapy services. Vision Therapy Services are limited to code 92065, Orthoptic and/or pleoptic training with continuing medical direction and evaluation. Use this code for initial evaluation exam:

(A) Limited to six sessions per calendar year;

(B) More than six sessions require prior authorization.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0290; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 24-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 56-2002, f. & cert. ef. 10-1-02

410-140-0300
Postsurgical Care

The Division of Medical Assistance Programs (DMAP) 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 and modifer codes.

Stat. Auth.: ORS 184.750 & 184.770

Stats. Implemented: ORS 414.065

Hist.: HR 15-1992, f. & cert. ef. 6-1-92; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05

410-140-0380
Administrative Exam Services Authorized by the Branch Office

Refer to the Administrative Examination and Billing Services rules for information on administrative examinations.

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

Stat. Auth.: ORS 409.010 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 37-1992, f. & cert. ef. 12-18-92; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04

410-140-0400
Contractor Services

(1) The Division of Medical Assistance Programs (DMAP) contracts with SWEEP Optical Laboratories to provide vision materials and supplies. 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. It is the responsibility of the requesting provider to check client eligibility prior to mailing or faxing an order to the Contractor. 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 DMAP 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 DMAP until the order has been completed and shipped.

(7) Contractor must bill DMAP using HCPCS Codes listed in the contract agreement. Payment will be at contracted rates. Refer to Supplemental Information, found on the DMAP website, for billing instructions.

(8) Contractor will provide display frames to the ordering provider at a cost not to exceed the contract cost.

(9) 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.

(10) Unisex frame styles for men, women, girls or boys are available through the Contractor.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 37-1992, f. & cert. ef. 12-18-92, Renumbered from 461-018-0300; HR 15-1994, f. & cert. e.f 3-1-94; HR 5-1995, f. & cert. ef. 3-1-95; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 44-2001, f. 9-24-01 cert. ef. 10-1-01; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05

DIVISION 141

OREGON HEALTH PLAN

410-141-0000
Definitions

(1) Action — In the case of a Prepaid Health Plan (PHP):

(a) The denial or limited authorization of a requested Covered Service, including the type or level of service;

(b) The reduction, suspension or termination of a previously authorized service;

(c) The denial in whole or in part, of payment for a service;

(d) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (DMAP);

(e) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For a DMAP Member in a single Fully Capitated Health Plan (FCHP) or Mental Health Organization (MHO) Service Area, the denial of a request to obtain Covered Services outside of the FCHP or MHO's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(2) Addictions and Mental Health Division (AMH) – The DHS office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.

(3) Administrative Hearing — A Department of Human Services (DHS) hearing related to an Action, including a denial, reduction, or termination of benefits that is held when requested by the Oregon Health Plan (OHP) Client or DMAP Member. A hearing may also be held when requested by an OHP Client or DMAP Member who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(4) Advance Directive — A form that allows a person to have another person make health care decisions when he/she cannot make decisions and tells a doctor if the person does not want any life sustaining help if he/she is near death.

(5) Aged — Individuals who meet eligibility criteria established by DHS Seniors and People with Disabilities Division (SPD) for receipt of medical assistance because of age.

(6) 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.

(7) Alternative Care Settings — Sites or groups of Practitioners that provide care to DMAP Members under contract with the DMAP Member's 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, and outpatient surgicenters.

(8) Ancillary Services — Those medical services under the OHP not identified in the definition of a Condition/Treatment Pair, but Medically Appropriate to support a service covered under the OHP Benefit Package. Ancillary Services and limitations are referenced in the General Rules Benefit Packages (410-120-1210), Exclusions (410-120-1200) and applicable individual program rules.

(9) Appeal — A request for review of an Action as defined in this rule.

(10) Automated Information System (AIS) — A computer system that provides information on the current eligibility status for clients under the Medical Assistance Program by phone or by Web access.

(11) Blind — Individuals who meet eligibility criteria established by DHS' SPD for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(12) Capitated Services — Those Covered Services that a PHP or Primary Care Manager (PCM) agrees to provide for a Capitation Payment under a DMAP OHP Contract or agreement.

(13) Capitation Payment:

(a) Monthly prepayment to a PHP for the provision of all Capitated Services needed by OHP Clients who are enrolled with the PHP;

(b) Monthly prepayment to a PCM to provide Primary Care Management Services for an OHP Client who is enrolled with the PCM. Payment is made on a per OHP Client, per month basis.

(14) Centers for Medicare and Medicaid Services (CMS) — The federal agency under the Department of Health and Human Services (DHHS), responsible for approving the waiver request to operate the OHP Medicaid Demonstration Project.

(15) CFR— Code of Federal Regulations.

(16) Chemical Dependency Organization (CDO) — a PHP that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the OHP. All Chemical Dependency Services covered under the OHP are covered as Capitated Services by the CDO.

(17) 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."

(18) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by DHS' DMAP (see Medical Assistance).

(19) Children Receiving Children, Adults and Families (CAF) Child Welfare or Oregon Youth Authority (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 CAF, DHS, or OYA who are in placement outside of their homes.

(20) Claim — (1) A bill for services, (2) a line item of a service, or (3) all services for one Client within a bill.

(21) Clinical Record — The Clinical Record includes the medical, dental, or mental health records of an OHP Client or DMAP Member. These records include the PCP's record, the inpatient and outpatient hospital records and the Exceptional Needs Care Coordinator (ENCC), Complaint and Disenrollment for cause records which may reside in the PHP's administrative offices.

(22) Cold Call Marketing — Any unsolicited personal contact by a PHP with a Potential Member for the purpose of Marketing as defined in this rule.

(23) 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 rules), 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 whose life-threatening conditions 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 with the intent to prolong life.

(24) 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 DHS Addictions and Mental Health Division (AMH).

(25) Co-morbid 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.

(26) Complaint — A DMAP Member's or DMAP Member's Representative's expression of dissatisfaction to a PHP or Participating Provider about any matter other than an Action, as "Action" is defined in this rule.

(27) Community Standard — Typical expectations for access to the health care delivery system in the DMAP Member's or PCM Member's community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, DMAP requires that the health care delivery system available to DMAP Members in PHPs and to PCM Members take into consideration the Community Standard and be adequate to meet the needs of DMAP and PCM Members.

(28) 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 the DHS AMH 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 referred to in OAR 410-141-0520.

(29) 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 an OHP Benefit Package that doesn't cover the treatment.

(30) Co-payment — The portion of a Covered Service that a DMAP Member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.

(31) Contract — The Contract between the State of Oregon, acting by and through its DHS, DMAP and an FCHP, Dental Care Organization (DCO), Physician Care Organization (PCO), or a CDO, or between AMH and an MHO for the provision of Covered Services to eligible DMAP Members for a Capitation Payment. Also referred to as a Service Agreement.

(32) Covered Services — Are Medically Appropriate health services that are funded by the Legislature and described in ORS 414.705 to 414.750; OAR 410-120-1210; 410-141-0120; 410-141-0520; and 410-141-0480; except as excluded or limited under OAR 410-141-0500 and rules in chapter 410, division 120.

(33) 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 OHP 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 a DMAP Member.

(34) Dental Care Organization (DCO) — A PHP that provides and coordinates capitated dental services. All dental services covered under the OHP are covered as Capitated Services by the DCO; no dental services are paid by DMAP on a Fee-for-Service (FFS) basis for OHP Clients enrolled with a DCO Provider.

(35) Dental Case Management Services — Services provided to ensure that eligible DMAP Members obtain dental services including a comprehensive, ongoing assessment of the dental and medical needs related to dental care of the DMAP Member plus the development and implementation of a plan to ensure that eligible DMAP Members obtain Capitated Services.

(36) Dental Emergency Services — Dental services that may include but are not limited to severe tooth pain, unusual swelling of the face or gums, and an avulsed tooth.

(37) Dental Practitioner — A Practitioner who provides dental services to DMAP Members under an agreement with a DCO, or is a FFS 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.

(38) Department of Human Services (DHS) — The Department or DHS or any of its programs or offices means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (DMAP). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMH). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and Families or CAF is used in contract or rule, it shall mean the Children, Adults and Families Division (CAF). Wherever the former Health Division is used in Contract or in rule, it shall mean the Public Health Division (PHD).

(39) 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.

(40) Disabled — Individuals who meet eligibility criteria established by the DHS' SPD for receipt of Medical Assistance because of a disability.

(41) Disenrollment — The act of discharging an OHP Client from a PHP's or PCM's responsibility. After the effective date of Disenrollment an OHP Client is no longer required to obtain Capitated Services from the PHP or PCM, nor be referred by the PHP for Medical Case Managed Services or by the PCM for PCM Case Managed Services.

(42) Division of Medical Assistance Programs (DMAP) — The Office of DHS responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and CHIP. DMAP writes and administers the state Medicaid rules for medical services, contracts with Providers, maintains records of client eligibility and processes and pays DMAP providers.

(43) Emergency Medical Condition — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

(44) Emergency Services — Covered Services furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(45) Enrollment — OHP Clients, subject to OAR 410-141-0060, become DMAP Members of a PHP or PCM Members of a PCM that contracts with DMAP to provide Capitated Services. An OHP Client's Enrollment with a PHP indicates that the DMAP 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 OHP Client's Enrollment with a PCM indicates that the PCM Member must obtain or be referred by the PCM for preventive and primary care and referred by the PCM for all PCM Case Managed Services subsequent to the effective date of Enrollment.

(46) Enrollment Area — Client Enrollment is based on the Client's residential address and zip code. The address is automatically assigned a county code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the DHS worker that PHPs are in the area.

(47) Enrollment Year — A twelve-month period beginning the first day of the month of Enrollment of the OHP 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 OHP Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(48) 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.

(49) Exceptional Needs Care Coordination (ENCC) — A specialized case management service provided by FCHPs to DMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405. ENCC includes:

(a) Early identification of those DMAP Members who are Aged, Blind or Disabled who 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.

(50) Family Health Insurance Assistance Program (FHIAP) — A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the Federal Poverty Level (FPL). FHIAP is funded with federal and states funds through Title XIX, XXI or both.

(51) 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.

(52) Fee-for-Service (FFS) Health Care Providers — Health care providers who bill for each service provided and are paid by DMAP for services as described in DMAP provider rules. Certain services are covered but are not provided by PHPs or by PCMs. The client may seek such services from an appropriate FFS Provider. PCMs provide primary care services on a FFS basis and might also refer PCM Members to specialists and other Providers for FFS 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 FFS Providers.

(53) FPL — Federal Poverty Level.

(54) Free-Standing Mental Health Organization (MHO) — The single MHO in each county that provides only mental health services and is not affiliated with an FCHP for that service area. In most cases this "carve-out" MHO is a county CMHP or a consortium of CMHPs, but may be a private behavioral health care company.

(55) Fully Capitated Health Plan (FCHP) — PHPs that contract with DMAP to provide Capitated Services under the OHP. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(56) Fully Dual Eligible — For the purposes of Medicare Part D coverage, Medicare Clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by DHS for full medical assistance coverage, including those not enrolled in a Medicare Part D plan.

(57) Grievance System —The overall system that includes Complaints and Appeals handled at the PHP level and access to the state fair hearing process. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the DMAP Member's rights.

(58) 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, Licensed 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 DMAP Members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification.

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

(60) Health Maintenance Unit (HMU) — The DMAP unit responsible for adjustments to enrollments, retroactive Disenrollment and Enrollment of newborns.

(61) Health Plan New/Noncategorical Client (HPN) — A person who is 19 years of age or older, 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 OHP Client.

(62) 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.

(63) 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.

(64) Hospital Hold — A Hospital Hold is a process that allows a hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the OHP due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP if clients become eligible through a Hospital Hold process and are placed in the adults/couples category.

(65) 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 OHP Medicaid Demonstration Project.

(66) Local and Regional Allied Agencies include the following: local Mental Health Authority; CMHPs; local DHS offices; 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.

(67) Marketing — Any communication from a PHP to an OHP Client who is not enrolled in that PHP which can reasonably be interpreted as an attempt to influence the OHP Client:

(a) To enroll in that particular PHP;

(b) To either Disenroll or not to enroll with another PHP.

(68) Marketing Materials — Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for Marketing as defined in this rule.

(69) Medicaid — A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS.

(70) Medical Assistance Program — A program for payment of health care provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and CHIP. The Medical Assistance Program is administered by DMAP, of DHS. Coordination of the Medical Assistance Program is the responsibility of DMAP.

(71) Medical Care Identification — The preferred term for what is commonly called the "medical card." It is a letter-sized document issued monthly to Medical Assistance Program Clients to verify their eligibility for services and enrollment in PHPs.

(72) Medical Case Management Services — Services provided to ensure that DMAP 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.

(73) 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 OHP Client or a Provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a DMAP Member or PCM Member in the PHP's or PCM's judgment.

(74) Medicare — The federal health insurance program for the Aged and Disabled administered by CMS under Title XVIII of the Social Security Act.

(75) Medicare Advantage— A capitated health plan that meets specific referral lines and contracts with CMS to provide Medicare benefits to Medicare enrollees.

(76) Mental Health Assessment — The determination of a DMAP 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.

(77) Mental Health Case Management — Services provided to DMAP 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 DMAP Member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring DMAP 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.

(78) Mental Health Organization (MHO) — A PHP under contract with AMH that provides mental health services as Capitated Services under the OHP. MHOs can be FCHPs, CMHPs or private behavioral organizations or combinations thereof.

(79) Non-Capitated Services — Those OHP-covered services that are paid for on a FFS basis and for which a capitation payment has not been made to a PHP.

(80) 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 OHP. Non-Covered Services for the OHP are identified in:

(a) OAR 410-141-0500;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual Provider administrative rules.

(81) Non-Participating Provider — A provider who does not have a contractual relationship with the PHP, i.e. is not on their panel of Providers.

(82) DMAP Member — An OHP Client enrolled with a PHP.

(83) Ombudsman Services — Services provided by DHS to Aged, Blind and Disabled OHP Clients by DHS Ombudsman Staff who may serve as the OHP Client's advocate whenever the OHP Client, Representative, a physician or other medical personnel, or other personal advocate serving the OHP Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the OHP. Ombudsman Services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about OHP systems.

(84) Oregon Health Plan (OHP) — The Medicaid demonstration project that expands Medicaid eligibility to eligible OHP Clients. The OHP 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.

(85) Oregon Health Plan (OHP) Plus Benefit Package — A benefit package available to eligible OHP Clients as described in OAR 410-120-1210.

(86) Oregon Health Plan (OHP) Standard Benefit Package — A benefit package available to eligible OHP Clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210.

(87) Oregon Health Plan (OHP) Client — An individual found eligible by DHS to receive services under the OHP. The OHP categories eligible for enrollment are defined as follows:

(a) Temporary Assistance to Needy Families (TANF) are categorically eligible with income under current eligibility rules;

(b) CHIP — children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;

(c) Poverty Level Medical (PLM) Adults under 100% of the FPL are OHP Clients who are pregnant women with income under 100% of FPL;

(d) PLM Adults over 100% of the FPL are OHP Clients who are pregnant women with income between 100% and 185% of the FPL;

(e) PLM children under one year of age have family income under 133% of the FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(h) OHP Adults and Couples are OHP Clients aged 19 or over and not Medicare eligible, with income below 100% of the 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;

(i) OHP Families are OHP Clients, aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) General Assistance (GA) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(k) Assistance to Blind and Disabled (AB/AD) with Medicare Eligibles are OHP Clients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(m) Old Age Assistance (OAA) with Medicare Eligibles are OHP Clients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(p) CAF Children are OHP Clients who are children with medical eligibility determined by CAF or OYA 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 CAF or OYA who are in placement outside of their homes.

(88) Oregon Youth Authority (OYA) — 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.

(89) Participating Provider — An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to DMAP Members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.

(90) PCM 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 (RHC), Migrant and Community Health Clinics, Federally Qualified Health Centers (FQHC), County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, CMHPs, MHOs; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(91) PCM Member — An OHP Client enrolled with a PCM.

(92) PHP Coordinator — the DHS DMAP employee designated by DMAP as the liaison between DMAP and the PHP.

(93) Physician Care Organization (PCO) — PHP that contracts with DMAP to provide partially capitated health services under the OHP. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.

(94) Post Hospital Extended Care Benefit — A 20-day benefit for non- Medicare DMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(95) Post Stabilization Services — Covered Services, related to an Emergency Medical Condition that are provided after a DMAP Member is stabilized in order to maintain the stabilized condition or to improve or resolve the DMAP Member's condition.

(96) Potential DMAP Member — An OHP Client who is subject to mandatory Enrollment in managed care, or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.

(97) 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.

(98) Prepaid Health Plan (PHP) — A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under the OHP. PHPs may be DCOs, FCHPs, MHOs, PCOs or CDOs.

(99) Preventive Services — Those services as defined under Expanded Definition of Preventive Services for OHP Clients in OAR 410-141-0480, and OAR 410-141-0520.

(100) Primary Care Management Services — Primary Care Management Services are services provided to ensure PCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care 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 PCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(101) Primary Care Manager (PCM) — A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician backups, who agrees to provide Primary Care Management Services as defined in rule to PCM Members. PCMs may also be hospital primary care clinics, RHCs, Migrant and Community Health Clinics, FQHCs, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCM provides Primary Care Management Services to PCM Members for a Capitation Payment. The PCM provides preventive and primary care services on a FFS basis.

(102) Primary Care Dentist (PCD) — A Dental Practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for DMAP Members. PCDs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(103) Primary Care Provider (PCP) — A Practitioner who has responsibility for supervising and coordinating initial and primary care within their scope of practice for DMAP Members. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(104) Prioritized List of Health Services — The listing of Condition and Treatment Pairs developed by the Health Services Commission for the purpose of implementing the OHP Demonstration Project. See OAR 410-141-0520, for the listing of Condition and Treatment Pairs.

(105) 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.

(106) Provider — An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(107) 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."

(108) Representative — A person who can make OHP related decisions for OHP 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 OHP Client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the OHP Client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

(109) Rural — A geographic area 10 or more map miles from a population center of 30,000 people or less.

(110) Seniors and People with Disabilities Division (SPD) — The division within DHS responsible for providing services such as:

(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;

(b) Cash assistance grants for persons with long-term disabilities through GA and the Oregon Supplemental Income Program (OSIP); and

(c) Administration of the federal Older Americans Act.

(111) Service Area — The geographic area in which the PHP has identified in their Contract or Agreement with DHS to provide services under the OHP.

(112) Stabilize — No material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

(113) 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.

(114) Triage — Evaluations conducted to determine whether or not an emergency condition exists, and to direct the DMAP Member to the most appropriate setting for Medically Appropriate care.

(115) Urban — A geographic area less than 10 map miles from a population center of 30,000 people or more.

(116) Urgent Care Services — Covered Services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of a DMAP Member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services.

(117) Valid Claim:

(a) An invoice received by the PHP for payment of covered health care services rendered to an eligible Client that:

(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.

(b) A Valid Claim does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A Valid Claim is synonymous with the federal definition of a Clean Claim as defined in 42 CFR 447.45(b).

(118) 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.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000. f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07

410-141-0010
Prepaid Health Plan Contract Procurement Screening and Selection Procedures

(1) Basis and scope:

(a) The Department of Human Services (DHS) will use screening and selection procedures to procure Managed Care Services pursuant to

ORS 414.725. DHS may award Qualified Managed Care Organizations (MCO) a Contract as a prepaid health plan (PHP) for purposes of administering the Oregon Health Plan (OHP);

(b) The OHP is funded with federal Medicaid funds. DHS will interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with PHPs. DHS will seek prior federal approval of PHP contracts;

(c) For purposes of source selection and screening in the procurement of Managed Care Services, DHS may use:

(A) The Request for Application (RFA) process described in sections (3) through (6) of this rule; or

(B) Any method described in the Department of Justice's (DOJ) Model Rules (chapter 137, division 047) for source selection and procurement process, except for bidding.

(2) In addition to the terms defined in OAR 410-141-0000, the following definitions for screening and selection procedures apply:

(a) Addendum or Addenda — an addition or deletion to, a material change in, or general interest explanation of an RFA;

(b) Application — Documents submitted by an MCO that seeks qualification to be Awarded a Contract. The Applicant is the MCO submitting the Application;

(c) Award — As the context requires, the act or occurrence of DHS' identification of a qualified MCO with which DHS will enter into a Contract;

(d) Closing — The date and time announced in an RFA as the deadline for submitting Applications;

(e) MCO — A corporation, governmental agency, public corporation or other legal entity that operates as a managed health, dental, chemical dependency, physician care, or mental health organization;

(f) Managed Care Services — Capitated Services provided by a PHP pursuant to ORS 414.725;

(g) Offer — A response to an RFA, including all required responses and assurances, and the Certification of Application;

(h) Request for Applications (RFA) — All documents used by DHS for soliciting Applications for qualification in a specific RFA issued by DHS, for one or more categories of Contracts, one or more Service Areas or such other objective as DHS may determine is appropriate for solicitation of Managed Care Services.

(3) RFA Process:

(a) DHS will provide public notice of every RFA on its Web site. The RFA will indicate how prospective Applicants will be made aware of Addenda by posting notice of the RFA on the electronic system for notifying the public of DHS procurement opportunities, or at the option of the requestor, mailing notice of the availability of the RFA to persons that have expressed interest in DHS procurement of Managed Care Services;

(b) The RFA process begins with a public notice of the RFA, which will be communicated with the electronic notification system used by DHS to notify the public of procurement opportunities. A public notice of a RFA shall identify the qualification requirements for the category of contract (e.g., FCHP, DCO, etc.), the designated Service Area(s) where Managed Care Services are requested or other objective that DHS determines appropriate for solicitation of Managed Care Services, and a sample Contract;

(c) DHS will provide notice of any RFA Addenda in a manner intended to foster competition and to make prospective Applicants aware of the Addenda. The RFA will specify how DHS will provide notice of Addenda;

(d) If the RFA so specifies, potential Applicants must submit a letter of intent to DHS within the time period specified in the RFA. The letter of intent does not commit any potential Applicant to apply, however, if required, DHS will not consider Applications from Applicants who do not submit a timely letter of intent;

(e) Submitting the Application — DHS will only consider Applications that are submitted in the manner described in the RFA. Applicants must:

(A) Identify electronic Application submissions as defined in the RFA. DHS is not responsible for any failure attributable to the transmission or receipt of electronic or facsimile Applications, including but not limited to receipt of garbled or incomplete documents, delay in transmission or receipt of documents, or security and confidentiality of data;

(B) Submit Applications, when sent by mail, in a sealed envelope that is marked appropriately;

(C) Ensure DHS receives their Applications at the required delivery point prior to the Closing date, listed in the RFA. DHS will not accept late Applications.

(f) The Application must be completed as described in the RFA. To avoid duplication and burden, DHS may permit a current contractor to submit an abbreviated Application that focuses only on additional or different requirements specific to the new Contract or the new Service Area or capacity or other DHS objective that is the subject of the RFA;

(g) DHS will enter into or renew a Contract only if it determines that the action would be within the scope of the RFA and consistent with the effective administration of the OHP, including but not limited to:

(A) The capacity of any existing PHP(s) in the Service Area compared to the capacity of an additional PHP for the number of potential enrollees in the Service Area;

(B) The potential opportunity for Clients to have a choice of more than one PHP.

(h) Disclosure of Application Contents and Release of Information:

(A) Application information, including the letter of intent, shall not be disclosed to any Applicant (or other person) until the completion of the RFA process. The RFA process shall be considered complete when a Contract has been Awarded. No information will be given to any Applicant (or other person) relative to their standing with other Applicants during the RFA process;

(B) Application information shall be subject to disclosure upon the Award date, with the exception of information that has been clearly identified and labeled "Confidential" under ORS 192.501–192.502, insofar as DHS determines it meets the requirements for an exemption from disclosure;

(C) Any requestor shall be able to obtain copies of non-exempt information after the RFA process has been completed. The requestor shall be responsible for the time and material expense associated with the request. This fee includes the copying of the document(s) and the staff time (and agency attorney time, if requested by DHS) associated with performing the task, in accordance with ORS 192.440(3). DHS may require prepayment of estimated charges before acting on a request:

(i) Protests must be submitted, in writing, to DHS prior to the protest date specified in the RFA. The protest shall state the reasons for the protest or request and any proposed changes to the RFA provisions, specifications or contract terms and conditions that the prospective Applicant believes will remedy the conditions upon which the protest is based. Protests and judicial review of the RFA shall be handled using the process set forth in OAR 137-047-0730;

(j) DHS is not obligated to enter into a Contract with any Applicant, and further, has no financial obligation to any Applicant.

(4) Application for qualification:

(a) An MCO seeking qualification as a PHP must meet the requirements and provide the assurances specified in the RFA. DHS determines whether the MCO qualifies based on the Application and any additional information and investigation that DHS may require;

(b) DHS determines an MCO is qualified when the MCO meets the requirements of the RFA, including written assurances, satisfactory to DHS, that the MCO:

(A) Provides or will provide the services described in the Contract;

(B) Provides or will provide the health services described in the Contract in the manner described in the Contract;

(C) Is organized and operated, and will continue to be organized and operated, in the manner required by the Contract and described in the Application;

(D) Under arrangements that safeguard the confidentiality of patient information and records, will provide to DHS, CMS, the Office of Inspector General, the Oregon Secretary of State, and the Oregon Medicaid Fraud Unit of the DOJ, or any of their duly authorized representatives, for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the MCO relating to its operation as a PHP and to any facilities that it operates; and

(E) Will continue to comply with any other assurances it has given DHS.

(c) DHS may determine that an MCO is potentially qualified if within a specified period of time the MCO is reasonably susceptible of being made qualified. DHS is not obligated to determine whether an Applicant is potentially qualified if, in its discretion, DHS determines that sufficient qualified Applicants are available to obtain DHS' objectives under the RFA. DHS determines that an MCO is potentially qualified if:

(A) DHS finds that the MCO is reasonably susceptible to meeting the operational and solvency requirements of the Application within a specified period of time; and

(B) The MCO enters into discussions with DHS about areas of qualification that must be met before the MCO is operationally and financially qualified. DHS will determine the date and required documentation and written assurances required from the MCO;

(C) If DHS determines that a potentially qualified Applicant cannot become a qualified MCO within the time announced in the RFA for Contract Award, DHS may:

(i) Offer the Contract at a future date when the Applicant demonstrates, to DHS' satisfaction, that the Applicant is a qualified MCO within the scope of the advertised RFA; or

(ii) Inform the Applicant that it is not qualified for Contract Award.

(5) Evaluation and determination procedures:

(a) DHS evaluates an Application for qualification on the basis of information contained in the RFA, the Application and any additional information that DHS obtains. Evaluation of the Application will be based on the criteria in the RFA;

(b) DHS will notify each MCO that applies for qualification of its qualification status;

(c) Review of DHS' qualification decisions shall be as set forth in ORS 279B.425;

(d) DHS may enter into negotiation with qualified or potentially qualified Applicants concerning potential capacity and enrollment in relation to other available, or potentially available, capacity and the number of potential enrollees within the Service Area. DHS may determine that it will limit Contract Award(s) to fewer than the number of qualified or potentially qualified Applicants, to achieve the objectives in the RFA.

(6) Contract award conditions:

(a) The Applicant's submission of the Application with the executed Certification of Application is the MCO's Offer to enter into a Contract. The Offer is a "Firm Offer," i.e., the Offer shall be held open by the Applicant for DHS' acceptance for the period specified in the RFA. DHS' Award of the Contract constitutes acceptance of the Offer and binds the Applicant to the Contract;

(b) No Contingent Offers. Except to the extent the Applicant is authorized to propose certain terms and conditions pursuant to the RFA, an MCO shall not make its Offer contingent upon DHS' acceptance of any terms or conditions other than those contained in the RFA;

(c) By timely signing and submitting the Application and Certification of Application, the Applicant acknowledges that it has read and understands the terms and conditions contained in the RFA and that it accepts and agrees to be bound by the terms and conditions of the RFA;

(d) DHS may Award multiple Contracts in accordance with the criteria set forth in the RFA. DHS may make a single Award or limited number of Awards rather than multiple Awards to all qualified or potentially qualified Applicants, in order to meet DHS' needs including but not limited to adequate capacity for the potential enrollees in the Service Area;

(e) An Applicant who claims to have been adversely affected or aggrieved by DHS Contract Award or intent to Award a Contract must file a written protest with the DHS issuing office within seven (7) calendar days after receiving the notice of Award. Protests and judicial review of Contract Award shall be handled using the procedures set forth in OAR 137-047-9740.

(7) Applicability of DOJ Model Rules: Except where inconsistent with the preceding sections of this rule, DHS will use the following DOJ Model Rules to govern solicitations for Managed Care Services:

(a) OAR 137-046 — General Provisions Related to Public Contracting: OAR 137-046-0100, 137-046-0110 and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 — Public Procurements for Goods or Services: OAR 137-047-0100, 137-047-0260 through 137-047-0330, 137-047-0400 through 137-047-0800.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 51-2005(Temp), f. 9-30-05, cert. ef. 10-1-05 thru 3-15-06; OMAP 3-2006, f. 2-7-06, cert. ef. 3-1-06

410-141-0020
Administration of Oregon Health Plan Regulation and Rule Precedence

(1) The Department of Human Services (DHS) and its Division of Medical Assistance Programs (DMAP) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.725 (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, DMAP will construe them as much as possible to be complementary. In the event that DMAP policies, procedures, rules and interpretations may not be complementary, DMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to DMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, DMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted DMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, DMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in DMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in OAR 410-141-0480 to 410-141-0520,and the provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by DMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs.

(b) For purposes of contract administration solely as between DMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to DMAP Clients:

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts;

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

410-141-0050
MHO Enrollment for Children Receiving Child Welfare Services

Pursuant to and in the administration of the authority in OAR 410-141-0060, Children, Adults and Families (CAF) or Oregon Youth Authority (OYA) selects Prepaid Health Plans (PHPs) or a Primary Care Manager (PCM) for a child receiving CAF Child Welfare Services or OYA Services, with the exception of children in subsidized adoption and guardianship. This rule implements and further describes how the Department of Human Services (DHS or Department) will administer its authority under OAR 410-141-0060 for purposes of making Enrollment decisions and OAR 410-141-0080 for purposes of making Disenrollment decisions for children receiving CAF Child Welfare Services or OYA Services;

(1) The Department has determined that, to the maximum extent possible, all children receiving CAF services should be enrolled in Mental Health Organizations (MHOs) at the next available enrollment date following eligibility, redetermination, or upon review by the Department, unless Disenrollment from a MHO is authorized by the Department in accordance with this section and OAR 410-141-0080:

(a) Notwithstanding OAR 410-141-0060(4)(a) or 410-141-0080(2)(b)(E), children receiving CAF services are not exempt from mandatory Enrollment in an MHO on the basis of Third Party Resources (TPR) mental health services coverage;

(b) A decision to use Fee-For-Service (FFS) open card for a child receiving CAF services should be reviewed by the Department if the child's circumstances change and at the time of redetermination to consider whether the child should be enrolled in a MHO.

(2) When a child receiving CAF services is being transferred from one MHO to another, or for children transferring from FFS to a MHO, the MHO must facilitate coordination of care consistent with OAR 410-141-0160:

(a) MHOs are required to work closely with the Department to ensure continuous MHO Enrollment for children receiving CAF services;

(b) If the Department determines that Disenrollment should occur, the MHO will continue to be responsible for providing Covered Services until the Disenrollment date established by the Department, which shall provide for an adequate transition to the next responsible MHO.

(3) It is not unusual for a child receiving CAF services to experience a change of placement that may be permanent or temporary in nature. Consistent with OAR 410-141-0080(2)(b)(F), DHS will verify the address change information to determine whether a child receiving CAF services no longer resides in the MHO's Service Area:

(a) A temporary absence as a result of a temporary placement out of the MHO's Service Area does not represent a change of residence if DHS determines that the child is reasonably likely to return to a placement in the MHO's Service Area at the end of the temporary placement;

(b) Unless a corresponding change in MHO capitation rates is implemented, a child receiving CAF services placed in Behavioral Rehabilitation Services (BRS) settings will be enrolled in the MHO that serves the region in which the BRS setting is located, unless an out of area exception is requested by the MHO and agreed to by DHS for purposes related to continuity of care.

(4) If the child receiving CAF services is enrolled in a MHO on the same day the child is admitted to psychiatric residential treatment services (PRTS), the MHO shall be responsible for Covered Services during that placement even if the location of the facility is outside of the MHO's Service Area:

(a) The child receiving CAF services is presumed to continue to be enrolled in the MHO with which the child was most recently enrolled. An admission to a PRTS facility shall be deemed a temporary placement for purposes of MHO Enrollment. Any address change or DHS system identifier (e.g., C5 status) change associated with the placement in the PRTS facility does not constitute a change of residence for purposes of MHO Enrollment and shall not constitute a basis for Disenrollment from the MHO, notwithstanding OAR 410-141-0080(2)(b)(F). If DHS determines that a child was disenrolled for reasons not consistent with these rules, DHS shall re-enroll the child with the appropriate MHO and assign an Enrollment date that provides for continuous MHO coverage with the appropriate MHO. If the child had been enrolled in a different MHO in error, the Department will disenroll the child from that MHO and recoup the Capitation Payments;

(b) Immediately upon discharge from Long Term Psychiatric Care and prior to admission to a PRTS, a child receiving CAF services should be enrolled in an MHO. At least two weeks prior to discharge of a child receiving CAF services from Long Term Psychiatric Care (SAIP, SCIP or STS) facility to a PRTS facility, the long term care facility shall consult with the Department about which MHO will be assigned in order to provide for Enrollment in the MHO and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO that will be assigned in order to provide for continuity of care upon discharge from Long Term Psychiatric Care.

(5) Notwithstanding OAR 410-141-0060(6)(d) and (7) and 410-141-0080(2)(b)(H), if a child receiving CAF services is enrolled in a MHO after the first day of an admission to PRTS, the date of Enrollment shall be effective the next available Enrollment date following discharge from PRTS to the MHO assigned by the Department:

(a) For purposes of these rules and to assure continuity of care for the child upon discharge, the next available Enrollment date shall mean immediately upon discharge;

(b) At least two weeks prior to discharge, the PRTS facility shall consult with the Department about which MHO will be assigned and shall make every reasonable effort within the laws governing confidentiality to consult with the MHO that will be assigned in order to provide for continuity of care upon discharge.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
Hist.: OMAP 30-2006(Temp), f. 6-30-06, cert. ef. 7-1-06 thru 10-27-06; OMAP 36-2006, f. 10-26-06, cert. ef. 10-27-06

410-141-0060
Oregon Health Plan Managed Care Enrollment Requirements

(1) Enrollment of an Oregon Health Plan (OHP) Client, excluding the Health Plan New/Noncategorical Client (HPN) and Children's Health Insurance Program (CHIP) clients in Prepaid Health Plans (PHPs) shall be mandatory unless exempted from Enrollment by the Department of Human Services (DHS), 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 PHPs or Primary Care Managers (PCMs).

(2) Enrollment of the HPN and CHIP Clients in PHPs shall be mandatory unless exempted from Enrollment by DHS under the terms in section (4) of this rule. Selection of PHPs in accordance with this rule is a condition of eligibility for HPN and CHIP Clients. If, upon reapplication, HPN or CHIP Clients do not select PHPs in accordance with this rule, PHPs will be selected by DHS. This selection will be based on which PHPs the HPN or CHIP Clients were previously enrolled in.

(3) OHP Clients, except HPN and CHIP Clients shall be enrolled with PHPs or PCMs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of Fully Capitated Health Plans (FCHP), Physician Care Organizations (PCO), and PCMs shall be called mandatory FCHP/PCO/PCM Service Areas. In mandatory FCHP/PCO/PCM Service Areas, an OHP Client shall select:

(A) An FCHP or PCO; or

(B) A PCM if exempt from FCHP or PCO Enrollment.

(b) Service areas with sufficient physical health service capacity through PCMs alone shall be called mandatory PCM Service Areas. An OHP Client shall select a PCM in a mandatory PCM Service Area;

(c) Service Areas without sufficient physical health service capacity through FCHPs, PCOs and PCMs shall be called voluntary FCHP/PCO/PCM Service Areas. In voluntary FCHP/PCO/PCM Service Areas, an OHP Client may choose to:

(A) Select any FCHP, PCO or PCM that is open for Enrollment; or

(B) Remain in the Medicaid Fee-for-Service (FFS) physical health care delivery system.

(d) Service 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) Service Areas without sufficient dental care service capacity through DCOs shall be called voluntary DCO Service Areas. In voluntary DCO Service Areas, an OHP Client may choose to:

(A) Select any DCO open for Enrollment; or

(B) Remain in the Medicaid FFS dental care delivery system;

(f) Service Areas with sufficient mental health service capacity through MHOs shall be called mandatory MHO Service Areas.OHP Clients will be enrolled in an MHO in a mandatory MHO Service Area;

(g) Service 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;

(h) When a Service Area changes from mandatory to voluntary, the DMAP Member will remain with their PHP for the remainder of their eligibility period, unless the DMAP Member meets the criteria stated in section (4) of this rule, or as provided by OAR 410-141-0080.

(4) The following are exemptions to mandatory Enrollment in PHPs that allow OHP Clients, including HPN and CHIP Clients, to enroll with a PCM 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, such as a Medicare supplemental policy, Medicare employer group policy or other third party resource (TPR) which covers the cost of services to be provided by a PHP, (excluding dental insurance. An OHP Client shall be enrolled with a DCO even if they have a dental TPR). The OHP Client shall enroll with a PCM if the insurance policy is not a private HMO;

(b) Clients who meet all of the criteria listed in section (4)(b)(A) through (C) are exempt from mandatory Enrollment:

(A) The OHP Client has an established relationship with aDMAP enrolled Practitioner from whom the Client receives ongoing treatment for a covered medical or dental condition, and;

(B) Subject to OAR 410-141-0080(1)(b)(B)(vi)(III), the DMAP enrolled Practitioner is not a member of the PHP's Participating Provider panel the OHP Client would be enrolled in, and;

(C) Loss of continuity of care for the covered medical or dental condition would have a significant negative effect on the health status of the OHP Client, as determined by DHS through medical review, to change Practitioners and receive treatment from the PHP's Participating Provider Panel;

(D) When the Practitioner is a Primary Care Practitioner (PCP) enrolled with DMAP as a PCM, the OHP Client shall enroll with this Practitioner as a PCM Member;

(E) Exemptions from mandatory Enrollment in PHPs for this reason may be granted for a period of four months. Extensions may be granted by DHS 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) OHP Clients shall be exempted from mandatory Enrollment with an FCHP or PCO, if the OHP Client became eligible through a hospital hold process and are placed in the Adults/Couples category. The OHP Client shall remain FFS for the first six (6) months of eligibility unless a change occurs with their eligibility or the category. At that time, the exemption shall be removed and the OHP Client shall be enrolled into an open FCHP or PCO. The exemption shall not affect the mandatory Enrollment requirement into a DCO or MHO.

(d) The OHP Client is a Native American or Alaska Native with Proof of Indian Heritage and chooses to receive services from an Indian Health Service facility or tribal health clinic;

(e) The OHP Client is a child in the legal custody of either the Oregon Youth Authority (OYA) or Children, Adults and Families (CAF) (Child Welfare Services), and the child is expected to be in a substitute care placement for less than 30 calendar days, unless:

(A) There is no FFS access; or

(B) There are continuity of care issues.

(f) 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 or PCO 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 or PCO during the three months preceding redetermination;

(B) If the DMAP Member moves out of her PHP's Service Area during the third trimester, the DMAP Member may be exempted from Enrollment in the new Service Area for continuity of care if the DMAP Member wants to continue obstetric-care with her previous physician, and that physician is within the travel time or distance indicated in 410-141-0220;

(C) If the Practitioner is a PCM, the DMAP Member shall enroll with that Practitioner as a PCM Member;

(D) If the Practitioner is not enrolled with DMAP as a PCM, then the DMAP Member 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 or PCO.

(g) The OHP Client has End Stage Renal Disease (ESRD). The OHP Client shall not enroll in an FCHP or PCO but shall enroll with a PCM unless exempt for some other reason listed in section (4) of this rule;

(h) The OHP Client has been accepted by the Medically Fragile Children's Unit of the Addictions and Mental Health Division (AMH);

(i) An OHP Client who is also a Medicare beneficiary and is in a hospice program shall not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The OHP Client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan or with a PCM unless exempt for some other reason listed in section (4) of this rule;

(j) The OHP Client is enrolled in Medicare and the only FCHP or PCO in the Service Area is a Medicare Advantage plan. The OHP Client may choose not to enroll in an FCHP or PCO;

(k) Other just causes as determined by DHS through medical review, which include the following factors:

(A) The cause is beyond the control of the OHP Client;

(B) The cause is in existence at the time that the OHP Client first becomes eligible for OHP;

(C) Enrollment would pose a serious health risk; and

(D) The lack of reasonable alternatives.

(l) A woman eligible for the Breast and Cervical Cancer Medical (BCCM) Program, (refer to BCCM rules established by CAF), shall not enroll in an FCHP, PCO, DCO or MHO. A woman in the BCCM Program shall remain in the Medicaid FFS delivery system.

(5) The primary person in the household group and benefit group as defined in OAR 461-110-0110, 461-110-0210, and 461-110- 0720, respectively, shall select PHPs or PCMs on behalf of all OHP Clients in the benefit group. PHP or PCM selection shall occur at the time of application for OHP in accordance with section (1) of this rule:

(a) All OHP Clients 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 in section (4) of this rule. If PCM selection is an option, OHP Clients in the benefit group may select different PCMs;

(b) If the OHP Client is not able to choose PHPs or PCMs on his or her own, the Representative of the OHP Client shall make the selection. The hierarchy used for making Enrollment decisions shall be in descending order as defined under Representative:

(A) If the Medicare Advantage Plan Election form (OHP 7208M), described in subsection (5)(d) of this rule, is signed by someone other than the OHP Client, the OHP Client's Representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M.

(B) If the OHP Client is a Medicare beneficiary who is capable of making Enrollment decisions, the Client's Representative shall not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components.

(c) CAF or OYA shall select PHPs or a PCM for a child receiving CAF (Child Welfare Services) or OYA Services, with the exception of children in subsidized adoptions;

(d) Enrollment in a FCHP or PCO of an OHP Client who is receiving Medicare and who resides in a Service Area served by PHPs or PCMs shall be as follows:

(A) If the OHP Client, who is Medicare Advantage eligible, selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the OHP Client shall complete the 7208M, or other CMS approved Medicare plan election form:

(i) If the FCHP or PCO has not received the form within 10 calendar days after the date of Enrollment, the FCHP or PCO shall send a letter to the DMAP Member with a copy sent to SPD branch manager. The letter shall:

(I) Explain the need for the completion of the form;

(II) Inform the DMAP Member that if the form is not received within 30 days, the FCHP or PCO may request Disenrollment; and

(III) Instruct the DMAP Member to contact their caseworker for other coverage alternatives.

(ii) The FCHP or PCO shall choose whether to disenroll or maintain Enrollment for all the OHP Clients from whom they do not receive a form at the end of 30 days, except as otherwise provided in this rule. The FCHP or PCO must notify the PHP Coordinator of the PHP's annual decision to disenroll or maintain Enrollment for the OHP Clients in writing. This notification must be submitted by January 31 of each year, or another date specified by DMAP. If the FCHP or PCO has decided to:

(I) Disenroll the OHP Clients and has not received a DMAP Client's form at the end of 30 days, the FCHP or PCO shall request Disenrollment. HMU will disenroll the DMAP Member effective the end of the month following the notification.

(II) Maintain Enrollment, the FCHP or PCO shall not request Disenrollment at the end of 30 days.

(B) If the OHP Client is enrolled as a private member of a Medicare Advantage plan, the OHP Client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare Advantage plan:

(i) If the OHP Client chooses to remain as a private member in the Medicare Advantage plan, the OHP Client 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 Advantage Enrollment and then, within 60 calendar days of Disenrollment from the Medicare Advantage plan, chooses the FCHP or PCO that corresponds to the Medicare Advantage plan that was discontinued, the OHP Client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other OHP Clients;

(iii) A Fully Dual Eligible (FDE) OHP Client who has been exempted from Enrollment in an MHO shall not be enrolled in a FCHP or PCO that has a corresponding Medicare Advantage plan unless the exemption was done for a Provider who is on the FCHP's or PCO's panel.

(e) MHO Enrollment options shall be based on the OHP Client's county of residence, the FCHP or PCO selected by the OHP Client, and whether the FCHP or PCO selected serves as a MHO:

(A) If the OHP Client selects a FCHP or PCO that is not a MHO, then the OHP Client shall enroll in the MHO designated as the freestanding MHO for that county;

(B) If the OHP Client selects a FCHP or PCO that is a MHO, then the OHP Client shall receive OHP mental health benefits through that FCHP or PCO.

(6) If the OHP Client resides in a mandatory Service Area and fails to select a DCO, MHO, PCO and/or FCHP or a PCM at the time of application for the OHP, DMAP may enroll the OHP Client with a DCO, MHO, PCO and/or FCHP or a PCM as follows:

(a) The OHP Client shall be assigned to and enrolled with a DCO, MHO, and FCHP, PCO or PCM 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 or PCO and second to a PCM;

(c) DHS 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, PCO or PCM 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 DHS enrolls the OHP Client and notifies the OHP Client of Enrollment and the name of the PHP or PCM: If Enrollment is initiated by a DHS worker on or before Wednesday, the date of Enrollment shall be the following Monday. If Enrollment is initiated by a DHS 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, PCO, MHO or DCO shall be initiated by an auto-Enrollment program of DHS effective the first of the month following the month-end cutoff. Monthly Enrollment in Service Areas where there is a choice of PHPs, shall be auto-Enrolled by computer algorithm.

(7) The provision of Capitated Services to a DMAP Member enrolled with a PHP or a PCM shall begin on the first day of Enrollment with the PHP or a PCM 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, PCO or MHO shall be the first possible Enrollment date after the date the OHP Client is discharged from inpatient hospital services and the date of Enrollment with a PCM shall be the first of the month for which Capitation Payment is made;

(c) For DMAP Members who are re-enrolled within 30 calendar days of Disenrollment. The date of Enrollment shall be the date specified by DHS that 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 DHS.

Stat. Auth.: ORS 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 8-1994(Temp), f. & cert. ef. 2-1-94; DEQ 24-1994, f. 5-31-94, cert. ef. 6-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 29-1996(Temp), f. 12-31-96, cert. ef. 1-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 12-2002, f. & cert. ef. 4-1-02; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 10-2006(Temp), f. & cert. ef. 5-4-06 thru 10-27-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07

410-141-0070
Oregon Health Plan Fully Capitated Health Plan (FCHP) and Physician Care Organization (PCO) Pharmaceutical Drug List Requirements

(1) Prescription drugs are a Covered Service based on the funded Condition/Treatment Pairs. FCHPs and PCOs shall pay for prescription drugs, except:

(a) As otherwise provided, such as Class 7 & 11 medications (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal and those drugs that the Division of Medical Assistance Programs (DMAP) specifically carved out from capitation according to sections (8) through (11) of this rule;

(c) Any applicable Co-payments;

(d) For drugs covered under Medicare Part D when the Client is Fully Dual Eligible.

(2) FCHPs and PCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list must:

(a) Include Federal Drug Administration (FDA)-approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the Provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) FCHPs and PCOs shall provide their Participating Providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but is not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) If a drug cannot be approved within the 24-hour time requirement for prior authorization of drugs and the medical need for the drug is immediate, FCHPs and PCOs must provide for the dispensing of at least a 72-hour supply of a drug that requires prior authorization

(5) FCHPs and PCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referring Provider, if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the DMAP Member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded; payment is governed solely by OAR 410-121-0150.

(7) FCHPs and PCOs shall not authorize payment for any Drug Efficacy Study Implementation (DESI) Less-Than-Effective drugs which have reached the FDA Notice-of-Opportunity-for Hearing stage. The DESI Less-Than-Effective list is available at DMAP's Web site at <http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/misc_files/desi1.pdf>.

(8) DMAP may exclude (commonly called "carve out") drugs from FCHP and PCO capitation that are FDA approved to treat a serious mental health disorder, such as major depressive, bi-polar and schizophrenic disorders.

(9) In order for a drug to be considered for carve out from FCHP and PCO capitation for the January contract period, DMAP must receive the request for carve out from the FCHP or PCO no later than March 1 of the previous calendar year to be considered for carve out for the following January contract cycle. The request must include:

(a) The drug name;

(b) The FDA approved indications that include an FDA approved use to treat a severe mental health condition; and

(c) The reason that DMAP should consider this drug for carve out.

(10) DMAP determines whether or not to carve out a drug.

(11) DMAP will pay for a drug that is subject to carve out pursuant to the Pharmaceutical Services Rules (chapter 410, division 121). An FCHP or PCO may not reimburse Providers for carved out drugs.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
Hist.: OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 57-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07

410-141-0080
Oregon Health Plan (OHP) Disenrollment from Prepaid Health Plans (PHPs)

(1) DMAP Member Requests for Disenrollment:

(a) All Oregon Health Plan (OHP) DMAP Member-initiated requests for Disenrollment from a Prepaid Health Plan (PHP) must be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For DMAP Members who are not able to request Disenrollment on their own, the request may be initiated by the DMAP Member's Representative;

(b) Primary person or Representative requests for Disenrollment shall be honored:

(A) Without cause:

(i) After six months of DMAP Member's Enrollment. The effective date of Disenrollment shall be the first of the month following the Department's approval of Disenrollment;

(ii) Whenever a DMAP Member's eligibility is redetermined by the Department of Human Services (DHS) and the primary person requests Disenrollment without cause. The effective date of Disenrollment shall be the first of the month following the date that the DMAP Member's eligibility is redetermined by the Department;

(B) With cause:

(i) At any time;

(ii) DMAP Members who disenroll from a Medicare Advantage plan shall also be Disenrolled from the corresponding Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO). The effective date of Disenrollment shall be the first of the month that the DMAP Member's Medicare Advantage plan Disenrollment is effective;

(iii) DMAP Members who are receiving Medicare and who are enrolled in a FCHP or PCO that has a corresponding Medicare Advantage component may disenroll from the FCHP or PCO at any time if they also request Disenrollment from the Medicare Advantage plan. The effective date of Disenrollment from the FCHP or PCO shall be the first of the month following the date of request for Disenrollment;

(iv) PHP does not, because of moral or religious objections, cover the service the DMAP Member seeks;

(v) The DMAP Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the DMAP Members' Primary Care Provider or another Provider determines that receiving the services separately would subject the DMAP Member to unnecessary risk; or

(vi) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of access to Participating Providers experienced in dealing with the DMAP Member's health care needs. Examples of sufficient cause include but are not limited to:

(l) The DMAP Member moves out of the PHP's Service Area;

(ll) The DMAP Member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program or urban clinic and the Fee-For-Service (FFS) delivery system;

(III) Continuity of care that is not in conflict with any section of 410-141-0060 or this rule. Participation in the Oregon Health Plan, including managed care, does not guarantee that any Oregon Health Plan client has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care will be denied if the basis for this request is primarily for the convenience of an Oregon Health Plan client or a provider of a treatment, service or supply, including but not limited to a decision of a provider to participate or decline to participate in a PHP.

(C) If the following conditions are met:

(i) The applicant is in the third trimester of her pregnancy and has just been determined eligible for OHP, or the OHP Client has just been re-determined eligible and was not enrolled in a FCHP or PCO within the past 3 months; and

(ii) The new FCHP or PCO the DMAP Member is enrolled with does not contract with the DMAP Member's current OB Provider and the DMAP Member wishes to continue obtaining maternity services from that Non-Participating OB Provider; and

(iii) The request to change FCHPs, PCOs or return to FFS is made prior to the date of delivery.

(c) In addition to the Disenrollment constraints listed in (b), above, DMAP Member Disenrollment requests are subject to the following requirements:

(A) The DMAP Member shall join another PHP, unless the DMAP Member resides in a Service Area where Enrollment is voluntary, or the DMAP 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 PHP from which the DMAP Member wishes to disenroll, the DMAP 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 DMAP;

(D) If the Department fails to make a Disenrollment determination by the first day of the second month following the month in which the DMAP Member files a request for Disenrollment, the Disenrollment is considered approved.

(2) Prepaid Health Plan requests for Disenrollment:

(a) Causes for Disenrollment:

(A) DMAP may Disenroll DMAP Members for cause when requested by the PHP, subject to American with Disabilities Act requirements. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of missed appointments is to be established by the 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 DMAP Member in receiving services. This rule does not apply to Medicare members who are enrolled in a FCHP's or PCO's Medicare Advantage plan;

(ii) DMAP Member's behavior is disruptive, unruly, or abusive to the point that his/her continued Enrollment in the PHP seriously impairs the PHP's ability to furnish services to either the DMAP Member or other members, subject to the requirements in (2)(a)(B)(vii);

(iii) DMAP 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 to the point that his/her continued Enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular DMAP Member or other DMAP Members, subject to the requirements in (2)(a)(B)(vii);

(iv) DMAP 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 (other than those addressed in (2)(a)(A)(ii) or (iii)) committed in any Provider or PHP's premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF) Fraud Unit as appropriate;

(v) OHP Clients who have been exempted from mandatory Enrollment with a FCHP or PCO, due to the OHP Client's eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060(4)(b)(F);

(vi) DMAP Member fails to pay co-payment(s) for Covered Services as described in OAR 410-120-1230.

(B) DMAP 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 DMAP Member's health;

(iii) Because of the DMAP Member's utilization of services, either excessive or lack thereof;

(iv) Because the DMAP Member requests a hearing;

(v) Because the DMAP Member has been diagnosed with End Stage Renal Disease (ESRD);

(vi) Because the DMAP Member exercises his/her option to make decisions regarding his/her medical care with which the PHP disagrees;

(vii) Because of uncooperative or disruptive behavior, including but not limited to threats or acts of physical violence, resulting from the DMAP Member's special needs (except when continued Enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this DMAP Member or other members).

(C) Requests by the PHP for Disenrollment of specific DMAP 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 a DMAP Member:

(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 the DMAP 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 DMAP Member either verbally or in writing, depending on the severity of the problem, to inform the DMAP Member of the problem that has been identified, and attempt to develop an agreement with the DMAP Member regarding the issue(s). If contact is verbal, it shall be documented in the DMAP Member's record. The PHP shall inform the DMAP Member that his/her continued behavior may result in Disenrollment from the PHP;

(iii) The PHP shall provide individual education, counseling, and/or other interventions with the DMAP Member in a serious effort to resolve the problem;

(iv)The PHP shall contact the DMAP Member's DHS caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution, within the laws governing confidentiality;

(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 the Provider, caseworker, DMAP Member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain an authorization for release of information from the DMAP Member for the 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 DMAP Member's record;

(vi) Any additional information or assessments requested by the DMAP PHP Coordinator;

(vii) If the DMAP Member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence, as the result of his/her special needs or disability, the PHP must also document each of the following:

(I) A written assessment of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a DMAP Member poses a direct threat to the health or safety of others, the PHP must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration and severity of the risk to the health or safety of others; the probability that potential injury to others will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(II) A PHP-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist or other health care professionals who have the appropriate clinical expertise in treating the DMAP Member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(III) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(IV) Documentation of any accommodations that have been attempted;

(V) Documentation of the PHP's rationale for concluding that the DMAP Member's continued enrollment in the PHP seriously impairs the PHP's ability to furnish services to either this particular DMAP Member or other members.

(viii) If a Primary Care Provider (PCP) terminates the Provider/patient relationship, the PHP shall attempt to locate another PCP on their panel who will accept the DMAP Member as their patient. If needed, the PHP shall obtain an authorization for release of information from the DMAP Member in order to share the information necessary for a new Provider to evaluate if they can treat the DMAP Member. All terminations of Provider/patient relationships shall be according to the PHP's policies and must be consistent with PHP or PCP's policies for commercial members.

(D) Requests will be reviewed according to the following process:

(i) If there is sufficient documentation, the request will be evaluated by the PHP's Coordinator or a team of PHP Coordinators who may request additional information from Ombudsman Services, AMH or other agencies as needed; If the request involves the DMAP Member's mental health condition or behaviors related to substance abuse, the PHP Coordinator should also confer with the OHP Coordinator in AMH;

(ii) If there is not sufficient documentation, the PHP Coordinator will notify the PHP within 2 business days of 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 of sufficient documentation from the PHP. Written decisions, including reasons for denials, will be sent to the PHP within 15 working days from receipt of request and sufficient documentation from the PHP.

(E) If the request is approved the PHP Coordinator must send the DMAP Member a letter within 14 days after the request was approved, with a copy to the PHP, the DMAP Member's DHS caseworker and DMAP's Health Management Unit (HMU). The letter must give the Disenrollment date, the reason for Disenrollment, and the notice of DMAP Member's right to file a Complaint (as specified in 410-141-0260 through 410-141-0266) and to request an Administrative Hearing. If the DMAP Member requests a hearing, the DMAP Member will continue to be disenrolled until a hearing decision reversing that Disenrollment has been sent to the DMAP Member and the PHP:

(i) In cases where the DMAP Member is also enrolled in the FCHP's or PCO's Medicare Advantage plan and the plan has received permission to disenroll the client, the FCHP or PCO will provide proof of the CMS approval to Disenroll the client and the date of Disenrollment shal be the date approved by CMS;

(ii) The Disenrollment date is 30 days after the date of approval, except as provided in subsections (iii) and (iv) of this section:

(I) The PHP Coordinator will determine when Enrollment in another PHP or with a PCM is appropriate. If appropriate, the PHP Coordinator will contact the DMAP Member's DHS caseworker to arrange Enrollment. DMAP may require the DMAP Member and/or the benefit group to obtain services from FFS Providers or a PCM until such time as they can be enrolled in another PHP;

(II) When the Disenrollment date has been determined, HMU will send a letter to the DMAP Member with a copy to the DMAP Member's DHS caseworker and the PHP. The letter shall inform the DMAP Member of the requirement to be enrolled in another PHP, if applicable.

(iii) If the PHP Coordinator approves a PHP's request for Disenrollment because of the DMAP Member's uncooperative or disruptive behavior, including threats or acts of physical violence directed at a medical Provider, the Provider's staff, or other patients, or because the DMAP Member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a), the following additional procedures shall apply:

(I) The DMAP Member shall be Disenrolled as of the date of the PHP's request for Disenrollment;

(II) All DMAP Members in the DMAP Member's benefit group, as defined in OAR 461-110-0720, may be Disenrolled if the PHP requests;

(III) At the time of Enrollment into another PHP, DMAP shall notify the new PHP that the DMAP Member and/or benefit group were previously Disenrolled from another PHP at that PHP's request.

(iv) If a DMAP Member who has been Disenrolled for cause is reenrolled in the PHP, the PHP may request a Disenrollment review by the PHP's PHP Coordinator. A DMAP Member may not be Disenrolled from the same PHP for a period of more than 12 months. If the DMAP Member is reenrolled after the 12-month period and is again Disenrolled for cause, the Disenrollment will be reviewed by DHS for further action.

(b) Other reasons for the PHP's requests for Disenrollment include the following:

(A) If the DMAP Member is enrolled in the FCHP or MHO on the same day the DMAP Member is admitted to the hospital, the FCHP or MHO shall be responsible for said hospitalization. If the DMAP Member is enrolled after the first day of the inpatient stay, the DMAP Member shall be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from inpatient hospital services;

(B) The DMAP 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 DMAP Member wishes to have the services performed by that Provider;

(C) The Medicare member is enrolled in a Medicare Advantage plan and was receiving Hospice Services at the time of Enrollment in the PHP;

(D) The DMAP Member had End Stage Renal Disease at the time of Enrollment in the PHP;

(E) Excluding the DCO, the PHP determines that the DMAP Member has a third party insurer. If after contacting The Health Insurance Group, the Disenrollment is not effective the following month, the PHP may contact HMU to request Disenrollment;

(F) If a PHP has knowledge of a DMAP Member's change of address, the bPHP shall notify DHS. DHS will verify the address information and Disenroll the DMAP Member from the PHP, if the DMAP Member no longer resides in the PHP's Service Area. DMAP Members shall be Disenrolled if out of the PHP's Service Area for more than three (3) months, unless previously arranged with the PHP. The effective date of Disenrollment shall be the date specified by DMAP and DMAP will recoup the balance of that month's Capitation Payment from the PHP;

(G) The DMAP Member is an inmate who is serving time for a criminal offense or confined involuntarily in a State or Federal prison, jail, detention facility, or other penal institution. This does not include DMAP Members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The PHP is responsible for identifying the DMAP Members and providing sufficient proof of incarceration to HMU for review of the Disenrollment request. DMAP will approve requests for Disenrollment from PHPs for DMAP Members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHPs are responsible for inpatient services only during the time a DMAP Member was an inmate;

(H) The DMAP Member is in a state psychiatric institution.

(3) DMAP Initiated Disenrollments:

(a) DMAP may initiate and Disenroll DMAP Members as follows:

(A) If DMAP determines that the DMAP Member has sufficient third party resources such that health care and services may be cost effectively provided on a FFS basis, DMAP may Disenroll the DMAP Member. The effective date of Disenrollment shall be the end of the month in which DMAP makes such a determination. DMAP may specify a retroactive effective date of Disenrollment if the DMAP Member's third party coverage is through the PHP, or in other situations agreed to by the PHP and DMAP;

(B) If the DMAP Member moves out of the PHP's Service Area(s), the effective date of Disenrollment shall be the date specified by DMAP and DMAP will recoup the balance of that month's Capitation Payment from the PHP;

(C) If the DMAP Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project or Children's Health Insurance Program, the effective date of Disenrollment shall be the date specified by DMAP;

(D) If the DMAP 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 Advantage plan, DMAP 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;

(F) If DMAP determines that the PHP's DMAP Member has enrolled with their Employer Sponsored Insurance (ESI) through FHIAP the effective date of the Disenrollment shall be the DMAP Member's effective date of coverage with FHIAP.

(b) Unless specified otherwise in these rules or in the DMAP notification of Disenrollment to the PHP, all Disenrollments are effective the end of the month after the request for Disenrollment is approved by DMAP;

(c) DMAP shall inform the DMAP Members of the Disenrollment decision in writing, including the right to request an Administrative Hearing. Oregon Health Plan Clients may request a DMAP hearing if they dispute a Disenrollment decision by DMAP;

(d) If the OHP Client requests a hearing, the OHP Client will continue to be Disenrolled until a hearing decision reversing that Disenrollment is sent the OHP Client.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 11-1997, f. 3-28-97, cert. ef. 4-1-97; HR 14-1997, f. & cert. ef. 7-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07

410-141-0085

Oregon Health Plan Disenrollment from Primary Care Managers

(1) PCM Member requests for Disenrollment:

(a) All PCM Member-initiated requests for Disenrollment from Primary Care 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 PCM Members who are not able to request Disenrollment on their own, the request may be initiated by the PCM Member's Representative;

(b) Primary Person or Representative requests for Disenrollment 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 PCM Member notification to DHS;

(B) After six months of PCM Member's Enrollment without cause. The effective date of Disenrollment shall be the first of the month following PCM Member notification to DHS;

(C) Whenever a PCM Member's eligibility is re-determined by DHS and the primary person requests Disenrollment without cause. The effective date of Disenrollment shall be the first of the month following the date that PCM Member's eligibility is re-determined by DHS;

(D) At any other time with cause:

(i) The Division of Medical Assistance Programs (DMAP) 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 PCM Member moves out of the Primary Care Manager Service Area;

(II) It would be detrimental to the PCM Member's health to remain enrolled with the Primary Care Manager;

(III) The PCM 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, PCM Member Disenrollment requests are subject to the following requirements:

(A) The PCM Member shall select another Primary Care Manager or Prepaid Health Plan, unless the PCM Member resides in a Service Area where Enrollment is voluntary;

(B) If the only Primary Care Manager or Prepaid Health Plan available in a PHP, PHP/ PCM or PCM mandatory Service Area is the PCM from which the PCM Member wishes to disenroll, the PCM Member may not disenroll without cause.

(2) Primary Care Manager requests for Disenrollment:

(a) Procedures for Primary Care Manager requests for Disenrollment are as follows:

(A) Requests by the Primary Care Manager for Disenrollment of specific PCM Members shall be submitted in writing to DMAP for approval prior to Disenrollment. The Primary Care 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 PCM Member's health. If the situation warrants, DMAP shall consider an oral request for Disenrollment, with written documentation to follow. DMAP shall approve Primary Care Manager requests for Disenrollment that meet DMAP criteria;

(B) DMAP shall respond to Primary Care Manager requests in a timely manner and in no event greater than 30 calendar days;

(C) The Primary Care Manager shall not disenroll or request Disenrollment of any PCM Member because of an adverse change in the PCM Member's health.

(b) DMAP may disenroll PCM Members for cause when requested by the Primary Care Manager:

(A) DMAP shall inform the PCM Member of:

(i) An approved Disenrollment decision;

(ii) Any requirement to select another Primary Care Manager;

(iii) Right to request a DMAP hearing if the Disenrollment decision by DMAP is disputed.

(B) Examples of cause include, but are no limited to the following:

(i) The PCM Member refuses to accept Medically Appropriate treatment and/or follow Medically Appropriate guidelines;

(ii) The PCM 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 PCM Member has permitted the use of his or her DMAP Medical Care Identification by another person or used another person's Medical Care Identification;

(iv) The PCM Member has missed three appointments without canceling and/or without explanation and the Primary Care Manager has documented attempts to accommodate the PCM Member's needs and to counsel with or educate the PCM Member.

(c) If DMAP approves the Primary Care Manager request for Disenrollment of a PCM Member because the PCM Member is abusive to others or threatens or commits an act of physical violence, the following procedures shall apply:

(A) DMAP shall inform the PCM Member of the Disenrollment decision;

(B) The PCM Member shall be disenrolled. All PCM Members in the PCM Member's benefit group, as defined in OAR 461-110-0720, may be disenrolled;

(C) The effective date of Disenrollment shall be the date of the Primary Care Manager's request for Disenrollment;

(D) DMAP shall require the PCM Member and/or the benefit group to obtain services from fee-for-service Providers for six months;

(E) After six months the PCM Member and/or the benefit group shall be required to select another Primary Care Manager, if available in the Service Area;

(F) DMAP shall notify the new Primary Care Manager that the PCM Member and/or benefit group was previously disenrolled from another Primary Care Manager at the Primary Care Manager's request.

(3) DMAP may initiate and disenroll PCM Members as follows:

(a) If DMAP determines the PCM Member has third party resources through a private HMO, DMAP may disenroll the PCM Member. The effective date of Disenrollment shall be specified by DMAP and shall be the first of the month after DMAP determines the PCM Member should be disenrolled;

(b) If the PCM Member moves out of the Primary Care Manager's Service Area, the effective date of Disenrollment shall be the date specified by DMAP, which may be retroactive up to one month prior to the month DMAP notifies the Primary Care Manager;

(c) If the PCM Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project, the effective date of Disenrollment shall be the date specified by DMAP;

(d) If the PCM 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 Manager by DMAP all Disenrollments are effective the first of the month after the request for Disenrollment is approved by DMAP.

(5) Oregon Health Plan clients may request a DMAP hearing if they dispute a Disenrollment decision by DMAP.

Stat. Auth.: ORS 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0110
Oregon Health Plan Prepaid Health Plan Member Satisfaction Survey

(1) The Division of Medical Assistance Programs (DMAP) shall conduct a statistically valid FCHP DMAP Member satisfaction survey each calendar year to survey DMAP Members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General DMAP Member satisfaction.

(2) DMAP may conduct a statistically valid DCO, PCO and CDO DMAP Member satisfaction survey to survey DMAP Member satisfaction.

(3) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0115
Oregon Health Plan Primary Care Manager Member Satisfaction Survey

(1) The Division of Medical Assistance Programs (DMAP) may conduct a statistically valid PCM Member satisfaction survey each calendar year to survey PCM Members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General PCM Member satisfaction.

(2) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0120
Oregon Health Plan Prepaid Health Plan Provision of Health Care Services

CAF: Children, Adults and Families
CMS: Centers for Medicare and Medicaid Services
DHS: Department of Human Services
FCHP: Fully Capitated Health Plans
MHO: Mental Health Organization
OHP: Oregon Health Plan
DMAP: Division of Medical Assistance Programs
AMH: Addictions and Mental Health Division
PCO: Physician Care Organization
PCP: Primary Care Provider
PHP: Prepaid Health Plan

(1) PHPs shall have written policies and procedures that ensure the provision of all Medically and Dentally Appropriate covered services, including Urgent Care Services and Emergency Services, Preventive Services and Ancillary Services, in those categories of services included in Contract or agreements with DMAP and/or AMH, respectively. PHPs shall communicate these policies and procedures to Providers, regularly monitor Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all Participating Providers providing covered services to DMAP Members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination, based on the requirements of the discipline or profession, that Participating Providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on November 14, 2000, thereby implementing ORS 442.807. PHPs shall retain responsibility for delegated activities, including oversight of processes:

(A) PHPs shall ensure that covered services are provided within the scope of license or certification of the Participating Provider or facility, and within the scope of the Participating Provider's contracted services and that Participating Providers are appropriately supervised according to their scope of practice;

(B) PHPs shall provide training for PHP staff and Participating Providers and their staff regarding the delivery of covered services, OHP Administrative Rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank;

(D) PHPs shall not refer DMAP Members to or use Providers who have been terminated from the Oregon Medical Assistance Program or excluded as Medicare/Medicaid Providers by CMS and/or by any lawful conviction by a Court for which the Provider could be excluded under 42 CFR 1001.101. PHPs shall not accept billings for services to DMAP Members provided after the date of such Provider's conviction or termination.

(b) FCHPs, PCOs, DCOs and CDOs shall have written procedures that provide newly enrolled DMAP Members with information about which Participating Providers are currently not accepting new patients (except for staff models);

(c) FCHPs, PCOs, DCOs and CDOs shall have written procedures that allow and encourage a choice of a PCP or clinic for physical health, and dental health services by each DMAP Member. These procedures shall enable a DMAP Member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that DMAP Member;

(d) If the DMAP Member does not choose a PCP within 30 calendar days from the date of Enrollment, the FCHP or PCO must ensure the

DMAP Member has an ongoing source of primary care appropriate to his or her needs by formally designating a Practitioner or entity. FCHPs and PCOs that assign DMAP Members to PCPs or clinics shall document the unsuccessful efforts to elicit the DMAP Member's choice before assigning a DMAP Member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after Enrollment, must notify the DMAP Member of the assignment and allow the DMAP Member 30 calendar days after assignment to change the assigned PCP or clinic.

(2) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to DMAP's satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded Providers for payment of point-of-contact services in the following categories:

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) DMAP Members may receive the following services from appropriate Non-Participating Medicaid Providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the Oregon Health Plan), DMAP is responsible for payment of such services:

(A) Family planning services; and

(B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded Providers for authorization of and payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health Providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and/or planning committees;

(e) FCHPs and PCOs shall report to DMAP on their status in executing agreements with publicly funded Providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(3) FCHPs and PCOs shall ensure a newly enrolled DMAP Member receives timely, adequate and appropriate health care services necessary to establish and maintain the health of the DMAP Member. An FCHP's liability covers the period between the DMAP Member's Enrollment and Disenrollment with the FCHP, unless the DMAP Member is hospitalized at the time of Disenrollment. In such an event, an FCHP is responsible for the inpatient hospital services until discharge or until the DMAP Member's PCP or designated Practitioner determines the care is no longer Medically Appropriate.

(4) A PCO's liability covers the period between the DMAP Members' Enrollment and Disenrollment with the PCO, unless the DMAP Member is hospitalized at the time of Disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services will be the responsibility of DMAP.

(5) The DMAP Member shall obtain all Covered Services, either directly or upon referral, from the PHP responsible for the service from the date of Enrollment through the date of Disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for Capitated Services, and shall coordinate benefits for shared DMAP Members to ensure that the DMAP Member receives all Medically Appropriate services covered under respective Capitation Payments. If the Fully Dual Eligible DMAP Member is enrolled in a FCHP or PCO with a Medicare HMO component the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(7) PHPs shall coordinate services for each DMAP 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 DMAP Member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with Local or Allied Agencies, Community Emergency Service Agencies, and local Providers;

(b) PHPs shall refer DMAP Members to the Offices of the Department of Human Services and Local and Regional Allied Agencies which may offer services not covered under the Capitation Payment;

(c) FCHPs and PCOs shall not require DMAP Members to obtain the approval of a PCP in order to gain access to mental health and alcohol and drug assessment and evaluation services. DMAP Members may refer themselves to MHO services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 & 442.807
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06

410-141-0140
Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services

(1) PHPs shall have written policies and procedures and monitoring systems that ensure the provision of appropriate Urgent, Emergency, and Triage services 24-hours a day, 7-days-a-week for all Division of Medical Assistance Programs (DMAP) Members. PHPs shall:

(a) Communicate these policies and procedures to Participating Providers;

(b) Regularly monitor Participating Providers' compliance with these policies and procedures; and

(c) Take any corrective action necessary to ensure Participating Provider's compliance. PHPs shall document all monitoring and corrective action activities.

(2) PHPs shall have written policies and procedures and monitoring processes to ensure that a Practitioner provides a Medically or Dentally Appropriate response as indicated to urgent or emergency calls consisting of the following elements:

(a) Telephone or face-to-face evaluation of the DMAP Member to determine the nature of the situation and the DMAP Member's immediate need for services;

(b) Capacity to conduct the elements of an assessment that is needed to determine the interventions necessary to begin stabilizing the urgent or emergency situation;

(c) Development of a course of action at the conclusion of the assessment;

(d) Provision of services and/or referral needed to address the urgent or emergency situation, begin Post-Stabilization Care or provide outreach services in the case of an MHO;

(e) Provision for notifying a referral emergency room, when applicable concerning the presenting problem of an arriving DMAP Member, and whether or not the Practitioner will meet the DMAP Member at the emergency room; and

(f) Provision for notifying other Providers requesting approval to treat DMAP Members of the determination.

(3) PHPs shall ensure the availability of an after-hours call-in system adequate to Triage urgent care and emergency calls from DMAP Members. Urgent calls shall be returned appropriate to the DMAP Member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the call shall be returned within 60 minutes in order to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call shall be returned immediately.

(4) If a screening examination in an Emergency Room leads to a clinical determination by the examining physician that an actual emergency medical condition exists under the prudent layperson standard as defined in Emergency Services, the PHP must pay for all services

required to stabilize the patient, except as otherwise provided in (6) of this rule. The PHP may not require prior authorization for Emergency Services:

(a) The PHP may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature;

(b) The PHP may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;

(c) The PHP may not deny a claim for emergency services merely because the Primary Care Physician (PCP) was not notified, or because the PHP was not billed within 10 calendar days of the service.

(5) When a DMAP Member's Primary Care Provider, designated Practitioner or other health plan representative instructs the DMAP Member to seek emergency care, in or out of the network, the PHP is responsible for payment of the screening examination and for other Medically Appropriate services. Except as otherwise provided in (6) of this rule, the PHP is responsible for payment of Post-Stabilization Care that was:

(a) Pre-authorized by the PHP;

(b) Not pre-authorized by the PHP if the PHP (or the on-call Provider) failed to respond to a request for pre-authorization within one hour of the request being made, or the PHP or Provider on call could not be contacted; or

(c) If the PHP and the treating physician cannot reach an agreement concerning the DMAP Member's care and a PHP representative is not available for consultation, the PHP must give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with care of the patient until a PHP physician is reached or one of the following criteria is met:

(A) The Participating Provider with privileges at the treating hospital assumes responsibilities for the DMAP Member's care;

(B) The Participating Provider assumes responsibility for the DMAP Member's care through transfer;

(C) A Contractor representative and the treating physician reach an agreement concerning the DMAP Member's care; or

(D) The DMAP Member is discharged.

(6) PCO responsibility with regard to Emergency Services, Urgent Care Services, or Post Stabilization Care Services is as follows:

(a) A PCO is not financially responsible for Emergency Services, Urgent Care Services, or Post Stabilization Services, to the extent such Services are Inpatient Hospital Services. The PCO shall not authorize, cause, induce or otherwise furnish any incentive for Emergency Services, Urgent Care Services, or Post Stabilization Services to be rendered as Inpatient Hospital Services except to the extent Medically Appropriate.

(b) A PCO is financially responsible for Post Stabilization Services (other than Inpatient Hospital Services) obtained by DMAP Members within or outside the PCO's network under the following circumstances:

(A) Post Stabilization Services have been authorized by the PCO's authorized representative;

(B) Post Stabilization Services have not been authorized by the PCO's authorized representative, but are administered to maintain the DMAP Member's stabilized condition within 1 hour of a request to the PCO's authorized representative for approval of further Post Stabilization Services;

(C) Post Stabilization Services have not been authorized by the PCOs authorized representative, but are administered to maintain, improve, or resolve the DMAP Member's stabilized condition if:

(i) The PCO's authorized representative does not respond to a request for authorization within 1 hour;

(ii) The PCO's authorized representative cannot be contacted; or

(iii) The PCO's authorized representative and the treating physician cannot reach an agreement concerning the DMAP Member's care and the Participating Provider is not available for consultation. In this situation, the PCO must give the treating physician the opportunity to consult with the Participating Provider and the treating physician may continue with the care of the DMAP Member until the Participating Provider is reached or one of the criteria in Section (6) of this rule has been met.

(c) The PCO's financial responsibility for non-Inpatient Post Stabilization Services it has not approved ends when:

(A) The Participating Provider with privileges at the treating hospital assumes responsibilities for the DMAP Member's care;

(B) The Participating Provider assumes responsibility for the DMAP Member's care through transfer;

(C) A PCO representative and the treating physician reach an agreement concerning the DMAP Member's care; or

(D) The DMAP Member is discharged.

(7) PHPs shall have methods for tracking inappropriate use of emergency care and shall take Action, including individual DMAP 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 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; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0160
Oregon Health Plan Prepaid Health Plan (PHP) Coordination and Continuity of Care

(1) PHPs shall have written policies, procedures, and monitoring systems that ensure the provision of Medical Case Management Services, delivery of primary care to and coordination of health care services for all Division of Medical Assistance Programs (DMAP) Members:

(a) PHPs are to coordinate and manage Capitated Services and Non-Capitated Services, and ensure that referrals made by the PHP's Providers to other Providers for covered services are noted in the appropriate DMAP Member's Clinical Record;

(b) PHPs shall ensure DMAP Members receiving Exceptional Needs Care Coordination (ENCC) services for the Aged, Blind, Disabled, and special needs, as described in 410-141-0405, are noted in the appropriate DMAP Member's record. ENCC is a service available through Fully Capitated Health Plans (FCHPs) or Physician Care Organizations (PCOs) that is separate from and in addition to Medical Case Management Services;

(c) These procedures must ensure that each DMAP Member has an ongoing source of primary care appropriate to his or her needs and a Practitioner or entity formally designated as primarily responsible for coordinating the health care services furnished to the DMAP Member in accordance with OAR 410-141-0120;

(d) FCHPs and PCOs shall communicate these policies and procedures to Providers, regularly monitor Providers' compliance with these policies and procedures and take any corrective action necessary to ensure Provider compliance. FCHPs and PCOs shall document all monitoring and corrective action activities:

(A) PHPs shall develop and maintain a formal referral system consisting of a network of consultation and referral Providers, including applicable Alternative Care Settings, for all services covered by Contracts/agreements with DMAP and/or AMH. 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 DMAP 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 DMAP Member shall obtain all covered services, either directly or upon referral, from the PHP or PCM responsible for the service from the date of Enrollment through the date of Disenrollment, except when the DMAP Member is enrolled in a Medicare HMO orMedicare AdvantageFCHP or PCO:

(i) FCHPs or PCOs with a Medicare HMO component or Medicare Advantageand MHOs have significant and shared responsibility for prepaid services, and shall coordinate benefits for the DMAP Member to ensure that the DMAP Member receives all Medically Appropriate services covered under respective Capitation Payments;

(ii) If the DMAP Member is enrolled in a FCHP or PCO with a Medicare HMO component or Medicare Advantage, then Medicare covered mental health services shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO, respectively. Mental health services that are not covered by the FCHP or PCO, but are covered by the MHO, shall be obtained from the MHO or upon referral by the MHO.

(C) PHPs shall have written procedures for referrals which ensure adequate prior notice of the referral to referral Providers and adequate documentation of the referral in the DMAP Member's Clinical Record;

(D) PHPs shall designate a staff member who is responsible for the arrangement, coordination and monitoring of the PHP's referral system;

(E) PHPs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a Health Care Professional;

(F) PHPs shall have written procedures that ensure that relevant medical, mental health, and/or dental information is obtained from referral Providers, including telephone referrals. These procedures shall include:

(i) Review of information by the referring Provider;

(ii) Entry of information into the DMAP Member's Clinical Record;

(iii) Monitoring of referrals to ensure that information, including information pertaining to ongoing referral appointments, is obtained from the referral Providers, reviewed by the referring Practitioner, and entered into the Clinical Record.

(G) PHPs shall have written procedures to orient and train their staff, participating Practitioners and their staff, 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 DMAP Members who have not been referred to them by the PHP. If the person responding to the call is not a Health Care Professional, the PHP shall have established written protocols that clearly describe when a Health Care Professional needs to respond to the call. These procedures and protocols shall be reviewed by the PHP for appropriateness. The procedures shall address notification of acceptance or denial and entry of information into the PCP's Clinical Record;

(I) FCHPs and PCOs shall have written policies and procedures to ensure information on all emergency department visits is entered into the DMAP Member's appropriate PCP's Clinical Record. FCHPs and PCOs shall communicate this policy and procedure to Providers, monitor Providers' compliance with this policy and procedure, and take corrective action necessary to ensure compliance;

(J) If a DMAP Member is hospitalized in an inpatient or outpatient setting for a covered service, PHPs shall ensure that:

(i) A notation is made in the DMAP Member's appropriate PCP's Clinical Record of the reason, date, and expected duration of the hospitalization;

(ii) Upon discharge, a notation is made in the DMAP Member's appropriate PCP's Clinical Record of the actual duration of the hospitalization and follow-up plans, including appointments for Provider visits; and

(iii) Pertinent reports from the hospitalization are entered in the DMAP 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 DMAP 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 DMAP Member has timely and appropriate access to covered services and to ensure coordination of care provided by the PHP and care provided by the facility or home. PHPs shall make provisions for a PCP or the facility's "house doctor or dentist" to provide care to DMAP Members who, due to physical, emotional, or medical limitations, cannot be seen in a PCP office.

(3) For DMAP Members living in residential facilities or homes providing ongoing care, FCHPs and PCOs shall provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, which meets state dispensing laws. FCHPs and PCOs shall provide emergency prescriptions on a 24-hour basis.

(4) For DMAP Members who are discharged to Post Hospital Extended Care, the FCHP shall notify the appropriate DHS office at the time of admission to the skilled nursing facility (SNF) and begin appropriate discharge planning. The FCHP is not responsible for the Post Hospital Extended Care Benefit unless the DMAP Member was a member of the FCHP during the hospitalization preceding the nursing facility placement. The FCHP shall notify the nursing facility and the DMAP Member no later than two full working days prior to discharge from Post Hospital Extended Care. For DMAP Members who are discharged to Medicare Skilled Care, the appropriate DHS office shall be notified at the time the FCHP learns of the admission. The FCHP shall initiate appropriate discharge planning at the time of the notification to the DHS office.

(5) PHPs shall coordinate the services the PHP furnishes to DMAP Members with the services the DMAP Member receives from any other PHP (FCHP, PCO, DCO, CDO, or MHO) in accordance with OAR 410-141-0120(6). PHPs shall ensure that in the process of coordinating care, each DMAP Member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.

(6) When a DMAP Member's care is being transferred from one PHP to another or for OHP Clients transferring from fee-for-service to a PHP, the PHP shall make every reasonable effort within the laws governing confidentiality to coordinate transfer of the OHP Client into the care of a PHP Participating Provider.

(7) PHPs shall make attempts to contact targeted DMAP population(s) by mail, telephone, in person or through the DHS 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 DMAP Member to his/her PCP or other resources as indicated by the assessment. Targeted DMAP population(s) shall be determined by the PHP and approved by DMAP.

(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 DMAP Member access to mental health services which are not provided under the Capitation Payment.

(9) MHOs shall ensure that DMAP 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 DMAP Members experiencing a mental health crisis.

(11) MHOs shall use a multi-disciplinary team service planning and case management approach for DMAP Members requiring services from more than one public agency. This approach shall help avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, Medically Appropriate care in the least restrictive treatment setting (e.g., clinic, home, school, community).

(12) MHOs shall consult with, and provide technical assistance to, FCHPs and PCOs to help assure that mental health conditions of DMAP Members are identified early so that intervention and prevention strategies can begin as soon as possible.

Stat. Auth.: ORS 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06

410-141-0180
Oregon Health Plan Prepaid Health Plan Record Keeping

(1) Maintenance and Security: Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by the Division of Medical Assistance Programs (DMAP) Members from the PHP's primary care and referral Providers. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any corrective action necessary to ensure Participating Provider compliance. PHPs shall document all monitoring and corrective action activities. Such policies and procedures shall ensure that records are secured, safeguarded and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).

(2) Confidentiality and Privacy: PHPs and PHP's Participating Providers shall have written policies and procedures to ensure that Clinical Records related to DMAP Member's Individual Identifiable Health Information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through 179.507, 411.320, 433.045(3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45

CFR 205.50 If the PHP is a public body within the meaning of the Oregon public records law, such policies and procedures shall ensure that DMAP Member privacy is maintained in accordance with ORS 192.502(2), 192.502(8) (Confidential under Oregon law) and 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their Participating Providers shall not release or disclose any information concerning a DMAP Member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the DMAP Member;

(b) Except in an emergency, PHPs' Participating Providers shall obtain a written authorization for release of information from the DMAP Member or the legal guardian, or the legal Power of Attorney for Health Care Decisions of the DMAP Member before releasing information. The written authorization for release of information shall specify the type of information to be released and the recipient of the information, and shall be placed in the DMAP 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 DMAP Member;

(c) PHPs may consider a DMAP 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 DMAP 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 a DMAP Member within ten working days of receiving a signed authorization for release of information;

(B) Mental Health Organizations (MHOs) shall assure that directly operated and subcontracted service components, as well as other cooperating health service Providers, have access to the applicable contents of a DMAP Member's mental health record when necessary for use in the diagnosis or treatment of the DMAP Member. Such access is permitted under ORS 179.505(6).

(b) DMAP Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' Participating Providers shall upon request, provide the DMAP Member access to his/her own Clinical Record, allow for the record to be amended or corrected and provide copies within ten working days of the request. PHPs' Participating Providers may charge the DMAP Member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' Participating Providers shall upon receipt of a written authorization for release of information for the DMAP Member provide access to DMAP Member's Clinical Record. PHPs' Participating Providers may charge for reasonable duplication costs;

(d) DHS Access to Records: PHPs shall cooperate with DMAP, the Addictions and Mental Health Division (AMH), the Medicaid Fraud Unit, and/or AMH representatives for the purposes of audits, inspection and examination of DMAP 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 that fully documents the DMAP Member's condition, and the Covered and Non-Covered Services received from PHPs' Participating or referred Providers. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) A Clinical Record shall be maintained for each DMAP 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:

(A) Incorrect data shall be crossed through with a single line;

(B) Correct and legible data shall be added followed by the date corrected and initials of the person making the correction;

(C) Removal or obliteration of errors shall be prohibited.

(d) The Clinical Record shall reflect a signed and dated authorization for treatment for the DMAP Member, his/her legal guardian or the Power of Attorney for Health Care Decisions for any invasive treatments;

(e) The PCP's or clinic's Clinical Record shall include data that forms the basis of the diagnostic impression of the DMAP Member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP or clinic's Clinical Record of the DMAP Members receiving services shall include the following information as applicable:

(A) DMAP 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 psychosocial 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 DMAP 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 department and screening services reports;

(v) Consultation reports;

(vi) Medical education and medical social services provided.

(N) Copies of signed authorizations for release of information forms;

(O) Copies of medical and/or mental health directives.

(f) Based on written policies and procedures, the Clinical Record keeping system developed and maintained by PHPs' Participating Providers shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the DMAP Member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment;

(g) The PCP or clinic shall have policies and procedures that accommodate DMAP Member's requesting to review and correct or amend their Clinical Record;

(h) 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 DMAP Member's prepaid health plans, primary care physician or clinic, primary dentist and mental health Practitioner, if any in the MHO records;

(B) Copies of Client Process Monitoring System (CPMS) 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 DMAP Member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;

(E) Evidence that the DMAP Member has been informed of his or her rights and responsibilities in the MHO records;

(F) ENCC records in the FCHP's or PCO's records;

(G) Complaint and Appeal records; and

(H) Disenrollment Requests for Cause and the supporting documentation.

Stat. Auth.: ORS 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0200
Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System

(1) QI Program:

(a) FCHPs, PCOs, DCOs and CDOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division of Medical Assistance Programs (DMAP) Members. This process shall include an internal Quality Improvement (QI) program based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with relevant law and the community standards for dental care, and/or with accepted medical practice, whichever is applicable, and with accepted professional standards. The QI program shall include policies, standards, and written procedures that adequately address the needs of DMAP Members, including those who are Aged, Blind, Disabled; or children receiving CAF (SOSCF) or OYA services. FCHPs, PCOs, DCOs and CDOs shall establish or adopt written criteria to monitor and evaluate the provision of adequate medical and/or dental care. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(b) MHOs shall abide by the Quality Assurance Requirements as stated in the MHO Agreement.

(2) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. FCHPs, PCOs, DCOs and CDOs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The Quality Improvement Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of DMAP Members including those who are Aged, Blind, Disabled and children receiving CAF (SOSCF) or OYA services, or shall be able to retain consultation from individuals who are qualified.

(3) FCHPs, PCOs, DCOs and CDOs shall establish a QI Committee that shall meet at least every two months; The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:

(a) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings;

(b) Conduct and submit to DMAP an annual written evaluation of the QI Program and of DMAP Member care as measured against the written procedures and protocols of DMAP Member care. The evaluation of the QI program and DMAP Member care is to include a description of completed and ongoing QI activities, DMAP Member education and an evaluation of the overall effectiveness of the QI program. This evaluation shall include:

(A) Prevention programs;

(B) Care of DMAP Members who are Aged, Blind, Disabled or children receiving CAF (SOSCF) or OYA services, and FCHP or PCO review of the Quality of Exceptional Needs Care Coordination program;

(C) Disease management programs;

(D) Adverse outcomes of DMAP Members and DMAP Members who are Aged, Blind, Disabled or children receiving CAF (SOSCF) or OYA services;

(E) Actions taken by the FCHPs, PCOs, DCOs or CDOs to address health care concerns identified by DMAP Members or their Representatives and changes which impact quality or access to care. This may include: Clinical Record keeping; utilization review; referrals; comorbidities; prior authorizations; Emergency Services; out of FCHPs, PCOs, DCOs or CDOs utilization; medication review; FCHPs, PCOs, DCOs or CDOs initiated Disenrollments; encounter data management; and access to care and services.

(c) Conduct a quarterly review and analysis of all Complaints and Appeals received including a focused review of any persistent and significant DMAP Member Complaints and Appeals;

(d) Review written procedures, protocols and criteria for DMAP Member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.

(4) FCHPs or PCOs that are NCQA accredited or accredited by other DMAP recognized accreditation organizations shall be deemed for Section (3)(b) of this rule. FCHPs and PCOs deemed by DMAP shall annually submit to DMAP an evaluation of the Exceptional Needs Care Coordination program; and an evaluation of DMAP Member care for DMAP Members who are Aged, Blind, Disabled or children receiving CAF (SOSCF) or OYA services. Copies of accreditation reports shall be submitted to DMAP within 60 days of issuance.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 15-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0220
Oregon Health Plan Prepaid Health Plan Accessibility

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all DMAP Members. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Participating Provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between DMAP Members and non-DMAP members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures which ensure that for 90% of their DMAP Members in each Service Area, routine travel time or distance to the location of the PCP does not exceed the Community Standard for accessing health care Participating Providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by DMAP:

(A) In urban areas — 30 miles, 30 minutes or the Community Standard, whichever is greater;

(B) In rural areas — 60 miles, 60 minutes or the Community Standard, whichever is greater.

(b) PHPs shall maintain and monitor a network of appropriate Participating Providers sufficient to ensure adequate service capacity to provide availability of, and timely access to, Medically Appropriate covered services for DMAP Members:

(A) PHPs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced Participating Provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act;

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to DMAP Members in terms of timeliness, amount, duration and scope as those services are to non-DMAP persons within the same Service Area. If the PHP is unable to provide those services locally, it must so demonstrate to DMAP and shall provide reasonable alternatives for DMAP Members to access care that must be approved by DMAP. PHPs shall have a monitoring system that will demonstrate to DMAP or AMH, as applicable, that the PHP has surveyed and monitored for equal access of DMAP Members to referral Providers pharmacy, hospital, vision and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that DMAP Members who are Aged, Blind, or Disabled or who are children receiving CAF (SOSCF services) or OYA services have access to primary care, dental care, mental health Providers and referral, as applicable. These Providers shall have the expertise to treat, take into account and accommodate the full range of medical, dental or mental health conditions experienced by these DMAP Members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs and Primary Care Managers (PCMs) Enrollment Standards:

(a) PHPs and PCMs shall remain open for Enrollment unless DHS has closed Enrollment because the PHP or PCM has exceeded their Enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by DMAP or AMH, as appropriate, and the PHP or PCM;

(b) PHPs Enrollment may also be closed by DMAP or AMH, as appropriate due to sanction provisions;

(c) PHPs and PCMs shall accept all OHP Clients, regardless of health status at the time of Enrollment, subject to the stipulations in Contracts/agreements with DHS to provide covered services or Primary Care management services;

(d) PHPs and PCMs 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 DMAP;

(B) The individual presents a valid Medical Care Identification that shows he or she is enrolled with the PHP or PCM;

(C) The Automated Information System (AIS) verifies that the individual is currently eligible and enrolled with the PHP or PCM;

(D) An appropriately authorized staff member of DHS states that the individual is currently eligible and enrolled with the PHP or PCM.

(e) PHPs shall have open Enrollment for 30 continuous calendar days during each twelve-month period of January through December, regardless of the PHPs Enrollment limit. The open Enrollment periods for consecutive years may not be more than 14 months apart.

(3) If a PHP is assumed by another PHP, DMAP Members shall be automatically enrolled in the succeeding PHP. The DMAP Member will have 30 calendar days to request Disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare Advantage plan, those DMAP Members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered Enrollment in the succeeding PHP.

(4) If a PHP engages in an activity, such as the termination of a Participating Provider or Participating Provider group which has significant impact on access in that Service Area and necessitates either transferring DMAP Members to other Providers or the PHP withdrawing from part or all of a Service Area, the PHP shall provide DHS 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 DHS upon approval by DHS when the PHP must terminate a Participating Provider or Participating Provider group due to problems that could compromise DMAP Member care, or when such a Participating Provider or Participating Provider group terminates its contract with the PHP and refuses to provide the required 90 calendar days notice;

(b) If DHS must notify DMAP Members of a change in Participating Providers or PHPs, the PHP shall provide DHS with the name, prime number, and address label of the DMAP Members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide DMAP 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 DMAP 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 DMAP Members have access to appointments according to the following standards:

(A) FCHPs and PCOs:

(i) Emergency Care — The DMAP Member shall be seen immediately or referred to an emergency department depending on the DMAP Member's condition;

(ii) Urgent Care — The DMAP Member shall be seen within 48 hours; and

(iii) Well Care — The DMAP Member shall be seen within 4 weeks or within the Community Standard.

(B) DCOs:

(i) Emergency Care — The DMAP Member shall be seen or treated within 24-hours;

(ii) Urgent Care — The DMAP Member shall be seen within one to two weeks depending on DMAP Member's condition; and

(iii) Routine Care –The DMAP Member shall be seen for routine care within an average of eight (8) weeks and within twelve (12) weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.

(C) MHOs and CDO's:

(i) Emergency Care — DMAP Member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care — DMAP Member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care — DMAP 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 DMAP Members through the office such that DMAP Members are not kept waiting longer than non-DMAP Member patients, under normal circumstances. If DMAP Members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, DMAP Members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through Complaint and Appeal reviews, DMAP termination reports, and DMAP 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 DMAP Member(s) when Participating Providers have notified the PHP that the DMAP 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 Record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the DMAP Member's diagnosis or disability or is due to lack of transportation to the PHP's Participating Provider office or clinic, PHPs shall provide outreach services as Medically Appropriate;

(d) PHPs shall have policies and procedures that ensure Participating Providers will attempt to contact DMAP Members if there is a need to cancel or reschedule the DMAP 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 DMAP Members who walk into the PCP's office or clinic with medical, mental health or dental care needs. Such Triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) DMAP Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the DMAP Member's needs or be evaluated for treatment within two hours by a medical, mental health or dental Provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by DMAP and/or AMH because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics, as an operative element of FCHP's and PCO's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate Clinical Record of the DMAP 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 DMAP Member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's Participating Providers) have sufficient communication skills and training to reassure DMAP 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 DMAP Members via TDD/TTY;

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take

corrective action as needed, and report findings to the PHP's Quality Improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours, including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with, and providing care to DMAP Members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of DMAP Member services and Complaint and Grievance representatives and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health or dental care visits, including home health visits, to interpret for DMAP Members with hearing impairment or in the primary language of non-English speaking DMAP Members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the DMAP Member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the Provider to be able to understand the DMAP Member's complaint; to make a diagnosis; respond to DMAP Member's questions and concerns; and to communicate instructions to the DMAP Member;

(c) PHPs shall ensure the provision of care and interpreter services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the DMAP Member;

(d) PHPs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all DMAP Members and shall arrange for services to be provided by Non-Participating referral Providers when necessary:

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether DMAP Members are receiving accommodations for access and to determine what will be done to remove existing barriers and/or to accommodate the needs of DMAP Members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all DMAP 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 wheelchair access.

(e) PHPs shall ensure that Participating Providers, their facilities and personnel are prepared to meet the special needs of DMAP Members who require accommodations because of a disability:

(A) PHPs shall have a written plan for meeting the needs of DMAP Members;

(B) PHPs shall monitor Participating Providers for compliance with the access plan and take corrective action, when necessary.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 38-1998, f. & cert. ef. 10-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07

410-141-0260
Oregon Health Plan Prepaid Health Plan Grievance System: PHP Complaint and Appeal Procedures

(1) Definitions:

(a) Action — In the case of a PHP:

(A) The denial or limited authorization of a requested covered service, including the type or level of service;

(B) The reduction, suspension or termination of a previously authorized service;

(C) The denial in whole or in part, of payment for a service;

(D) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (DMAP);

(E) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or

(F) For a DMAP Member in a single PHP Service Area, the denial of a request to obtain covered services outside of the PHP's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(b) Appeal — A request by a DMAP Member or Representative for a PHP to review an "Action" as defined in this Section;

(c) Complaint — A DMAP Member's or DMAP Member's Representative's expression of dissatisfaction to a PHP or to a Practitioner about any matter other than an Action, as "Action" is defined in this section;

(d) Grievance System — The overall system that includes Complaints and Appeals handled at the PHP level, and access to the DMAP Administrative Hearing process.

(2) The purpose of OAR 410-141-0260 through 410-141-0266 is to describe the requirements for the overall Grievance System that includes Complaint and Appeal procedures, which are handled at the PHP level, and that provides for access to the DMAP Administrative Hearing process. These rules will apply to all PHPs as defined in OAR 410-141-0000, excluding MHOs.

(3) All PHPs shall have written policies and procedures for a Grievance System that ensures that they meet the requirements of sections OAR 410-141-0260 to 410-141-0266.

(4) Information provided to the DMAP Member shall include at least:

(a) Written material describing the PHP's Complaint and Appeal procedures, and how to make a Complaint or file an Appeal; and

(b) Assurance in all written, oral, and posted material of DMAP Member confidentiality in the Complaint and Appeal processes.

(5) A DMAP Member or a DMAP Member's Representative may file a Complaint and a PHP level Appeal orally or in writing, and may request a DMAP Administrative Hearing.

(6) PHPs shall keep all information concerning a DMAP Member's Complaint or Appeal confidential as specified in OAR 410-141-0261 and 410-141-0262.

(7) Consistent with confidentiality requirements, the PHP's staff person who is designated to receive Complaints or Appeals, shall begin to obtain documentation of the facts concerning the Complaint or Appeal upon receipt of the Complaint or Appeal.

(8) PHPs shall afford DMAP Members full use of the Grievance System procedures. If the DMAP Member decides to pursue a remedy through the DMAP Administrative Hearing process, the PHP will cooperate by providing relevant information required for the hearing process.

(9) A request for a DMAP Administrative Hearing made to DMAP outside of the PHP's Appeal procedures, or without previous use of the PHP's Appeal procedures shall be reviewed by the PHP through the PHP's Appeal process upon notification by DMAP as provided for in OAR 410-141-0264.

(10) Under no circumstances may a PHP discourage a DMAP Member or a DMAP Member's Representative from using the DMAP Administrative Hearing process.

(11) Neither implementation of a DMAP hearing decision nor a DMAP Member's request for a hearing may be a basis for a request by the PHP for a DMAP member's disenrollment.

(12) PHPs shall make available a supply of blank Complaint forms (DMAP 3001) in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to Complaints or Appeals. PHPs shall develop an Appeal form and shall make the forms available in all PHP administrative offices and in those medical/dental offices where staff have been designated by the PHP to respond to Complaints or Appeals.

(13) The PHP must provide information about the Grievance System to all participating providers and subcontractors at the time they enter into a contract.

(14) The PHP must maintain logs that are in compliance with OAR 410-141-0266 to document Complaints and Appeals received by the PHP, and the State must review the information as part of the State quality strategy.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert.ef. 6-1-04

410-141-0261
PHP Complaint Procedures

(1) A Complaint procedure applies only to those situations in which the Division of Medical Assistance Programs (DMAP) Member or their representative expresses concern or dissatisfaction about any matter other than an "Action." PHPs shall have written procedures to acknowledge the receipt, disposition and documentation of each Complaint from DMAP Members. The PHP's written procedures for handling Complaints, shall, at a minimum:

(a) Address how the PHP will accept, process and respond to each Complaint from a DMAP Member or their Representative, including:

(A) Acknowledgment to the DMAP Member or representative of receipt of each Complaint;

(B) Ensuring that DMAP Members who indicate dissatisfaction or concern are informed of their right to file a Complaint and how to do so;

(C) Ensuring that each Complaint is transmitted timely to staff who have authority to act upon it;

(D) Ensuring that each Complaint is investigated and resolved in accordance with these rules; and

(E) Ensuring that the Practitioner(s) or staff person(s) who make decisions on the Complaint must be persons who are:

(F) Not involved in any previous level of review or decision-making; and

(G) Who are health care professionals who have appropriate clinical expertise in treating the DMAP Member's condition or disease if the Complaint concerns denial of expedited resolution of an Appeal or if the Complaint involves clinical issues.

(b) Describe how the PHP informs DMAP Members, both orally and in writing, about the PHP's Complaint procedures;

(c) Designate the PHP staff member(s) or a designee who will be responsible for receiving, processing, directing, and responding to Complaints;

(d) Include a requirement for Complaints to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(2) The PHP must provide DMAP Members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a Complaint. This includes, but is not limited to, providing interpreter services and toll free phone numbers that have adequate TTY/TTD and interpreter capabilities.

(3) The PHP shall assure DMAP Members that Complaints are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq., the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The PHP shall safeguard the DMAP Member's right to confidentiality of information about the Complaint as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a DMAP Member's Complaint is kept confidential, consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any Practitioner whose services, items or quality of care is alleged to be involved in the Complaint have a right to use this information for purposes of the PHP resolving the Complaint, for purposes of maintaining the log required in OAR 410-141-0266, and for health oversight purposes, without a signed release from the DMAP Member;

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the DMAP Member to authorize a release of information regarding the Complaint to other individuals as needed for resolution. Before any information related to the Complaint is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the Complaint file. Copies of the form for obtaining the release of information shall be included in the PHP's written process.

(4) The PHPs procedures shall provide for the disposition of Complaints within the following timeframes:

(a) The PHP must resolve each Complaint, and provide notice of the disposition, as expeditiously as the DMAP Member's health condition requires, within the timeframes established in this rule;

(b) For standard disposition of Complaints and notice to the affected parties, within 5 working days from the date of the PHP's receipt of the Complaint, the PHP must either:

(A) Make a decision on the Complaint and notify the DMAP Member; or

(B) Notify the DMAP Member in writing that a delay in the PHP's decision of up to 30 calendar days from the date the Complaint was received by the PHP is necessary to resolve the Complaint. The PHP shall specify the reasons the additional time is necessary.

(5) The PHP's decision about the disposition of a Complaint shall be communicated to the DMAP Member orally or in writing within the timeframes specified in (4) of this rule:

(a) An oral decision about a Complaint shall address each aspect of the DMAP Member's Complaint and explain the reason for the PHP's decision;

(b) A written decision must be provided if the Complaint was received in writing. The written decision on the Complaint shall review each element of the DMAP Member's Complaint and address each of those concerns specifically, including the reasons for the PHP's decision.

(6) All Complaints made to the PHP's staff person designated to receive Complaints shall be entered into a log and addressed in the context of Quality Improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(7) All Complaints that the DMAP Member chooses to resolve through another process, and that the PHP is notified of, shall be noted in the Complaint log.

(8) DMAP Members who are dissatisfied with the disposition of a Complaint may present their complaint to the DMAP Ombudsman.

Stat. Auth.: ORS 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; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04

410-141-0262
PHP Appeal Procedures

(1) The PHP must have a system in place for Division of Medical Assistance Programs (DMAP) Members that includes an Appeal process. For purposes of this rule, an Appeal means a request to the PHP for review of an Action, as Action is defined in OAR 410-141-0260. A DMAP Member must complete the PHP's Appeal process before requesting a DMAP Administrative Hearing. If the DMAP Member initiates an Appeal, it shall be documented in writing by the PHP and handled as an Appeal.

(2) An Appeal must be filed with the PHP no later than 45 calendar days from the date on the Notice of Action required under OAR 410-141-0263.

(3) The DMAP Member or DMAP Member's Representative may file an Appeal with the PHP either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed Appeal.

(4) Each PHP must adopt written policies and procedures for handling Appeals that, at a minimum, meet the following requirements:

(a) Give DMAP Members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an Appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity;

(b) Address how the PHP will accept, process and respond to such Appeals, including how the PHP will acknowledge receipt of each Appeal;

(c) Ensuring that DMAP Members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an Appeal and how to do so;

(d) Ensuring that each Appeal is transmitted timely to staff who have authority to act on it;

(e) Ensuring that each Appeal is investigated and resolved in accordance with these rules; and

(f) Ensuring that the individuals who make decisions on Appeals are individuals:

(A) Who were not involved in any previous level of review or decision making; and

(B) Who are health care professionals who have the appropriate clinical expertise in treating the DMAP Member's condition or disease if an Appeal of a denial is based on lack of Medical Appropriateness or if an Appeal involves clinical issues.

(g) Include a requirement for Appeals to be documented in the log to be maintained by the PHP that is in compliance with OAR 410-141-0266.

(5) The PHP shall assure DMAP Members that Appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq., the HIPAA Privacy Rules, and other applicable federal and state confiden-

tiality laws and regulations. The PHP shall safeguard the DMAP Member's right to confidentiality of information about the Appeal as follows:

(a) PHPs shall implement and monitor written policies and procedures to ensure that all information concerning a DMAP Member's Appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the PHP, as those terms are defined in 45 CFR 164.501. The PHP and any Practitioner whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the Appeal have a right to use this information for purposes of resolving the Appeal and for purposes of maintaining the log required in OAR 410-141-0266 and for health oversight purposes by DMAP, without a signed release from the DMAP Member. The Administrative Hearing regarding the Appeal without a signed release from the DMAP Member, pursuant to OAR 410-120-1360(4);

(b) Except as provided in subsection (a) or as otherwise authorized by all other applicable confidentiality laws, PHPs shall ask the DMAP Member to authorize a release of information regarding the Appeal to other individuals. Before any information related to the Appeal is disclosed under this subsection, the PHP shall have an authorization for release of information documented in the Appeal file.

(6) The process for Appeals must:

(a) Provide that oral inquiries seeking to Appeal an Action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing, unless the DMAP Member or DMAP Member's Representative requests expedited resolution;

(b) Provide the DMAP Member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The PHP must inform the DMAP Member or the DMAP Member's Representative of the limited time available in the case of an expedited resolution);

(c) Provide the DMAP Member and/or the DMAP Member's Representative an opportunity, before and during the Appeals process, to examine the DMAP Member's file, including medical records and any other documents or records to be considered during the Appeals process; and

(d) Include as parties to the Appeal the DMAP Member, the DMAP Member's Representative, or the legal Representative of a deceased DMAP Member's estate.

(7) The PHP must resolve each Appeal and provide a client notice of the Appeal resolution as expeditiously as the DMAP Member's health condition requires and within the time frames in this section:

(a) For the standard resolution of Appeals and client notices to the DMAP Member and/or DMAP Member's Representative, the PHP shall resolve the Appeal and provide a client notice no later than 45 calendar days from the day the PHP receives the Appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(b) When the PHP has granted a request for expedited resolution of an Appeal, the PHP shall resolve the Appeal and provide a client notice no later than 3 working days after the PHP receives the Appeal. This timeframe may be extended pursuant to subsection (c) of this section;

(c) The PHP may extend the timeframes from subsections (a) or (b) of this section by up to 14 calendar days if:

(A) The DMAP Member requests the extension; or

(B) The PHP shows (to the satisfaction of DMAP, upon its request) that there is need for additional information and how the delay is in the DMAP Member's interest.

(d) If the PHP extends the timeframes, it must, for any extension not requested by the DMAP Member, give the DMAP Member a written notice of the reason for the delay.

(8) For all Appeals, the PHP must provide written Notice of Appeal Resolution to the DMAP Member or their Representative. For notice on an expedited resolution, the PHP must also make reasonable efforts to provide oral notice.

(9) The written Notice of Appeal Resolution must include the following:

(a) The results of the resolution process and the date it was completed; and

(b) For Appeals not resolved wholly in favor of the DMAP Member, the notice must also include the following information:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the Appeal;

(B) The right to request a DMAP Administrative Hearing, and how to do so, which includes attaching the "Notice of Hearing Rights (DMAP 3030) and the Hearing Request Form (CAF 443);

(C) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(D) That the DMAP Member may be held liable for the cost of those benefits if the hearing decision upholds the PHP's Action.

(10) A DMAP Member may request a DMAP Administrative Hearing not later than 45 calendar days from the date on the PHP's Notice of Appeal Resolution, consistent with section (7)(a) of this rule. The parties to the DMAP Administrative Hearing include the PHP as well as the DMAP Member and/or DMAP Member's Representative, or the Representative of the deceased DMAP Member's estate.

(11) Each PHP shall establish and maintain an expedited review process for Appeals, consistent with OAR 410-141-0265.

(12) Each PHP shall maintain records of Appeals, enter Appeals and their resolution into a log, and address the Appeals in the context of Quality Improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

(13) Continuation of benefits pending Appeal:

(a) As used in this section, "timely" filing means filing on or before the later of the following:

(A) Within 10 calendar days of the PHP mailing the Notice of Action; or

(B) The intended effective date of the PHP's proposed Action.

(b) The PHP must continue the DMAP Member's benefits if:

(A) The DMAP Member or DMAP Member's Representative files the Appeal timely;

(B) The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(C) The services were ordered by an authorized Provider;

(D) The original period covered by the original authorization has not expired; and

(E) The DMAP Member requests extension of benefits.

(c) Continuation of benefits pending Administrative Hearing — If, at the DMAP Member's request, the PHP continues or reinstates the DMAP Member's benefits while the Appeal is pending and the Notice of Appeal Resolution is adverse to the DMAP Member, the benefits must be continued pending Administrative Hearing pursuant to OAR 410-141-0264.

(14) If the final resolution of the Appeal is adverse to the DMAP Member, that is, upholds the PHP's Action, the PHP may recover the cost of the services furnished to the DMAP Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR 431.230(b).

(15) If the PHP, or a DMAP hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the DMAP Member's health condition requires.

(16) If the PHP, or the DMAP hearing decision reverses a decision to deny authorization of services, and the DMAP Member received the disputed services while the Appeal was pending, the PHP or DMAP must pay for the services in accordance with DMAP policy and regulations.

Stat. Auth.: ORS 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; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04

410-141-0263
Notice of Action by a Prepaid Health Plan

(1) When a PHP (or authorized Practitioner acting on behalf of the PHP) takes or intends to take any Action, including but not limited to denials or limiting prior authorizations of a requested covered service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other Action, the PHP (or authorized Practitioner acting on behalf of the PHP) shall mail a written client Notice of Action in accordance with section (2) of this rule to the Division of Medical Assistance Programs (DMAP) Member within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be a DMAP approved format and it must be used for all denials of a requested covered service(s), reductions, discontinuations or terminations of previously authorized services, denials of claims payment, or other Action. The

client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the DMAP Member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) DMAP Member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service; and

(G) Effective date of the Action.

(b) The Action the PHP or its Participating Provider has taken or intends to take;

(c) Reasons for the Action, including but not limited to the following reasons:

(A) Treatment is not covered;

(B) The item requires pre-authorization and it was not pre-authorized;

(C) The service is not Dentally or Medically Appropriate;

(D) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(E) The person was not a DMAP Member at the time of the service or is not a DMAP Member at the time of a requested service; and

(F) The Provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan Rules).

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section, in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The DMAP Member's right to file an Appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The circumstances under which expedited Appeal resolution is available and how to request it;

(g) The DMAP Member's right to have benefits continue pending resolution of the Appeal, how to request that benefit(s) be continued, and the circumstances under which the DMAP Member may be required to pay the costs of these services; and

(h) The telephone number to contact the PHP for additional information.

(3) The PHP or Practitioner(s) acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension, or reduction of previously authorized OHP covered services, the following time frames apply:

(A) The notice must be mailed at least 10 calendar days before the date of Action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP (or authorized Practitioner acting on behalf of the PHP) may mail a notice not later than the date of Action if:

(i) The PHP or Practitioner receives a clear written statement signed by the DMAP Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The DMAP Member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The DMAP Member's whereabouts are unknown and the post office returns PHP or Practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another State, territory, or commonwealth has accepted the DMAP Member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the DMAP Member's PCP or PCD; or

(vi) The date of Action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12(a)(5)(ii), related to discharges or transfers and long-term care facilities.

(C) The PHP may shorten the period of advance notice to 5 calendar days before the date of the Action if the PHP has facts indicating that an Action should be taken because of probable fraud by the DMAP Member. Whenever possible, these facts should be verified through secondary sources.

(b) For denial of payment, at the time of any Action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the DMAP Member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the DMAP Member or the Provider requests the extension; or if the PHP justifies (to DMAP upon request) a need for additional information and how the extension is in the DMAP Member's interest;

(B) If the PHP extends the timeframe, in accordance with subsection (A) of this section, it must give the DMAP Member written notice of the reason for the decision to extend the timeframe and inform the DMAP Member of their right to file a Complaint if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the DMAP Member's health condition requires and no later than the date the extension expires.

(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section, (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire;

(e) For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

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

Stat. Auth.: ORS 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; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

410-141-0264
Administrative Hearings

(1) An individual who is or was a Division of Medical Assistance Programs (DMAP) Member at the time of the Notice of Action is entitled to an Administrative Hearing by DMAP regarding the Notice of Appeal Resolution by a PHP that has denied requested services, payment of a claim, or terminates, discontinues or reduces a course of treatment, or any other Action. There is no right to a state administrative hearing based solely on a Notice of Action. The DMAP Member must go through the appeal process with their PHP before they can request a state administrative hearing. The decision in the Notice of Appeal Resolution is the document that will trigger the right to request a state administrative hearing. DMAP does not need to grant an Administrative Hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all DMAP Members. Client Administrative Hearings are governed by OAR 410-120-1860, 410-120-1865, and this rule.

(2) A written hearing request must be received by the Hearings Unit at DMAP not later than the 45th day following the date of the Notice of Appeal Resolution.

(3) If, at the DMAP Member's request, the PHP continued or reinstated services while the Appeal was pending, the benefits must be continued pending the Administrative Hearing until one of the following occurs:

(a) The DMAP Member withdraws the request for an Administrative Hearing;

(b) Ten calendar days pass after the PHP mails the Notice of Appeal Resolution, providing the resolution of the Appeal against the DMAP Member, unless the DMAP Member within the 10-day timeframe, has requested a DMAP Administrative Hearing with continuation of benefits until the DMAP Administrative Hearing decision is reached;

(c) A final order is issued in a DMAP Administrative Hearing adverse to the DMAP Member; or

(d) The time period or service limits of a previously authorized service have been met.

(4) The DMAP Representative shall review the Administrative Hearing request, documentation related to the Administrative Hearing issue, and computer records to determine whether the claimant or the person for whom the request is being made is or was a DMAP Member at the time the Action was taken, and whether the hearing request was timely.

(5) PHPs shall immediately transmit to DMAP any Administrative Hearing request submitted on behalf of a DMAP Member, including a copy of the DMAP Member's Notice of Appeal Resolution.

(6) If the DMAP Member files a request for an Administrative Hearing with DMAP, DMAP will send a copy of the hearing request to the PHP.

(7) PHPs shall review an Administrative Hearing Request, which has not been previously received or reviewed as an Appeal, using the PHP's Appeal process as follows:

(a) The Appeal shall be reviewed immediately and shall be resolved, if possible, within 45 calendar days, pursuant to OAR 410-141-0262;

(b) The PHP's Notice of Appeal Resolution shall be in writing and shall be provide to the DMAP Member.

(8) When an Administrative Hearing is requested by a DMAP Member who has exhausted the PHP Appeal process, the PHP shall cooperate with providing relevant information required for the hearing process to DMAP, as well as the results of the review by the PHP of the Appeal and the Administrative Hearing request, and any attempts at resolution by the PHP.

(9) Information about DMAP Members used for Administrative Hearings is handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq., the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. DMAP will safeguard the DMAP Member's right to confidentiality of information used in the Administrative Hearing as follows:

(a) DMAP, the DMAP Member and their representative, the PHP and any Practitioner whose authorization, treatment, services, items, or request for payment is involved in the Administrative Hearing have a right to use this information for purposes of resolving the Administrative Hearing without a signed release from the DMAP Member. DMAP may also use this information, pursuant to OAR 410-120-1360(4), for health oversight purposes, and for other purposes authorized or required by law. The information may also be disclosed to the Office of Administrative Hearings and the Administrative Law Judge assigned to the Administrative Hearing, and to the Court of Appeals if the DMAP Member seeks judicial review of the final order;

(b) Except as provided in subsection (a), DMAP will ask the DMAP Member to authorize a release of information regarding the Administrative Hearing to other individuals. Before any information related to the Administrative Hearing is disclosed under this subsection, DMAP must have an authorization for release of information documented in the Administrative Hearing file.

(10) The hearings request (CAF 443), along with the Notice of Appeal Resolution, shall be referred to the Office of Administrative Hearings and the hearing will be scheduled:

(a) The parties to the Administrative Hearing shall include the PHP, as well as the DMAP Member and his or her Representative, or the Representative of a deceased DMAP Member's estate;

(b) The procedures applicable to the Administrative Hearing shall be conducted consistent with OAR 410-120-1860 and 410-120-1865;

(c) A final order should be issued or the case otherwise resolved by DMAP not later than 90 calendar days following DMAP's receipt of the request for Administrative Hearing. Delay due to a postponement or continuance granted at the request of a party or DMAP, or with the consent of the parties or DMAP, shall not be counted in computing the time limit. The final order is the final decision of DMAP.

(11) If the final resolution of the Administrative Hearing is adverse to the DMAP Member, that is, if the final order upholds the PHP's Action, the PHP may recover the cost of the services furnished to the DMAP Member while the Administrative Hearing is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR 438.420.

(12) The PHP must promptly correct the Action taken up to the limit of the original request or authorization, retroactive to the date the Action was taken, if the hearing decision is favorable to the DMAP Member, or DMAP and/or the PHP decides in the DMAP Member's favor before the hearing even if the DMAP Member has lost eligibility after the date the Action was taken:

(a) If the PHP, or a DMAP hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the Administrative Hearing was pending, the PHP must authorize or provide the disputed services promptly, and as expeditiously as the DMAP Member's health condition requires;

(b) If the PHP, or the DMAP hearing decision reverses a decision to deny authorization of services, and the DMAP Member received the disputed services while the Administrative Hearing was pending, the PHP must pay for the services in accordance with DMAP policy and regulations in effect when the request for services was made by the DMAP Member.

Stat. Auth.: ORS 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; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04

410-141-0265
Request for Expedited Appeal or Expedited Administrative Hearing

(1) Each PHP shall establish and maintain an expedited review process for Appeals, when the PHP determines (upon request from the Division of Medical Assistance Programs (DMAP) Member) or the Provider indicates (in making the request on a DMAP Member's behalf or supporting the DMAP Member's request) that taking the time for a standard resolution could seriously jeopardize the DMAP Member's life, health, or ability to attain, maintain or regain maximum function.

(2) The PHP must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a DMAP Member's Appeal.

(3) If the PHP provides an expedited Appeal, but denies the services or items requested in the expedited Appeal, the PHP shall inform the DMAP Member of the right to request an expedited Administrative Hearing and shall provide the DMAP Member with a copy of both the CAF Form 443 and Notice of Hearing Rights (DMAP 3030) with the Notice of Appeal Resolution.

(4) If the PHP denies a request for expedited resolution on Appeal, it must:

(a) Transfer the Appeal to the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the DMAP Member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) A DMAP Member who believes that taking the time for a standard resolution of a request for an Administrative Hearing could seriously jeopardize the DMAP Member's life or health or ability to attain, maintain or regain maximum function may request an expedited Administrative Hearing.

(6) The PHP shall submit relevant documentation to the DMAP Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. The DMAP Medical Director shall decide within, as nearly as possible, 2 working days from the date of receiving the medical documentation applicable to the request, whether that DMAP Member is entitled to an expedited Administrative Hearing.

(7) If the DMAP Medical Director denies a request for expedited Administrative Hearing, DMAP must:

(a) Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and

(b) Make reasonable efforts to give the DMAP Member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04

410-141-0266
PHP's Responsibility for Documentation and Quality Improvement Review of the Grievance System

(1) The PHP's documentation shall include, at minimum, a log of all oral and written Complaints and Appeals received by the PHP. The log shall identify the Division of Medical Assistance Programs (DMAP) Member and the following additional information:

(a) For Complaints, the date of the Complaint, the nature of the Complaint, the disposition and date of disposition of the Complaint;

(b) For Appeals, the date of the Notice of Action, the date of the Appeal, the nature of the Appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the Appeal. If an Administrative Hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the Administrative Hearing.

(2) The PHP shall also maintain a record for each of the Complaints and Appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the DMAP Member. The PHPs shall retain documentation of Complaints and Appeals for the term of the OHP Demonstration Project plus two years to permit evaluation.

(3) The PHPs shall have written procedures for the review and analysis of the Grievance System, including all Complaints and Appeals received by the PHP. The analysis of the Grievance System shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards:

(a) PHPs shall monitor the completeness and accuracy of the written log, on a monthly basis;

(b) Monitoring of Complaints and Appeals shall review, at minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of Complaints and Appeals, and compliance with Oregon Health Plan rules.

Stat. Auth.: ORS 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; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04

410-141-0270
Oregon Health Plan Marketing Requirements

(1) PHPs may not conduct, directly or indirectly, door-to-door, telephonic, electronic, mail or other cold call marketing practices to entice OHP Clients to enroll into their PHP.

(2) PHPs or their subcontractors shall not seek to influence OHP Client's Enrollment with the PHP. PHPs are allowed to engage in activities for purposes of outreach to existing Division of Medical Assistance Programs (DMAP) Members, health promotion and health education.

(3) Any written communication by the PHP or its subcontractors and providers which is intended solely for DMAP Members and pertains to provider requirements for obtaining services, care at service sites, or benefits, must be approved by DMAP and/or Addictions and Mental Health Division (AMH) prior to distribution.

(4) PHPs may also communicate with providers, caseworkers, community agencies and other interested parties for informational purposes. The intent of these communications should be informational and not to entice or solicit membership. Communication methodologies may include, but are not limited to;

(a) Brochures, pamphlets, newsletters, posters, fliers, web sites, health fairs, or sponsorship of health-related events;

(b) The creation of name recognition, as a result of PHP's health promotion or education activities, shall not be deemed to constitute an attempt by PHPs to influence a OHP Client's Enrollment;

(c) PHP shall cooperate in developing a comprehensive explanation of the services available from PHP under Contract/Agreement with DHS for the DMAP Comparison Charts.

(5) Subcontractors may post a sign listing all OHP PHPs to which the provider belongs and display PHP-sponsored health promotional materials.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0280
Oregon Health Plan Prepaid Health Plan Informational Requirements

(1) Prepaid Health Plans (PHPs) shall develop informational materials for Potential Division of Medical Assistance Programs (DMAP) Members:

(a) PHPs shall provide DMAP and/or Addictions and Mental Health Division (AMH) with informational materials sufficient for the potential DMAP Member to make an informed decision about PHP selection and Enrollment. Information on Participating Providers must be made available from the PHP, upon request to Potential DMAP Members, and must include Participating Providers' name, location, qualification and the availability of the PCP, clinic and specialists. Informational materials may be included in the application packet for Potential DMAP Members;

(b) PHPs shall ensure that all PHP's staff who have contact with Potential DMAP Members are fully informed of PHP and DMAP and/or AMH policies, including Enrollment, Disenrollment, Complaint and Grievance policies and the provision of interpreter services including which Participating Providers' offices have bilingual capacity;

(c) PHPs shall cooperate and provide accurate information to DMAP for the updating of the comparison charts.

(2) Informational materials that PHPs develop for DMAP Members and Potential DMAP Members shall meet the language requirements of, and be culturally sensitive to the PHP's DMAP membership including members with disabilities or reading limitations, and including substantial populations whose primary language is not English in its particular Service Area(s):

(a) PHPs shall be required to follow the DMAP substantial household criteria required by ORS 411.062, which determines and identifies those populations that are considered non-English speaking households; however, PHP shall only be responsible for those identified languages, if the substantial population is 35 or more non-English speaking households with the same language in its Service Area. The PHP shall be required to provide informational materials, which at a minimum, shall include the DMAP Member handbook and information about Complaints and Appeals in the primary language of each substantial population. Alternative forms may include, but are not limited to audio tapes, close-captioned videos, large type and Braille;

(b) Form correspondence sent to DMAP Members, including but not limited to, Enrollment information, choice and DMAP Member counseling letters and denial of service notices shall include instructions in the appropriate languages of each substantial population of non-English speaking DMAP Members on how to receive an oral translation of the material;

(c) All written informational materials distributed to DMAP Members shall be written at the sixth grade reading level and printed in 12 point print or larger;

(d) PHPs shall provide written notice to affected DMAP Members of any significant changes in program or service sites that impacts the DMAP Members' ability to access care or services from PHP's Participating Providers. Such notice shall be provided at least 30 calendar days prior to the effective date of that change, or as soon as possible if the Participating Provider(s) has not given the PHP sufficient notification to meet the 30 days notice requirement. DMAP and/or AMH will review and approve such materials within two working days.

Stat. Auth.: ORS 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; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0300
Oregon Health Plan Prepaid Health Plan Member Education

CDO: Chemical Dependency Organization
DCO: Dental Care Organization
DHS: Department of Human Services
ENCC: Exceptional Needs Care Coordination
FCHP: Fully Capitated Health Plan
MHO: Mental Health Organization
OHP: Oregon Health Plan
DMAP: Division of Medical Assistance Programs
AMH: Addictions and Mental Health Division
PCD: Primary Care Dentist
PCO: Physician Care Organization
PCP: Primary Care Provider
PHP: Prepaid Health Plan (FCHP, PCO, DCO, CDO and MHO)

(1) PHPs shall have an ongoing process of DMAP Member education and information sharing that includes orientation to the PHP, a PHP DMAP Member handbook and health education. DMAP Member education shall include:

(a) The availability of ENCC through FCHPs and PCOs for DMAP Members with special health care needs, who are Aged, Blind or Disabled; and

(b) The appropriate use of the delivery system, including a proactive and effective education of DMAP Members on how to access Emergency Services and Urgent Care Services appropriately.

(2) PHPs shall offer PHP orientation to new DMAP 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 DMAP, and a DHS agency is unable to assist in delivering the information to the DMAP Member.

(3) PHP DMAP Member handbook materials:

(a) The PHP DMAP Member handbook shall be made available for new DMAP Members, as described in OAR 410-141-0280, Oregon Health Plan PHP Informational Requirements, and shall be distributed within 14 calendar days of the DMAP Member's effective date of coverage with PHP;

(b) At a minimum the information in the PHP DMAP Member handbook shall contain the following elements:

(A) Location(s), office hours and availability of physical access for DMAP Members with disabilities to PHP and PCP and PCD offices;

(B) Telephone number(s) (including TTY) for DMAP Members to call for more information and telephone numbers relating to information listed below;

(C) DMAP Member's choice and use of PCPs, PCDs and policies on changing PCPs, PCDs;

(D) Use of the PHP's appointment system;

(E) Use of the PHP's referral system, including procedures for obtaining benefits, including authorization requirements;

(F) How DMAP Members are to access Urgent Care Services and advice;

(G) How and when DMAP Members are to use Emergency Services including information on Post-Stabilization Care Services, related to an emergency medical condition that are provided after a DMAP Member is stabilized in order to maintain the stabilized condition, or, under the circumstances to improve or resolve the DMAP Member's condition;

(H) Information on the PHP's Complaint process and information on fair hearing procedures;

(I) How DMAP Members are to access interpreter services including sign interpreters;

(J) Information on the DMAP Member's rights and responsibilities;

(K) Information on the DMAP Member's possible responsibility for charges including Medicare deductibles and coinsurances (if they go outside of PHP for non-emergent care), co-payments, and charges for non-covered services;

(L) The transitional procedures for new DMAP Members to obtain prescriptions, supplies and other necessary items and/or services in the first month of Enrollment with the PHP if they are unable to meet with a PCP, PCD, other prescribing Practitioner or obtain new orders during that period;

(M) What services can be self-referred to both Participating and Non-Participating Providers (FCHPs, PCOs and MHOs only);

(N) To adult DMAP Members written information on Advance Directive policies including:

(i) A description of applicable state law;

(ii) DMAP Member rights under Oregon law;

(iii) The contractor's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(O) How to request information on the PHP's physician incentives;

(P) The DMAP Member's right to request and obtain copies of their Clinical Records (and that they may be charged a reasonable copying fee) and to request that the record be amended or corrected;

(Q) How DMAP Members are to obtain emergent and non-emergent ambulance services (FCHP and PCO only) and other medical transportation to appointments, as appropriate;

(R) Explanation of the amount, scope and duration of covered and non-covered Services in sufficient detail to ensure that DMAP Members understand the benefits to which they are entitled;

(S) How DMAP Members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs (FCHPs and PCOs only);

(T) PHP's confidentiality policy;

(U) Name, locations, telephone numbers of, and non-English languages offered by current Participating Providers, including information on PHP's PCPs/PCDs that are not accepting new DMAP Members (not MHOs) including at a minimum, information on PCPs, specialists and hospitals in the DMAP Member's Service Area;

(V) The extent to which; and how, DMAP Members may obtain benefits, including Family Planning Services, from Non-Participating Providers;

(W) Any restrictions on the DMAP Member's freedom of choice among Participating Providers;

(X) Policies on referrals for specialty care and for other benefits not furnished by the DMAP Member's PCP;

(Y) How and where DMAP Members are to access any benefits that are available under OHP but are not covered under the PHPs' Contract, including any cost sharing, and how transportation is provided.

(c) If the PHP DMAP Member handbook is returned with a new address, the PHP shall re-mail the PHP DMAP Member handbook or use the telephone number provided by DHS to reach the DMAP Member. If the PHP is unable to reach the DMAP Member by either mail or telephone, the PHP shall retain the PHP DMAP Member handbook and have it available upon request for the DMAP Member;

(d) PHPs shall, at a minimum, annually and upon request provide the PHP DMAP Member handbook to DMAP Members, DMAP Member's Representative and to clinical offices for distribution to DMAP Members;

(e) The PHP DMAP 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 DMAP Members' ability to use services or benefits, the updated materials shall be distributed to all DMAP Members;

(f) The DHS "Oregon Health Plan Client Handbook" is in addition to the PHP DMAP Member handbook and cannot be used to substitute for the PHP DMAP Member handbook.

(4) PHPs shall have written procedures and criteria for health education of DMAP 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 non-dominant cultures: PHPs shall ensure development and maintenance of an individualized health educational plan for DMAP Members who have been identified by their Practitioner as requiring specific educational intervention. DHS may assist in developing materials that address specifically identified health education problems to the population in need.

(5) PHPs shall provide an identification card to DMAP Members, unless waived by DMAP and/or AMH, 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, DMAP Members and Providers.

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

Stat. Auth.: ORS 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; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0320

Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure Division of Medical Assistance Programs (DMAP) 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 DMAP Member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) DMAP Members shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by Participating Providers the same as other people seeking health care benefits to which they are entitled;

(c) To choose a PHP or PCM as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Physician (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies;

(d) To refer oneself directly to mental health, Chemical Dependency or Family Planning Services without getting a referral from a PCP or other Participating Provider;

(e) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(f) To be actively involved in the development of 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 that is understandable to the DMAP Member;

(k) To receive necessary and reasonable services to diagnose the presenting condition;

(l) To receive Covered Services under the Oregon Health Plan that meet generally accepted standards of practice and is Medically Appropriate;

(m) To obtain covered Preventive Services;

(n) To have access to urgent and emergency services 24 hours a day, 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 or Appeal with the PHP and receive a response as defined in OAR 410-141-0260 to 410-141-0266;

(v) To request an Administrative Hearing with the Department of Human Services (DHA or Department);

(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) DMAP Members shall have the following responsibilities:

(a) To choose, or help with assignment to, a PHP or PCM 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 Services appropriately and notify the PHP within 72 hours of an emergency;

(h) To give accurate information for inclusion in the Clinical Record;

(i) To help the Practitioner, Provider or clinic obtain Clinical Records from other Providers which may include signing an authorization for 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 DMAP Medical Care Identification form;

(o) To tell the DHS worker of a change of address or phone number;

(p) To tell the DHS worker if the DMAP Member becomes pregnant and to notify the DHS worker of the birth of the DMAP Member's child;

(q) To tell the DHS worker if any family members move in or out of the household;

(r) To tell the DHS worker if there is any other insurance available;

(s) To pay for Non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(t) To pay the monthly OHP premium on time if so required;

(u) To assist the PHP in pursuing any third party resources available and to pay the PHP the amount of benefits it paid for an injury from any recovery received from that injury;

(v) To bring issues, or Complaints or Grievances to the attention of the PHP; and

(w) To sign an authorization for release of medical information so that DHS and the PHP can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0340
Oregon Health Plan Prepaid Health Plan Financial Solvency

(1) Prepaid Health Plans (PHPs) shall assume the risk for providing Capitated Services under their Contracts/agreements with the Division of Medical Assistance Programs (DMAP) and/or the Addictions and Mental Health Division (AMH). PHPs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to DMAP and/or AMH, as applicable:

(a) PHPs shall comply with solvency requirements specified in Contracts/agreements with DMAP and/or AMH, as applicable. Solvency requirements of PHPs shall include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in Contracts/agreements with DMAP and/or AMH. If the PHP has Contracts/agreements with both DMAP and AMH, separate restricted reserve fund accounts shall be maintained for each Contract/agreement;

(B) Protection against catastrophic and unexpected expenses related to Capitated Services for PHPs. The method of protection may include the purchase of stop loss coverage, reinsurance, self-insurance or any other alternative determined acceptable by DMAP and/or AMH, as applicable. Self-insurance must be determined appropriate by DMAP and/or AMH;

(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 DMAP Members and accounting for Capitation Payments;

(iv) Tracking claims payment;

(v) Tracking all monies collected from third party resources on behalf of DMAP 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 DMAP and/or AMH:

(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 DMAP and/or AMH.

(B) PHP-specific quarterly financial reports. Such quarterly reports shall include, but are not limited to:

(i) Statement of Revenue, Expenses and Net Income;

(ii) Balance Sheet;

(iii) Statement of Cash Flows;

(iv) Incurred But Not Reported (IBNR) Expenses;

(v) Fee-for-service liabilities and medical/hospital expenses that are covered by risk-sharing arrangements;

(vi) Restricted reserve documentation;

(vii) Third party resources collections (AMH contractors); and

(viii) Corporate Relationships of Contractors (FCHPs, DCOs, CDOs and PCOs) or Incentive Plan Disclosure and Detail (MHOs).

(C) PHP-specific utilization reports;

(D) PHP-specific quarterly documentation of the Restricted Reserve. Restricted reserve funds of FCHPs, PCOs, 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 AMH 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 AMH. Regardless of the alternative selected, MHOs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with AMH;

(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 AMH, the MHO shall provide advance notice to AMH 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 AMH access to restricted reserve funds if insolvency occurs;

(e) MHOs shall have written policies and procedures to ensure that, if insolvency occurs, DMAP Members and related clinical records are transitioned to other MHOs or providers with minimal disruption.

Stat. Auth.: ORS 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; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0400
Oregon Health Plan Prepaid Health Plan Case Management Services

DCO: Dental Care Organization
FCHP: Fully Capitated Health Plan
MHO: Mental Health Organization
OHP: Oregon Health Plan
PCO: Physician Care Organization
PHP: Prepaid Health Plan

(1) Prepaid Health Plans provide Case Management Services under the Oregon Health Plan.

(2) Prepaid Health Plan Case Management Services are defined as follows:

(a) FCHPs and PCOs provide Medical Case Management as defined in OAR 410-141-0000, Definitions;

(b) DCOs provide Dental Case Management as defined in OAR 410-141-0000, Definitions. DCOs shall make Dental Case Management staff available for training, Regional OHP meetings, and case conferences involving their division of Medical Assistance Programs (DMAP) Members in all service areas;

(c) MHOs provide Mental Health Case Management for Capitated and Non-Capitated mental health services as defined in OAR 410-141-0000, Definitions.

Stat. Auth.: ORS 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; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0405
Oregon Health Plan Fully Capitated Health Plan and Physician Care Organization Exceptional Needs Care Coordination (ENCC)

Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health Plan:

(1) FCHPs and PCOs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all Capitated Services;

(2) FCHPs and PCOs shall make ENCC services available at the request of the Aged, Blind or Disabled Division of Medical Assistance Programs (DMAP) Member, his or her Representative, a physician, or other medical personnel serving the DMAP Member, or the Aged, Blind or Disabled DMAP Member's agency case manager;

(3) FCHPs and PCOs shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving their Aged, Blind and Disabled DMAP Members in all their Service Areas;

(4) FCHP and PCO staff who coordinate or provide ENCC services shall be trained to and exhibit skills in communication with and sensitivity to the unique health care needs of people who are Aged, Blind, Disabled or have special health care needs. FCHPs and PCOs shall have a written position description for the staff member(s) responsible for managing ENCC services and for staff who provide ENCC services;

(5) FCHPs and PCOs shall have written policies that outline how the level of staffing dedicated to ENCC is determined;

(6) FCHPs and PCOs shall make ENCC services available to DMAP Members who are Aged, Blind, Disabled or having special health care needs during normal office hours, Monday through Friday. Information on ENCC services shall be made available when necessary to a DMAP Member's Representative during normal business hours, Monday through Friday;

(7) FCHPs and PCOs shall provide the Aged, Blind, Disabled or special health care need DMAP 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 and PCOs shall periodically inform all of their Practitioners and the Practitioner's staff of the availability of ENCC services, provide training for medical office staff on ENCC services and other support services available for serving the Aged, Blind, Disabled or special need DMAP Members; FCHPs and PCOs shall assure that the ENCCs name(s) and telephone number(s) are made available to both agency staff and DMAP Members or their Representatives;

(9) FCHPs and PCOs shall have written procedures that describe how they will respond to ENCC requests;

(10) FCHPs and PCOs shall make ENCC services available to coordinate the provision of Covered Services to Aged, Blind, Disabled or special need DMAP Members who exhibit inappropriate, disruptive or threatening behaviors in a Practitioner's office;

(11) Exceptional Needs Care Coordinators shall document ENCC services in DMAP Member medical records as appropriate and/or in a separate DMAP Member case file.

Stat. Auth.: ORS 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; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0407
Oregon Health Plan Ombudsman Services

(1) Department of Human Services (DHS) provides Ombudsman services for Aged, Blind and Disabled Oregon Health Plan clients and

Division of Medical Assistance Programs (DMAP) Members as defined in OAR 410-141-0000, Definitions.

(2) DHS shall inform all Aged, Blind and Disabled Oregon Health Plan clients and DMAP Members of the availability of Ombudsman Services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0410
Oregon Health Plan Primary Care Managers

(1) Primary Care Managers provide Primary Care Management Services under the Oregon Health Plan. Primary Care Managers provide Primary Care Management Services as defined in OAR 410-141-0000, Definitions, for the following PCM 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; and

(c) Outpatient hospital services except laboratory, x-ray and maternity management services.

(2) Services which are not PCM Case Managed Services include, but are not limited to, the following:

(a) Anesthesiology services;

(b) Dental care services;

(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 case 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 andhuman immuno-deficiency 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; and

(p) Diagnostic imaging.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 69-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0420
Oregon Health Plan Prepaid Health Plan Billing and Payment Under the Oregon Health Plan

(1) All billings for Oregon Health Plan Clients to Prepaid Health Plans (PHPs) and to Division of Medical Assistance Programs (DMAP) shall be submitted within four (4) months and twelve (12) months, respectively, of the date of service, subject to other applicable DMAP billing rules. Submissions shall be made to PHPs within the four (4) month time frame except in the following cases:

(a) Pregnancy;

(b) Eligibility issues such as retroactive deletions or retroactive Enrollments;

(c) Medicare is the primary payor;

(d) Other cases that could have delayed the initial billing to the PHP (which does not include failure of Provider to certify the DMAP Member's eligibility); or

(e) Third Party Resource (TPR). Pursuant to 42 CFR 36.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payor of last resort and is not considered an alternative resource or TPR.

(2) Providers must be enrolled with DMAP to be eligible for Fee-for-Service (FFS) payment by DMAP. Mental health Providers, except Federally Qualified Health Centers, must be approved by the Local Mental Health Authority (LMHA) and the Addictions and Mental Health Division (AMH) before enrollment with DMAP. 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 DMAP to be eligible for payment for services by PHPs except that Providers who have been excluded as Medicare/Medicaid Providers by DMAP, CMS or by lawful court orders are ineligible to receive payment for services by PHPs.

(4) Providers shall verify, before rendering services, that the DMAP Member is eligible for the Medical Assistance Program 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 DMAP 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 DMAP 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 DMAP specifies otherwise. PHPs may require Providers to obtain preauthorization 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-authorization 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 preauthorization requests to obtain additional 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 preauthorization;

(vi) Sending notice of the decision with Appeal rights to the DMAP Member when the determination is made to deny the requested service as specified in 410-141-0263.

(B) PHPs shall make a determination on at least 95% of Valid Pre-Authorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in a skilled nursing facility. Pre-authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If a pre-authorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHP shall notify Providers of such determination within 2 working days of receipt of the request;

(C) For expedited prior authorization requests in which the Provider indicates, or the PHP determines, that following the standard timeframe could seriously jeopardize the DMAP Member's life or health or ability to attain, maintain, or regain maximum function:

(i) The PHP must make an expedited authorization decision and provide notice as expeditiously as the DMAP Member's health condition requires and no later than three working days after receipt of the request for service;

(ii) The PHP may extend the three working days time period by up to 14 calendar days if the DMAP Member requests an extension, or if the PHP justifies to DMAP a need for additional information and how the extension is in the DMAP Member's interest.

(D) For all other pre-authorization requests, PHPs shall notify Providers of an approval, a denial or a need for further information within 14 calendar days of receipt of the request. PHPs must make reasonable efforts to obtain the necessary information during that 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information, if the PHP justifies the need for additional information and how the delay is in the interest of the DMAP Member. The PHP shall make a determination as the DMAP Member's health condition requires, but no later than the expiration of the extension. PHPs shall notify DMAP Members of a denial within five working days from the final determination using a DMAP or AMH approved client notice format.

(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 DMAP 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 provide written notification of PHP determinations when such determinations result in a denial of payment for services, for which the DMAP Member may be financially responsible. Such notice shall be provided to the DMAP Member and the treating Provider within 14 calendar days of the final determination. The notice to the DMAP Member shall be a DMAP or AMH approved notice format and shall include information on the PHPs internal appeals process, and the Notice of Hearing Rights (DMAP 3030) shall be attached. The notice to the Provider shall include the reason for the denial;

(D) PHPs shall not require Providers to delay billing to the PHP;

(E) 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;

(F) PHPs shall not deny payment of Valid Claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the DMAP Member's Clinical Record;

(G) PHPs shall not delay nor deny payments because a Co-payment was not collected at the time of service.

(c) FCHPs, PCOs, and MHOs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for Covered Services the DMAP Member receives within the PHP, for authorized referral care, and for Urgent Care Services or Emergency Services the DMAP Member receives from Non-Participating Providers. FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care DMAP Members receive from Non-Participating Providers;

(d) FCHPs and PCOs shall pay transportation, meals and lodging costs for the DMAP Member and any required attendant for out-of-state services (as defined in General Rules) that the FCHP and PCO has arranged and authorized when those services are available within the state, unless otherwise approved by DMAP;

(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 (Providers enrolled with DMAP that do not have a contract with the PHP) for Covered Services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule does not apply to Providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.

(7) Other services:

(a) DMAP Members enrolled with PHPs may receive certain services on a DMAP FFS 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 DMAP on a DMAP FFS basis. Before providing services, Providers should contact the PHPs identified on the DMAP Member's Medical Care Identification or, for some mental health services, the CMHP. Alternatively, the Provider may call the DMAP Provider Services Unit to obtain information about coverage for a particular service and/or pre-authorization requirements;

(c) Services authorized by the PHP or CMHP are subject to the rules and limitations of the appropriate DMAP administrative rules and supplemental information, including rates and billing instructions;

(d) Providers shall bill DMAP directly for Non-Capitated Services in accordance with billing instructions contained in the DMAP administrative rules and supplemental information;

(e) DMAP shall pay at the Medicaid FFS 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 DMAP administrative rules and supplemental information;

(f) DMAP 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 DMAP, AMH, nor a PHP except as provided for in DMAP administrative rules and supplemental information (e.g., Capitated Services that are not included in the nursing facility all-inclusive rate);

(h) FCHPs and PCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the FCHP or PCO would make for the same service(s) furnished by a Provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(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 PCM receive services on a FFS basis:

(a) PCMs are paid a per client/per month payment to provide Primary Care Management Services, in accordance with OAR 410-141-0410, Primary Care Manager Medical Management;

(b) PCMs provide Primary Care access, and management services for Preventive Services, primary care services, referrals for specialty services, limited inpatient hospital services and outpatient hospital services. DMAP payment for these PCM managed services is contingent upon PCCM authorization;

(c) All PCM managed services are Covered Services that shall be billed directly to DMAP in accordance with billing instructions contained in the DMAP administrative rules and supplemental information;

(d) DMAP shall pay at the DMAP FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate DMAP administrative rules and supplemental information.

(10) All OHP Clients who are enrolled with a PCO receive inpatient hospital services on a DMAP FFS basis:

(a) May receive services directly from any appropriately enrolled DMAP Provider;

(b) All services shall be billed directly to DMAP in accordance with FFS billing instructions contained in the DMAP administrative rules and supplemental information;

(c) DMAP shall pay at the DMAP FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate DMAP administrative rules and supplemental information.

(11) OHP Clients who are not enrolled with a PHP receive services on a DMAP FFS basis:

(a) Services may be received directly from any appropriate enrolled DMAP Provider;

(b) All services shall be billed directly to DMAP in accordance with billing instructions contained in the DMAP administrative rules and supplemental information;

(c) DMAP shall pay at the DMAP FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate DMAP administrative rules and supplemental information.

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

Stat. Auth.: ORS 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; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 15-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 52-2001, f. & cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2004(Temp), f. & cert. ef. 3-23-04 thru 8-15-04; OMAP 33-2004, f. 5-26-04, cert. ef. 6-1-04; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 23-2006, f. 6-12-06, cert.

ef. 7-1-06; OMAP 53-2006(Temp), f. 12-28-06, cert. ef. 1-1-07 thru 6-29-07; DMAP 9-2007, f. 6-14-07, cert. ef. 6-29-07

410-141-0440
Prepaid Health Plan Hospital Contract Dispute Resolution

When there is a failure to reach agreement on a contract between a Fully Capitated Health Plan (FCHP) or a Physician Care Organization (PCO) and a non Type A, Type B, or Critical Access hospital, the two disagreeing parties must engage in non-binding mediation. This requirement to engage in non-binding mediation does not apply to disagreements involving emergency or urgent services as defined in Oregon Health Plan Administrative Rules. Either the hospital, FCHP, or the PCO can call for mediation. If the parties agree on a mediator their selection shall stand. If a mediator cannot be mutually agreed on, the State will make the selection from the recommended names forwarded by each party. The cost of mediation will be evenly split between the FCHP or PCO and the hospital.

(1) The mediation will proceed under the following guidelines:

(a) Access to care for Oregon Health Plan Members is of critical importance;

(b) Any agreement must operate within the capitation rate received by the FCHP or PCO;

(c) Reimbursement levels must bear some relationship to the cost of the services;

(d) Consideration shall be given to the efforts of each part to manage the overall utilization of health care resources and control costs;

(e) A comparison to statewide averages of each party's cost of services, service utilization rates and administrative costs may be considered in reaching a mediation recommendation.

(2) No client medical information, communication between parties, nor any other non public information used in the mediation may be disclosed to any person not a party to the mediation. All such information shall not be admissible nor disclosed in any subsequent administrative, judicial or mediation proceeding.

(3) Within thirty (30) days of the conclusion of the mediation, the mediator will issue a report to the State and to the involved parties that will include mediation findings, and recommendations. All confidential information will be excluded from the mediator's report.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05

410-141-0480
Oregon Health Plan Benefit Package of Covered Services

(1) DMAP Members are eligible to receive, subject to Section (11) of this rule, those treatments for the condition/treatment pairs funded on the Oregon Health Services Commission's Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are Medically or Dentally appropriate, except that services must also meet the prudent layperson standard defined in OAR 410-141-0140. Refer to 410-141-0520 section (4) for funded line coverage information.

(2) Medical Assistance Benefit Packages follow practice guidelines adopted by the Health Services Commission (HSC) in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.

(3) Diagnostic Services that are necessary and reasonable to diagnose the presenting condition of the DMAP Member are Covered Services, regardless of the placement of the condition on the Prioritized List of Health Services.

(4) Comfort care is a Covered Service for a DMAP Member with a Terminal Illness.

(5) Preventive Services promoting health and/or reducing the risk of disease or illness are Covered Services for DMAP Members. 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 Prioritized List of Health Services, adopted in OAR 410-141-0520).

(6) Ancillary Services are covered, subject to the service limitations of the OHP Program rules, when the services are Medically or Dentally Appropriate for the treatment of a covered Condition/Treatment Pair, or the provision of Ancillary Services will enable the DMAP Member to retain or attain the capability for independence or self-care. (7) The provision of Chemical Dependency Services must be in compliance with the Addictions and Mental Health Division (AMH) Administrative Rules, OAR 415-020-0000 to 0090 and 415-051-0000 to 0130 and the requirements in the Chemical Dependency subsection of the Statement of Work in the Fully Capitated Health Plan and Physician Care Organization contracts.

(8) In addition to the coverage available under section (1) of this rule, a DMAP Member may be eligible to receive, subject to section (11), services for treatments that are below the funded line or not otherwise excluded from coverage:

(a) Services can be provided if it can be shown that:

(A) The OHP Client has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition;

(D) Ancillary Services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded Co-Morbid Conditions or disabilities must be represented by an ICD-9-CM diagnosis code or when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there must be a medical determination and finding by DMAP for fee-for-service OHP Clients or a finding by the Prepaid Health Plan (PHP) for DMAP Members that the terms of section (a)(A)–(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any DMAP Member, especially a DMAP Member with a disability or with a Co-Morbid Condition, Providers must determine whether the DMAP Member has a funded Condition/Treatment Pair that would entitle the DMAP Member to treatment under the program and both the funded and unfunded conditions must be represented by an ICD- 9-CM diagnosis code; or, when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity.

(9) DMAP 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, DMAP shall make a retrospective determination under this subsection, provided DMAP is notified of the emergency situation during the next business day. If DMAP denies a requested service, DMAP 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.

(10) If a Condition/Treatment Pair is not on the Health Services Commission's Prioritized List of Health Services and DMAP determines the Condition/Treatment Pair has not been identified by the Commission for inclusion on the list, DMAP shall make a coverage decision in consultation with the Health Services Commission.

(11) 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.

(12) General anesthesia for dental procedures which are Medically and/or Dentally Appropriate to be performed in a hospital or ambulatory surgical setting, is to be used only for those DMAP Members with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure as outlined below:

(a) Children under three years old with dental needs determined by the dentist or oral surgeon as requiring general anesthesia;

(b) Children over three years old requiring substantial dental care determined by the dentist or oral surgeon as requiring general anesthesia that may protect the child from unnecessary trauma;

(c) DMAP Members with physical, mental or medically compromising conditions;

(d) DMAP Members with dental needs for who local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;

(e) Acute situational anxiety, fearfulness, extremely uncooperative or uncommunicative client with dental needs, determined by the dentist or oral surgeon, sufficiently important that dental care cannot be deferred;

(f) DMAP Members who have sustained extensive orofacial and dental trauma; or

(g) DMAP Members with dental needs who otherwise would not obtain necessary dental care when, in the decision of the dentist or oral surgeon, the need for dental treatment outweighs the risks of general anesthesia. The DMAP Member's dental record must clearly document the justification for the level of anesthesia and why, in the estimation of the dentist or oral surgeon, the treatment in an office setting is not possible.

Stat. Auth.: ORS 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; OMAP 17-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 32-1998, f. & cert. ef. 9-1-98; OMAP 39-1998, f. & cert. ef. 10-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07

410-141-0500
Excluded Services and Limitations for Oregon Health Plan Clients and/or DMAP Members (Effective for services rendered on or after October 1, 2003)

(1) The following services are excluded:

(a) Any service or item identified in OAR 410-120-1200 and 410-120-1210, Excluded Services and Limitations. Services that are excluded under the Oregon Medical Assistance program shall be excluded under the Oregon Health Plan;

(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 included on the funded lines of the Prioritized List of Health Services except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(d) Services that are currently funded on the Prioritized List of Health Services that are not included in the OHP Client's and/or Division of Medical Assistance Programs (DMAP) Member's OHP benefit package, are excluded;

(e) Any treatment, service, or item for a condition which is listed as a Condition/Treatment Pair in both currently funded and non-funded lines where the qualifying description of the diagnosis appears only on the non-funded lines of the Prioritized list of Health Services, except as specified in OAR 410-141-0480, OHP Benefit Package of Covered Services, subsection (8);

(f) Diagnostic services not reasonably necessary to establish a diagnosis for a covered or non-covered condition/ treatment pair;

(g) Services requested by Oregon Health Plan (OHP) Clients and/or DMAP Member's in an emergency care setting which after a screening examination are determined not to meet the definition of Emergency Services and the provisions of 410-141-0140;

(h) Services provided to an Oregon Health Plan Client and/or DMAP Member outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program;

(i) Services or items, other than inpatient care, provided to an Oregon Health Plan Client and/or DMAP Member who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-0080(2)(b)(G);

(j) Services received while the DMAP Member is outside the Contractor's Service Area that were either:

(A) Not authorized by the DMAP Member's Primary Care Provider; or

(B) Not urgent or Emergency Services, subject to the DMAP Member's Appeal rights, that the DMAP Member was outside Contractor's Service Area because of circumstances beyond the DMAP Member's control. Factors to be considered include but are not limited to death of a family member outside of Contractor's Service Area.

(2) The following services are limited or restricted:

(a) Any service which exceeds those that are Medically Appropriate to provide reasonable diagnosis and treatment or to enable the 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 and 410-120-1210, Excluded Services and Limitations. Services that are limited under the Oregon Medical Assistance program shall be limited under the Oregon Health Plan.

(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 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 26-1995, f. 12-29-95, cert. ef. 1-1-96; HR 19-1996, f. & cert. ef. 10-1-96; HR 1-1997(Temp), f. 1-31-97, cert. ef. 2-1-97; HR 12-1997, f. 5-30-97, cert. ef. 6-1-97; HR 18-1997, f. 7-11-97, cert. ef. 7-12-97; OMAP 17-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 32-1998, f. & cert. ef. 9-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 33-2003, f. & cert. ef. 4-15-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04

410-141-0520
Prioritized List of Health Services

(1) The Prioritized List of Health Services (Prioritized List) is the Oregon Health Services Commission's (HSC) listing of physical health services with "expanded definitions" of Preventive Services and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The HSC maintains the most current list on the HSC website: www.oregon.gov/DHS/healthplan/priorlist/main, or, for a hardcopy contact the Office of Oregon Health Policy and Research. This rule incorporates by reference the January 1, 2005 (-07) Prioritized List, with technical revisions effective October 1, 2007, including expanded definitions and practice guidelines that are available on the HSC website.

(2) 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) or Physician Care Organization (PCO). These codes are identified on their own Mental Health (MH) section of the appropriate lines on the Prioritized List of Health Services.

(3) Chemical dependency (CD) services are covered for eligible OHP clients when provided by an FCHP, PCO, or by a provider who has a letter of approval from the Office of Mental Health and Addiction Services and approval to bill Medicaid for CD services.

(4) The January 1, 2005 (-07) Prioritized List, with technical revisions effective October 1, 2007, is in effect and condition/treatment pairs through line 530 are funded.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 33-1998, f. & cert. ef. 9-1-98; OMAP 40-1998(Temp), f. & cert. ef. 10-1-98 thru 3-1-99; OMAP 48-1998(Temp), f. & cert. ef. 12-1-98 thru 5-1-99; OMAP 21-1999, f. & cert. ef. 4-1-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 9-2000(Temp), f. 4-27-00, cert. ef. 4-27-00 thru 9-26-00; OMAP 13-2000, f. & cert. ef. 9-12-00; OMAP 14-2000(Temp), f. 9-15-00, cert. ef. 10-1-00 thru 3-30-01; OMAP 40-2000, f. 11-17-00, cert. ef. 11-20-00; OMAP 22-2001(Temp), f. 3-30-01, cert. ef. 4-1-01 thru 9-1-01; OMAP 28-2001, f. & cert. ef. 8-10-01; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 18-2002, f. 4-15-02, cert. ef. 5-1-02; OMAP 64-2002, f. & cert. ef. f. & cert. ef. 10-2-02; OMAP 65-2002(Temp), f. & cert. ef. 10-2-02 thru 3-15-0; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 30-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 17-2004(Temp), f. 3-15-04 cert. ef. 4-1-04 thru 9-15-04; OMAP 28-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 48-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 68-2004(Temp), f. 9-14-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 83-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 54-2005(Temp), f. & cert. ef. 10-14-05 thru 4-1-06; OMAP 62-2005, f. 11-29-05, cert. ef. 12-1-05; OMAP 71-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 6-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 14-2007(Temp), f. & cert. ef. 10-1-07 thru 3-28-08

410-141-0660
Oregon Health Plan Primary Care Manager (PCM) Provision of Health Care Services

Primary Care Managers shall ensure provision of Medically Appropriate covered services, including Preventive Services, in those categories of service included in the agreement with Division of Medical Assistance Programs (DMAP):

(1) Each Primary Care Manager shall provide primary care, including Preventive Services.

(2) Primary Care Managers shall ensure that PCM Members have the same access to the Primary Care Manager PCM referral Practitioners that is available to non-DMAP patients.

(3) Primary Care Managers shall provide primary care to the PCM Members and arrange, coordinate, and monitor other PCM managed services for the PCM Member on an ongoing basis.

(4) Primary Care Managers shall ensure that professional and related health services provided by the Primary Care Manager or arranged through referral by the Primary Care Manager to another Provider are noted in the PCM Member's Clinical Record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0680
Oregon Health Plan Primary Care Manager Emergency and Urgent Care Medical Services

Primary Care Managers shall ensure the provision of triage services for all PCM Members on a 24-hour, seven-day-a-week basis:

(1) Primary Care Managers shall ensure that appropriate Emergency Services are available to PCM Members on a 24-hour, seven-day-a-week basis.

(2) Primary Care Managers shall ensure the availability of an after-hours call-in system adequate to triage Urgent Care Services and emergency calls from PCM Members.

(3) Primary Care Managers shall have procedures for notifying a referral emergency room concerning an arriving PCM Member's presenting problem, and whether or not the Practitioner will meet the PCM Members there.

(4) During normal hours of operation, Primary Care Managers shall ensure that a health professional is available to triage Urgent Care and emergencies for Members as follows:

(a) PCM Members who walk in for service shall be assessed to determine appropriate action;

(b) PCM Members who telephone shall be assessed to determine appropriate action;

(c) Phone calls from other Providers requesting approval to treat Members shall be assessed to determine appropriate action.

(5) Primary Care Managers shall have procedures for educating PCM Members on how to access Urgent Care and emergency care. Primary Care Managers shall have methods for tracking inappropriate use of outpatient hospital emergency care and shall take action to improve appropriate use of Urgent Care and emergency care settings.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0700
OHP PCM Continuity of Care

(1) Primary Care Managers shall ensure the provision of PCM Managed Services for all PCM Members and note in the PCM Member's medical record referrals made by the Primary Care Manager to other providers for covered services:

(a) Primary Care Managers shall maintain a network of consultation and referral providers for all PCM Managed Services covered by the Primary Care Manager's agreement with Division of Medical Assistance Programs (DMAP). Primary Care Managers shall establish and follow procedures for referrals;

(b) Primary Care Managers shall have policies and procedures for the use of urgent care centers and emergency rooms. Primary Care Managers shall ensure that services provided in these alternative settings are documented and incorporated into the PCM Member's medical record;

(c) Primary Care Managers shall have procedures for referrals that ensure adequate notice to referral providers and adequate documentation of the referral in the PCM Member's medical record;

(d) Primary Care Managers shall personally take responsibility for, or designate a staff member who is responsible for, arrangement, coordination and monitoring of the Primary Care Manager's referral system;

(e) Primary Care Managers shall have procedures that ensure that relevant medical information is obtained from referral providers. These procedures shall include:

(A) Review of information by the Primary Care Manager;

(B) Entry of information into the PCM Member's medical record;

(C) Arrangements for periodic reports from ongoing referral appointments; and

41(D) Monitoring of all referrals, where appropriate, to ensure that information is obtained from the referral providers.

(f) Primary Care Managers shall have procedures to orient and train their staff/practitioners in the appropriate use of the Primary Care Manager's referral system. Procedures and education shall ensure use of appropriate settings of care;

(g) Primary Care 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 PCM Member's medical record, information requested from referral source);

(h) Primary Care Managers shall have procedures which ensure that an appropriate health professional will respond to calls from other providers requesting approval to provide care to PCM Members who have not been referred to them by the Primary Care Manager;

(i) Primary Care Managers shall enter medical information from approved emergency visits into the PCM Member's medical record;

(j) If a PCM Member is hospitalized, Primary Care Managers shall ensure that:

(A) A notation is made in the PCM Member's medical record of the reason, date, and expected duration of hospitalization;

(B) A notation is made in the PCM 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 PCM Member's medical record. Such reports shall include the reports of consulting practitioners and shall document discharge planning.

(k) Primary Care Managers shall have written policies and procedures that ensure maintenance of a record keeping system adequate to document all aspects of the referral process and to facilitate the flow of information to the PCM Member's medical record.

(2) For PCM Members living in residential facilities or homes providing ongoing care, Primary Care Managers shall either provide the PCM Member's primary care or make provisions for the care to be delivered by the facility's "house doctor" for PCM Members who cannot be seen in the Primary Care Manager's office.

Stat. Auth.: ORS 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; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0720
Oregon Health Plan Primary Care Manager Medical Record Keeping

Primary Care Manager shall ensure maintenance of a medical record keeping system adequate to fully disclose and document the medical condition of the PCM Member and the extent of covered services and/or PCM Case managed services received by PCM Members from the Primary Care Manager or the Primary Care Manager referral Provider.

(1) Primary Care Manager shall ensure maintenance of a medical record for each PCM Member that documents all types of care delivered whether during or after office hours.

(2) The medical record shall include data that forms the basis of the diagnostic impression or the PCM 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) PCM 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 PCM 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 Managers shall have written procedures that ensure maintenance of a medical record keeping 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 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 record keeping within the applicable Provider type, whichever time period is longer.

(5) Primary Care Managers shall have written procedures that ensure the maintenance and confidentiality of medical record information and may release such information only to the extent permitted by the Primary Care Manager's agreement with the Division of Medical Assistance Programs (DMAP), by federal regulation **42 CFR 431 Subpart F** and by Oregon Revised Statutes. Primary Care Managers shall ensure that confidentiality of PCM 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 Managers shall cooperate with DMAP representatives for the purposes of audits, inspection and examination of PCM Member medical records.

Stat. Auth.: ORS 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; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

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 Division of Medical Assistance Programs (DMAP) 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 Division 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 Division 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 Division 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 409
Stats. Implemented: ORS 414.725
Hist.: HR 7-1994, f. & cert. ef. 2-1-94

410-141-0760
Oregon Health Plan Primary Care Managers Accessibility

(1) Primary Care Managers shall have written procedures which ensure that primary care, including Preventive Services, is accessible to PCM Members.

(2) The Primary Care Managers shall not discriminate between PCM Members and non- PCM member patients as it relates to benefits to which they are both entitled.

(3) Primary Care Managers shall have procedures for scheduling of PCM Member appointments which are appropriate to the reasons for the visit (e.g., PCM Members with non-emergency needs; PCM Members with persistent symptoms; PCM Member routine visits; new PCM Member initial assessment).

(4) Primary Care Managers are encouraged to establish a relationship with new PCM Members.

(5) Under normal circumstances, Primary Care Managers shall ensure that PCM Members are not kept waiting longer than non-PCM Member patients.

(6) Primary Care Managers shall have procedures for following up of failed appointments, including rescheduling of appointments, as deemed medically appropriate, and documentation in the PCM Member medical record of broken appointments and recall efforts.

(7) Primary Care Managers shall have procedures to ensure the provision of triage of walk-in PCM Members with urgent non-emergency medical need.

(8) When not an emergency, walk-in PCM Members should either be scheduled for an appointment as Medically Appropriate or be seen within two hours.

(9) Primary Care Managers shall have procedures that ensure the maintenance of telephone coverage (not a recording) at all times either on-site or through call sharing or an answering service, unless the Division of Medical Assistance Programs (DMAP) waives this requirement in writing because of the Primary Care Manager's submission of an alternative plan that will provide equal or improved telephone access.

(10) Primary Care Managers shall ensure that the persons responding to telephone calls enter relevant information into the PCM Member's medical record.

(11) Primary Care Managers shall ensure a response to each telephone call within a reasonable length of time. The length of time shall be appropriate to the PCM Member's stated condition.

(12) Primary Care Managers shall have procedures that ensure that all persons answering the telephone have sufficient communication skills to reassure PCM Members and encourage them to wait for a return call in appropriate situations.

(13) Primary Care 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 PCM 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 PCM Members and be able to translate medical information effectively. A substantial population is 35 non-English speaking households, enrolled with the Primary Care Manager, which have the same language. A non-English speaking household is a household that does not have an adult PCM Member who is capable of communicating in English.

(14) Primary Care Managers shall provide education on the use of services, including Urgent Care Services and Emergency Services. DMAP may provide Primary Care Managers with appropriate written information on the use of services in the primary language of each substantial population of non-English speaking PCM Members enrolled with the Primary Care Manager.

(15) Primary Care 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.

(16) Primary Care Managers shall have adequate practitioner back-up as an operative element of the Primary Care Manager's after-hours care. Should the Primary Care Manager be unable to act as PCM for the PCM Member, the Primary Care Manager shall designate a substitute Primary Care Manager.

(17) Primary Care Managers shall ensure compliance with requirements of the Americans with Disabilities Act of 1990.

(18) Primary Care Managers shall ensure that services, facilities and personnel are prepared to meet the special needs of visually and hearing impaired PCM Members.

(19) Primary Care Managers shall arrange for services to be provided by referral providers when the Primary Care Manager does not have the capability to serve specific disabled populations.

Stat. Auth.: ORS 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0780
Oregon Health Plan Primary Care Manager (PCM) Complaint Procedures

(1) PCMs shall have procedures for accepting, processing and responding to all Complaints from PCM Members or their Representatives:

(a) PCMs shall have procedures for resolving all Complaints. PCMs shall afford PCM Members the full use of the procedures, and shall cooperate if the PCM Member decides to pursue a remedy through the Division of Medical Assistance Programs (DMAP) hearing process. Complaints are defined in OAR 410-141-0000, Definitions;

(b) PCMs shall designate PCM staff member or staff members who shall be responsible for receiving, processing, directing, and responding to Complaints;

(c) PCMs shall ensure that all information concerning a PCM Member's Complaint is kept confidential except that DMAP has a right to this information without a signed authorization for release of medical information from the PCM member. If a PCM Member makes a Complaint or files a hearing request, the PCM may ask the PCM Member to sign an authorization for release of medical information to those persons and to the extent necessary to resolve the Complaint or hearing request. The PCM shall inform the PCM Member that failure to sign an authorization for release of medical information may make it impossible to resolve the Complaint or hearing request;

(d) PCMs shall have procedures for informing PCM 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 PCM Member confidentiality in the Complaint process;

(C) Upon request, Division of Medical Assistance Programs shall provide PCMs with standard materials for tracking and documenting PCM Member Complaints.

(e) PCMs shall have procedures for the receipt, disposition and documentation of all Complaints from PCM Members PCMs shall make available copies of the Complaint forms (DMAP 3001). PCM Members may register a Complaint in the following manner. Complaints: A PCM Member may relate any incident or concern to the PCM or other staff person by stating this is a Complaint:

(A) If the PCM Member indicates dissatisfaction, the PCM or staff person shall advise the PCM Member that he or she may make a Complaint;

(B) A staff person shall direct the PCM Member to the PCMs staff person designated for receiving Complaints;

(C) A PCM Member may choose to utilize the PCM's internal Complaint procedure in addition to or in lieu of a DMAP hearing. If a PCM Member makes a Complaint to the PCM staff person designated for receiving Complaints, the staff person shall notify the PCM Member that the PCM Member has the right to enter a written Complaint with the PCM 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 PCM staff person designated to receive Complaints shall be entered into a log. The log shall identify the PCM Member, the date of the Complaint, the nature of the Complaint, the resolution and the date of resolution;

(F) If the PCM denies a service or service coverage, the PCM shall notify the PCM Member of the right to a hearing.

(f) Oral Complaints:

(A) If the PCM Member chooses to pursue the Complaint orally through the PCM's internal Complaint procedure, the PCM shall within five working days from the date the oral Complaint was received by the PCM either:

(i) Make a decision on the Complaint; or

(ii) Notify the PCM Member in writing that a delay in the PCM's decision of up to 30 calendar days from the date the oral Complaint was received by the PCM is necessary to resolve the Complaint. The PCM shall specify the reasons the additional time is necessary.

(B) The PCM's decision shall be communicated to the PCM 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 (DMAP 3030) and the Complaint form (DMAP 3001) attached. An oral communication shall include informing the PCM Member of their right to a hearing;

(C) If the PCM Member indicates dissatisfaction with the decision, the PCM shall notify the PCM Member that the PCM Member may pursue the Complaint further with a DMAP hearing.

(g) Written Complaints: If the PCM Member files a written Complaint with the PCM, 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 PCM;

(B) A written decision shall be made on a PCM Member's written Complaint. The decision shall be sent to the PCM 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 PCM Member. If the PCM Member fails to provide the requested information within 30 calendar days of the request by the PCM, or another mutually agreed upon time-frame, the Complaint may be resolved against the PCM Member. The decision on the Complaint shall review each element of the PCM Member 's Complaint and address each of those concerns specifically;

(C) The PCM's decision shall have the Notice of Hearing Rights (DMAP 3030) attached.

(h) Complaints concerning denial of service or service coverage: If a Complaint made to the PCM 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 PCM staff person shall notify the PCM 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 PCM Member has a right to request a DMAP hearing, and that in order to request such a hearing the PCM Member must submit a Fair Hearing Request Form (CAF 443) to the PCM Member's DHS office within 45 calendar days of the date of the PCM's decision on an oral or written Complaint concerning denial of service or service coverage;

(E) A statement that a DMAP hearing request may be made in addition to or instead of using the PCM's Complaint procedure;

(F) A copy of the Notice of Hearing Rights (DMAP 3030) and Fair Hearing Request (CAF 443) shall be attached.

(i) PCM Member use of PCM Complaint procedure with request for hearing:

(A) If the PCM Member chooses to use the PCM's Complaint procedure as well as the DMAP hearing process, the PCM shall ensure that either the Complaint procedure is completed prior to the date on which the DMAP hearing is scheduled or obtain the written consent of the PCM Member to postpone the DMAP hearing. If the PCM Member consents to a postponement of the DMAP hearing, the PCM shall immediately send such written consent to DMAP and to the local DHS office;

(B) The PCM staff person shall encourage the PCM Member to use the PCM's Complaint procedure first, but shall not discourage the PCM Member from requesting a DMAP hearing;

(C) If the PCM Member files a request for a DMAP hearing, DMAP shall immediately notify the PCM. The DMAP hearing process cannot be delayed without the PCM Member's consent;

(D) The PCM staff person shall begin the process of establishing the facts concerning the Complaint upon receipt of the Complaint regardless of whether the PCM Member seeks a DMAP hearing or elects the Complaint process, or both;

(E) If a DMAP hearing is requested by a PCM Member, PCM 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 PCM Member feel that his or her medical problem cannot wait for the normal PCM review process, including the PCM's final

resolution, at the PCM Member's request, the PCM shall submit documentation to the DMAP medical director within, as nearly as possible, two working days for decision as to the necessity of an expedited DMAP hearing. The DMAP medical director shall decide within, as nearly as possible, two working days if that PCM Member is entitled to an expedited DMAP hearing.

(2) The PCM'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) PCMs shall review and analyze all Complaints.

(4) PCMs shall comply with and fully implement the DMAP hearing decision. Neither implementation of a DMAP hearing decision nor a PCM Member's request for a hearing may be a basis for a request by the PCM for Disenrollment of a PCM Member.

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

Stat. Auth.: ORS 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0800

Oregon Health Plan Primary Care Manager (PCM) Informational Requirements

(1) The Division of Medical Assistance Programs (DMAP) shall provide basic models of informational materials which PCMs may adapt for PCM Members' use.

(2) PCMs shall ensure that all of their staff who have contact with potential PCM Members are fully informed of the PCM and DMAP policies, including Enrollment, Disenrollment and Complaint policies.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0820

Oregon Health Plan Primary Care Manager (PCM) Member Education

PCMs shall have an ongoing process of PCM Member education and information sharing which includes orientation to the PCM, health education and appropriate use of emergency facilities and Urgent Care:

(1) The Division of Medical Assistance Programs (DMAP) shall provide basic information about the use of PCM services in a PCM Member Handbook;

(2) PCMs shall provide new PCM Members with written information sufficient for the PCM Member to use the PCM's services appropriately. Written information shall contain, at a minimum, the following elements:

(a) Location and office hours of the PCM;

(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) PCMs shall have procedures and criteria for health education designed to prepare PCM Members for their participation in and reaction to specific medical procedures, and to instruct PCM Members in self-management of medical problems and in disease and accident prevention. Health education may be provided by the PCM, by any health Practitioner or by any other individual or program approved by the PCM. The PCM shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures;

(4) PCMs shall develop an educational plan for PCM Members for health promotion, disease and accident prevention, and patient self-care. DMAP may assist in developing materials that address specifically identified health education problems to the population in need.

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0840

Oregon Health Plan Primary Care Manager (PCM) Member Rights And Responsibilities

(1) Primary Care Managers (PCM) shall ensure that PCM Members are treated with the same privacy, dignity and respect as other patients who receive services from the Primary Care Managers.

(2) PCM Members have both rights and responsibilities as follows:

(a) PCM Members have the right to appropriate access to the Primary Care Manager. PCM Members have the responsibility to keep appointments made with the Primary Care Manager;

(b) PCM Members have the right to Preventive Services. PCM 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) PCM Members have the right to services necessary and reasonable to diagnose the presenting condition of the PCM Member. PCM Members have the responsibility to seek out diagnostic services from the Primary Care Manager except in an emergency.

(d) PCM Members have the right to appropriate Urgent Care Services; and Emergency Services. PCM Members have the responsibility to use the Primary Care Manager whenever possible. PCM Members have the responsibility to use Urgent Care Services before Emergency Services whenever possible:

(A) PCM Members have the right to written information on how to access emergency care and urgent care. PCM Members have the responsibility to use emergency care appropriately. PCM 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 Manager. PCM Members may request a hearing before a Division of Medical Assistance Programs (DMAP) representative if their Complaint is not acted on, to their satisfaction, by the Primary Care Manager;

(B) In addition to access to emergency care, PCM Members have the right to the following Triage services:

(i) A service which allows PCM Members to access Primary Care Managed Services and contact the Primary Care Manager on a 24-hour, 7-day-a-week basis, when the PCM Member requires urgent or emergency care;

(ii) To have the referral emergency room notified about the PCM Member's presenting problem, and whether or not the Primary Care Manager will meet the PCM Member there;

(iii) To have a health professional available to Triage urgent care and emergencies for PCM Members during regular working hours. This service includes individuals who walk in for service or who telephone for assessment.

(e) PCM Members have the right to access specialty Practitioners with the Primary Care Manager's referral when their condition warrants a referral. PCM Members have the responsibility to access specialty services through referral by the Primary Care Manager;

(f) PCM Members have the right to maintenance of a medical record which documents the medical condition of the PCM Member and the services received by the PCM Member. The PCM 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. PCM 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) PCM Members have the right to Medically Appropriate covered services which meet generally accepted standards of practice. PCM Members have the right to information about medical services which permits them to make an informed decision about proposed medical services. PCM Members have the right to refuse any recommended services. PCM Members have the responsibility to use the information to make informed decisions about services. PCM Members have the responsibility to follow prescribed treatment plans, once the PCM Member has agreed to the plan;

(h) PCM 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) PCM Members have the right to Medically Appropriate services covered under the Oregon Health Plan. PCM Members have the responsibility to inform medical Providers of their coverage as PCM Members prior to receiving services

(4) PCM Members enrolled with Primary Care Managers or their Representatives have the right to make Complaints to Primary Care Managers and to request hearings through the DMAP hearings process. PCM Members have the responsibility to attempt resolution of Complaints with the Primary Care Manager and to sign a authorization for release of pertinent files and medical records.

Stat. Auth.: ORS 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; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03

410-141-0860
Oregon Health Plan Primary Care Manager Provider Qualification and Enrollment

(1) Primary Care 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 Managers:
(a) Hospital primary care clinics;
(b) Rural Health Clinics;
(c) Community and Migrant 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 Managers must:
(a) Be enrolled as Oregon Division of Medical Assistance Programs (DMAP) Providers;
(b) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;
(c) Complete and sign the Primary Care Manager Application (DMAP 3119 (12/93)).
(5) If DMAP determines that the Primary Care Manager or an applicant for enrollment as a Primary Care Manager does not comply with the OHP Administrative Rules pertaining to the PCM program and/or DMAP General Rules; or if DMAP determines that the health or welfare of DMAP Members may be adversely affected or in jeopardy; DMAP may:
(a) Deny the application for enrollment as a Primary Care Manager;
(b) Close enrollment with an existing Primary Care Manager; and/or
(c) Transfer the care of those PCM Members enrolled with that Primary Care Manager until such time it can be determined that the Primary Care Manager is in compliance.
(6) DMAP may terminate the PCM Agreement without prejudice to any obligations or liabilities of either party already accrued prior to such termination, except when the obligations or liabilities result from the Primary Care Manager's failure to terminate care for those PCM Members. The Primary Care Manager shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the Primary Care Manager's failure to terminate care for those PCM Members.
[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

DIVISION 142

HOSPICE SERVICES

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 individual'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": Certification by the Oregon Health Division as a program of services eligible for 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 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; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00

410-142-0040
Eligibility for Hospice Services

(1) Hospice services are covered for clients who have:

(a) Been certified as terminally ill in accordance with OAR 410-142-0060, and;

(b) Oregon Health Plan (OHP) Plus or OHP Standard benefit package coverage.

(2) Hospice services for clients with Medicare Part A coverage must be provided by a Medicare certified hospice. If a Medicare certified hospice is not available in the area, services may be provided in a hospice as defined in OAR 410-142-0020. For services provided by Medicare certified hospices, bill Medicare. Medicare's payment is considered payment in full.

Stat. Auth.: ORS 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; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

410-142-0060
Certification of Terminal Illness

(1) In order to receive reimbursement from the Division of Medical Assistance Programs (DMAP), the hospice must obtain and retain a physician's written certification of a client's terminal illness in accordance with the following procedures. DMAP will not pay for services provided prior to certification.

(2) The attending physician is a doctor of medicine or osteopathy or a nurse practitioner and is identified by the client at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care. A nurse practitioner serving as the attending physician may not certify or re-certify the terminal illness.

(3) Certifications may be completed up to two weeks before hospice care is elected.

(4) The certification of a client who elects hospice is based on the physician's or medical director's clinical judgment regarding the normal course of the client's illness and must include:

(a) The statement that the client's medical prognosis indicates a life expectancy of six months or less if the terminal illness runs its normal course; and

(b) Clinical information and other documentation which support the medical prognosis must accompany the certification and be filed in the medical record with the certification.

(5) A written certification signed by the physician(s) must be on file in the hospice client's record prior to submission of a claim to DMAP for all benefit periods.

(6) For the initial period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the client's attending physician (if the client has an attending physician). If the written certification is not dated, a notarized statement or some other acceptable documentation may be obtained to verify the actual certification date.

(7) For any subsequent periods, the hospice must obtain, no later than two calendar days after the first date of each period, a written certification from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days.

(8) The requirements specified in this rule also apply to clients who had been previously discharged during a benefit period and are again being certified for hospice care.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 58-2002, f. & cert. ef. 10-1-02; OMAP 34-2006, f. 9-15-06

410-142-0080
Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form has been obtained for every individual, either from the individual or representative as defined in OAR 410-142-0020. The form must specify the type of care and services that may be provided as hospice care during the course of the illness.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-142-0100
Election of Hospice Care

(1) An individual who meets the eligibility requirements of OAR 410-142-0040 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative may file the election statement.

(2) The election statement must include the following:

(a) Identification of the particular hospice that will provide care to the individual;

(b) The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;

(c) Acknowledgment that certain otherwise covered services are waived by the election. Election of a hospice benefit means that the Division of Medical Assistance Programs (DMAP) will only reimburse the hospice for those services included in the hospice benefit;

(d) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement;

(e) The signature of the individual or representative.

(3) Re-election of hospice benefits. If an election has been revoked in accordance with OAR 410-142-0160, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

(4) File the election statement in the medical record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-142-0120
Duration of Hospice Care

(1) An eligible individual may elect to receive hospice care during one or more of the following election periods:

(a) An initial 90-day period;

(b) A subsequent 90-day period;

(c) An unlimited number of subsequent 60-day periods.

(2) An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(a) Remains in the care of a hospice; and

(b) Does not revoke the election under the provisions of OAR 410-142-0160.

(3) For the duration of an election of hospice care, an individual waives all rights to the Division of Medical Assistance Programs (DMAP) 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 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98

410-142-0140
Changing the Designated Hospice

(1) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

(2) The change of the designated hospice is not a revocation of the election for the period in which it is made.

(3) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following:

(a) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care;

(b) The date the change is to be effective.

(4) The statement shall be kept on file in the medical record.

Stat. Auth.: ORS 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 with the Hospice a statement to be placed in the medical record that includes the following information:

(a) A signed statement that the individual or representative revokes the individual's election for coverage of hospice care for the remainder of that election period;

(b) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made.)

(3) An individual, upon revocation of the election of coverage of hospice care for a particular election period:

(a) Is no longer covered for hospice care;

(b) Resumes eligibility for all covered services as before the election to hospice; and

(c) May at any time elect to receive hospice coverage for any other hospice election periods he or she is eligible to receive, in accordance with OAR 410-142-0120.

Stat. Auth.: ORS 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; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00

410-142-0180
Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan:

(1) Establishment of Plan. The plan is established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(2) Content of Plan. The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(3) Review of Plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

Stat. Auth.: ORS 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, or, in the case of a doctor, be under contract with the hospice:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A social worker;

(d) A pastoral or other counselor.

(2) Role of Interdisciplinary Group. Members of the group interact on a regular basis and have a working knowledge of the assessment and care of the patient/family unit by each member of the group. The interdisciplinary group is responsible for:

(a) Participation in the establishment of the plan of care;

(b) Provision or supervision of hospice care and services;

(c) Periodic review and updating of the plan of care for each individual receiving hospice care; and

(d) Establishment of policies governing the day-to-day provision of hospice care and services.

(3) If a hospice has more than one interdisciplinary group, it must document in advance the group it chooses to execute the functions described in Paragraph (1) of this section;

(4) Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-142-0220
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 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94

410-142-0225
Signature Requirements

(1) The Division of Medical Assistance Programs (DMAP) requires practitioners to sign for services they order. This signature may be handwritten, electronic, or stamped, and it must be in the client's medical record.

(2) The ordering practitioner is responsible for the authenticity of the signature. If a practitioner allows a signature stamp, the provider performing the service must retain a signed statement in their records that this practitioner is the only person who has and uses the stamp.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2006, f. 12-15-06, cert. ef. 1-1-07

410-142-0240
Hospice Core Services

The following services are covered hospice services when consistent with the plan of care and must be provided in accordance with recognized standards of practice:

(1) Nursing Services. The hospice must provide nursing care and services by or under the supervision of a registered nurse:

(a) Nursing services must be directed and staffed to assure that the nursing needs of the patient are met;

(b) Patient care responsibilities of nursing personnel must be specified;

(c) Services must be provided in accordance with recognized standards of practice.

(2) Medical Social Services. Medical social services must be provided by a qualified social worker, under the direction of a physician;

(3) Physician Services. In addition to palliative and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s), of the interdisciplinary group, must also meet the general medical needs of the patient to the extent these needs are not met by the attending physician:

(a) Reimbursement for physician supervisory and interdisciplinary 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 Division of Medical Assistance Programs (DMAP) fee schedule. These physicians must bill DMAP for their services;

(c) Reimbursement of attending physician services (not including supervisory and interdisciplinary group services) for those physicians employed by the hospice agency is according to the DMAP fee schedule. These physicians must bill DMAP for their services;

(d) Reimbursement of the hospice for consulting physician services furnished by hospice employees or by other physicians under arrangements by the hospice is included in the rate paid to the agency.

(4) Counseling Services. Counseling services must be available to both the patient and the family. Counseling includes bereavement counseling provided after the patient's death as well as dietary, spiritual and any other counseling services for the patient and family provided while the individual is enrolled in the hospice;

(5) Short-Term Inpatient Care. Inpatient care must be available for pain control, symptom management and respite purposes;

(6) Medical Appliances and Supplies:

(a) Includes drugs and biologicals as needed for the palliation and management of the terminal illness and related conditions;

(b) Drugs prescribed for conditions other than for the palliation and management of the terminal illness are not covered under the hospice program.

(7) Home Health Aide and Homemaker Services;

(8) Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services;

(9) Other services. Other services specified in the plan of care that are covered by OHP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

410-142-0260
Hospice Level of Care

(1) Each day of hospice care is classified into one of five levels of care. The level of care determines the payment for each day of hospice benefit:

(a) Routine Home Care. A routine home care day is a day on which a patient who has elected to receive hospice care is in a place of residence and is not receiving continuous home care;

(b) Continuous Home Care. A continuous home care day is a day on which a patient who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aid or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as necessary to maintain the terminally ill individual at home. Nursing care must be provided by a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care must be provided during a 24-hour day, which begins and ends at midnight. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care;

(c) In-Home Respite Care. An in-home respite care day is a day on which short-term in-home care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the patient's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Home health aide/CNA or homemaker services or both may be utilized for providing in-home respite care;

(d) Inpatient Respite Care. An inpatient respite care day is a day on which short-term inpatient care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth, and any subsequent days, is to be made at the routine home care rate. Respite care may not be provided when the hospice patient is a nursing home resident;

(e) General Inpatient Care. A general inpatient care day is a day on which a hospice patient receives care in an inpatient facility for pain control, acute or chronic symptom management, or other procedures which cannot be managed or provided in any other setting.

(2) Inpatient care must be provided by a facility that has an agreement with the hospice:

(a) A hospice capable of providing inpatient care;

(b) A hospital; or

(c) A nursing facility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98; OMAP 58-2002, f. & cert. ef. 10-1-02

410-142-0280
Recipient Benefits

An individual who has elected to receive hospice care remains entitled to receive other services not included in the hospice benefit. These services are subject to the same rules as for non-hospice clients. Typical services used that are not covered by the hospice benefit include:

(1) Attending physician care (e.g. office visits, hospital visits, etc.);

(2) Medical transportation;

(3) 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 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 28-1997, f. 12-31-97, cert. ef. 1-1-98

410-142-0300
Hospice Reimbursement and Limitations

(1) The Division of Medical Assistance Programs (DMAP) recalculates its hospice rates annually and publishes them in the Supplemental Information for Hospice Services. When billing for hospice services, the provider must bill the usual charge or the rate based upon the geographic location in which the care is furnished (as shown in the Supplemental Information), whichever is lower.

(2) Rates:

(a) DMAP bases its rates on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts;

(b) Under the Medicaid hospice benefit regulations, DMAP cannot impose cost sharing for hospice services rendered to Medicaid recipients;

(c) DMAP sets rates no lower than the rates used under Part A of Title XVIII of the Social Security Act (Medicare);

(d) DMAP uses prospective hospice rates;

(e) DMAP makes no retroactive adjustments other than the optional application of the cap on overall payments and the limitation on payments for inpatient care, if applicable.

(3) With the exception of payment for physician services, DMAP reimburses providers of hospice services for each day of care at one of five predetermined rates. Rates are based on intensity and type of care, which DMAP defines as:

(a) Routine Home Care. DMAP pays the hospice the Routine Home Care rate for each day that the client is under the care of the hospice and that DMAP does not reimburse at another rate. DMAP pays this rate without regard to the volume or intensity of services provided on any given day;

(b) Continuous Home Care. The Hospice must provide a minimum of eight hours of continuous home care per day to receive the Continuous Home Care rate:

(A) The Continuous Home Care rate is divided by 24 hours in order to arrive at an hourly rate;

(B) DMAP pays the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

(c) Inpatient Respite Care. DMAP pays the hospice at the Inpatient Respite Care rate for each day on which the client is in an approved inpatient facility and is receiving respite care:

(A) DMAP pays for Inpatient Respite Care for a maximum of five days at a time, including the date of admission but not counting the date of discharge;

(B) DMAP pays for the sixth and any subsequent days at the Routine Home Care rate.

(d) General Inpatient Care. DMAP pays providers at the general inpatient rate when General Inpatient Care is provided;

(e) In-Home Respite Care. An in-home respite care day is a day on which short-term in-home care is provided to the client only when necessary to relieve the family members or other persons caring for the client at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the client's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Home health aide/CNA or homemaker services or both may be utilized for providing in-home respite care.

(4) On the day of discharge from an inpatient unit, DMAP pays the appropriate home care rate unless the client dies as an inpatient. When the client is discharged deceased, DMAP pays the appropriate inpatient rate (General or Respite) for the discharge date.

Stat. Auth.: ORS 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; OMAP 47-1998, f. & cert. ef. 12-1-98; OMAP 40-1999, f. & cert. ef. 10-1-99; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 55-2001(Temp) f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02; OMAP 65-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 41-2002(Temp), f. & cert. ef. 10-1-02 thru 3-15-03; OMAP 15-2003, f. & cert. ef. 2-28-03; OMAP 80-2003(Temp), f. & cert. ef. 10-10-03 thru 3-15-04; OMAP 86-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 66-2004, f. 9-13-04, cert. ef. 10-1-04; OMAP 79-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; OMAP 90-2004, f. 11-24-04 cert. ef. 12-16-04; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 34-2006, f. 9-15-06

410-142-0380
Death With Dignity

(1) Death with dignity services are defined in the Division of Medical Assistance Programs (DMAP) Medical-Surgical Services and Pharmaceutical Services program rules.

(2) All death with dignity services must be billed directly to DMAP, even if the client is in a prepaid health plan (PHP).

(3) Death with dignity services are not included in the hospice care per diem payment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 40-1999, f. & cert. ef. 10-1-99; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

DIVISION 143

HIV/AIDS PREVENTION SERVICES PROGRAM

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 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 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 409
Stats. Implemented: ORS 414.085
Hist.: HR 1-1995, f. 1-13-95, cert. ef. 1-17-95

DIVISION 145

COOPERATIVE TRANSPLANT PROGRAM APPROVAL AND MONITORING

410-145-0000
Definitions

As used in this division unless the context requires otherwise:

(1) "Board of governors" means the governors of a cooperative program as described in OAR 410-145-0020.

(2) "Cooperative program" means a program among two or more health care providers for the purpose of providing heart and kidney transplant services including, but not limited to, the sharing, allocation and referral of physicians, patients, personnel, instructional programs, support services, facilities, medical diagnostic, laboratory or therapeutic services, equipment, devices or supplies, and other services traditionally offered by health care providers.

(3) "Director" means the Director of the Department of Human Services.

(4) "Health care provider" means a hospital, physician or entity, a significant part of whose activities consist of providing hospital or physician services in this state. For purposes of the immunities provided under ORS 442.700 to 442.760 and 646.740, "health care provider" includes any officer, director, trustee, employee, or agent of, or any entity under common ownership and control with, a health care provider.

(5) "Hospital" means a health care facility defined in ORS 442.015(14)(a) to (d) and licensed under ORS 441.015–441.097 and includes community health programs established under ORS 430.610–430.700. In other words, as used in this division the term "hospital" includes health care facilities licensed as hospitals, special inpatient care facilities, skilled and intermediate long-term care facilities, and ambulatory surgical centers. It also includes community mental health and developmental disabilities programs established under ORS 430.610 to 430.700. It does not include establishments furnishing primarily domiciliary care.

(6) "Order" means a decision issued by the director under OAR 410-145-0010 either approving or denying an application for a cooperative program and includes modification of an original order under OAR 410-145-0040(3)(b) and orders under 410-145-0060(1) and (4).

(7) "Party to a cooperative agreement" or "party" means an entity that enters into the principal agreement to establish a cooperative program and applies for approval under this division and any other entity that, with the approval of the director, becomes a member of the cooperative program.

(8) "Physician" means a physician defined in ORS 677. 010(12) and licensed under ORS Chapter 677.

(9) "Urban area" means a Metropolitan Statistical Area as defined by the federal Bureau of the Census.

Stat. Auth.: ORS 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 646.705–646.836 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 Services, Human Services Building, Salem, Oregon 97310. The application must be accompanied by an application fee of $30,000. Checks should be made payable to the Oregon Department of Human Services.

(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
Stats. Implemented:
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
Stats. Implemented:
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
Stats. Implemented:
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
Stats. Implemented:
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
Stats. Implemented:
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 183.310–183.550, as applicable, shall govern the hearing procedure and any judicial review.

(6) The only effect of an order suspending or terminating approval under ORS 442.700–442.760 shall be to withdraw the immunities granted under 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
Stats. Implemented:
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

410-145-0070
Confidentiality of Information

(1) If parties to a cooperative program agreement provide the director with written or oral information that is confidential or otherwise protected from disclosure under Oregon law, the disclosures shall not be considered a waiver of any right to protect the information from disclosure in other proceedings.

(2) The parties to a cooperative agreement shall specifically identify to the director any information that meets the requirements of section (1) of this rule, and the director shall considered only information that has been so identified by the parties to be confidential. The director will make the decision as to whether such information is in fact protected from disclosure under Oregon law. The director shall inform the party who submitted the information of any decisions regarding its confidentiality. Information which has been found to be subject to disclosure under Oregon law may be released by the director to any requesting persons subject to the provisions of ORS 192.410–192.505.

Stat. Auth.: ORS 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 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
Stats. Implemented:
Hist.: HR 16-1994, f. & cert. ef. 3-31-94

DIVISION 146

AMERICAN INDIAN/ALASKA NATIVE

410-146-0000
Foreword

(1) The Division of Medical Assistance Programs (DMAP) American Indian/Alaska Native (AI/AN) billing rules are designed to assist AI/AN Tribal Clinics/Health Centers, Indian Health Services (IHS), Federally Qualified Health Clinics (FQHC) with a 638 designation including, Urban Clinics, that are enrolled as AI/AN providers, to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage. Providers should follow the DMAP rules in effect on the date of service.

(2) AI/AN clients can choose to be exempt from managed care organizations (see OAR 410-141-0060) and receive their care from AI/AN Health Care Facilities, or any other private provider enrolled with DMAP.

(3) AI/AN clients can choose to enroll in a managed care organization and continue to receive care on an infrequent basis from AI/AN Health Care Facilities. If the client chooses to remain in a managed care organization they must follow all managed care rules when seeking services outside of AI/AN Health Care Facilities. When a client chooses to utilize services through a managed care organization they must contact their plan for coverage and prior authorization information.

(4) These rules contain information on policy, special programs services outside of the encounter rate, such as, pharmacy, lab, x-ray, and Durable Medical Equipment (DME), etc., and criteria for some services. All DMAP rules are used in conjunction with the DMAP General Rules and the Oregon Health Plan Administrative Rules.

(5) AI/AN Health Care Facilities that have a pharmacy will need the DMAP Pharmacy rules. AI/AN pharmacies that provide DME and Medical Supplies will also need the DMEPOS rules.

(6) The Health Services Commission's Prioritized List of Health Services (see OAR 410-141-0520), defines the covered services under DMAP.

(7) Note: Urban Tribal Clinics are not recognized under the Centers for Medicare and Medicaid Services (CMS) 1996 Memorandum of Agreement (MOA).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0020
Memorandum of Agreement (MOA)

(1) The State of Oregon, Division of Medical Assistance Programs (DMAP) recognizes the Centers for Medicare and Medicaid Services (CMS) Memorandum of Agreement (MOA).

(2) MOA outlines payment methodologies available to Tribal Facilities. Refer to 410-146-0420 for specific details.

(3) Urban Tribal Clinics are not recognized under CMS's MOA.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0021
American Indian/Alaska Native (AI/AN) Provider Enrollment

(1) Any of the following facilities may enroll as an AI/AN clinic provider:

(a) Indian Health Services (IHS) Health facility;

(b) Federally recognized Indian tribe, tribal organization; or

(c) Federally Qualified Health Clinic (FQHC) with a 638 designation excluding Urban Tribal Clinics.

(2) AI/AN Urban Health Care Facilities refer to OAR 410-146-0400 for enrollment information.

(3) If an IHS or other federally recognized Indian tribe or tribal organization applies to enroll as an AI/AN provider, that clinic must show proof of federal recognition.

(4) If an IHS or other federally recognized Indian tribe or tribal organization has a pharmacy or supplies durable medical equipment (DME) and medical supplies, that clinic must apply for a pharmacy provider number and/or apply for a DME provider number in addition to the clinic provider number.

(5) If an IHS or other federally recognized Indian tribe or tribal organization provides van/sedan transportation the clinic does not apply for a transportation provider number. Their AI/AN clinic number is used as outlined in OAR 410-146-0240.

(6) Urban Tribal Healthcare Facilities with 638 designations may enroll as an Urban Tribal Facility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0022
OHP Standard Benefit for AI/AN Clients

Once the Division of Medical Assistance Programs (DMAP) receives authorization to implement SB 878 from the Centers for Medicare and Medicaid Services, OHP Standard AI/AN clients have the following benefits:

(1) AI/AN Clients eligible for the OHP Standard Benefit are allowed by the authority of SB 878 to receive all services allowed under the OHP Plus Benefit that are reimbursed by CMS at 100% FPL;

(2) AI/AN Clients eligible for the OHP Standard Benefit do not change eligibility group unless allowed by OAR. For example OHP Standard female client becomes pregnant and moves into OHP Plus during pregnancy;

(3) Excluded Services: Transportation.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03

410-146-0025
Reimbursement for AI/AN Health Care Facilities

(1) Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organizations, and funded by Title I or IV of the Indian Self Determination and Education Assistance Act (Public Law 93-638), may select the reimbursement methodology as outlined in 410-146-0420.

(2) AI/AN Health Care Facilities that qualify under the Memorandum of Agreement may choose one of the following payment methodologies:

(a) Paid at the rates negotiated between the Centers for Medicare and Medicaid Services (CMS) and IHS, which are published in the Federal Register or Federal Register Notices annually. This methodology is referred to as the Tribal encounter rate;

(b) Tribal Health Care Facility excluding AI/AN Urban Health Care Facilities, with a Title I or V designation serving as an Indian Tribal Health Center may be reimbursed using 100% reasonable costs paid on a per encounter basis; or

(c) Reimbursed on a per service basis. This is also known as fee-for-service.

(3) If a Tribal Health Care Facility chooses the 100% reasonable costs encounter rate, they are not eligible for Administrative Match contracts.

(4) AI/AN Urban Tribal Health Care Facilities are not eligible for Administrative Match contracts.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 36-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0040
ICD-9-CM Diagnosis Codes

(1) The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the encounter/visit. Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnosis codes may be listed on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(3) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth-digit subcategories and/or fifth-digit subcategories are provided, they must be assigned. A code is invalid if it has not been coded to its highest specificity.

(4) The Division of Medical Assistance Programs (DMAP) requires accurate coding and applies the national standards in effect for calendar years 2004 and 2005 set by the American Hospital Association, American Medical Association, and Centers for Medicare and Medicaid Services (CMS). DMAP has unique coding and claim submission requirements for Administrative Exams; specific diagnosis coding instructions are provided in the Administrative Examination and Report Billing provider rules.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0060
Prior Authorization

(1) No prior authorization (PA) is required for services provided within an American Indian/Alaska Native (AI/AN) Health Care Facility with the sole exception of pharmacy, DME and Hospital Dentistry services. Refer to the Pharmacy and DME program rules for more detailed information.

(2) If a client is enrolled in a managed care plan there may be PA requirements for some services that are provided through the managed care plan. Contact the client's managed care plan for specifics.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03

410-146-0075
Client Copayments

(1) American Indian/Alaska Native (AI/AN) are not required to pay copayments for services provided through Indian Health Services (IHS), a Federally recognized Indian Tribe or Tribal Organization. This includes any health care services provided to the AI/AN member and is defined as provided directly, by referral, or under contracts or other arrangements

between IHS, a Federally recognized Indian Tribe, Tribal Organization or an Urban Tribal Health Clinic and another health care provider.

(2) AI/AN are not required to pay copayments for services provided at an Urban Tribal Health Clinic.

(3) AI/AN Tribal Health Facilities may not charge copayments to non-AI/AN Medical Assistance Program clients receiving care at the Tribal Health Facility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 89-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03

410-146-0080
Professional Services

(1) Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or Home Health services are not limited except as directed by the General Rules — Medical Assistance Benefits: Excluded Services and Limitations and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows:

(a) Coverage for diagnostic services and treatment for those services funded on the HSC List; and

(b) Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HSC List;

(c) The date of service determines the appropriate version of the General Rules and the HSC List to determine coverage;

(d) The OHP Standard Benefit Package is a limited benefit package. See OAR 410-120-1210 for details.

(2) American Indian/Alaska Native (AI/AN) Health Care Facilities are eligible under the Memorandum of Agreement (MOA) for reimbursement at the Tribal encounter rate for professional services.

(3) Urban clinics are not eligible, under the MOA, for reimbursement but are eligible to bill for all professional services as outlined in this rule.

(4) AI/AN Health Care Facilities, that have chosen to be reimbursed using the per service payments also known as fee-for-service, do not use the per encounter definitions. However, all services listed in (1) of this rule apply.

(5) Encounter:

(a) An encounter is defined as "A face-to-face contact between a health care professional and an Indian Health Services (IHS) beneficiary eligible for the Medical Assistance Program for the provision of Title XIX/CHIP defined services in an AI/AN Health Care Facility within a 24-hour period ending at midnight, as documented in the client's medical record";

(b) An encounter can occur either within or through the AI/AN Health Care Facility;

(6) The following encounters are reimbursable under the MOA encounter rate, 100% cost based reimbursement or an Urban Tribal Clinic eligible to bill as a Federally Qualified Health Center with or without a 638 designation:

(a) Physicians:

(b) Licensed Physician Assistants;

(c) Nurse Practitioners;

(d) Nurse Midwives;

(e) Dentists;

(f) Pharm D; or

(g) Other health care professionals:

(A) To provide: Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Drug, Maternity Case Management, Speech, Hearing, or Home Health Services;

(B) Professional services provided in a hospital setting;

(C) Services outside of the encounter rate include but not limited to Pharmacy, DME, Lab, Radiology, Targeted Case Management, Administrative Examinations, and Medical Transportation. These services are reimbursed under the Division of Medical Assistance Programs (DMAP) fee-for service system;

(D) Effective March 1, 2003, the OHP Standard Benefit has limited services. See OAR 410-120-1235 for detailed list of non-covered services.

(7) Multiple Encounters: Each service must be a distinctly different service in order to meet the criteria for multiple encounters. For example: a medical visit and a dental visit on the same day is considered two distinctly different services.

(8) Similar services, even when provided by two different health care. practitioners are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;

(d) A mental health and addiction encounter;

(e) Any time a client receives only a partial service with one provider and partial service from another provider it is considered a single encounter.

(9) Medical encounter definitions:

(a) More than one outpatient visit, with a medical professional, within a 24-hour period, for the same diagnosis, constitutes a single encounter. For example: a client comes to the clinic in the morning for an examination. During the examination the client is diagnosed with hypertension. The practitioner prescribes medication and asks the client to return in the afternoon for a blood pressure check;

(b) More than one outpatient visit, with a medical professional, within a 24-hour period, for distinctly different diagnoses, report as two encounters. For example, a client comes to the clinic in the morning for an immunization and in the afternoon falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a client that comes to the clinic for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter;

(c) This does not imply that if a client is seen at a single office visit with multiple problems, that multiple encounters can be billed.

(10) The following services may be considered as multiple encounters when two or more services are provided on the same date of service:

(a) Dental;

(b) Mental Health or Addiction Services — If both services are provided on the same date of service, then it's considered a single encounter. In addition, if the client is also seen for a medical office visit with a mental health or addiction diagnosis, it is considered a single encounter;

(c) Ophthalmologic services — fitting and dispensing of eyeglasses is included in the encounter that the vision exam is performed;

(d) Maternity Case Management (MCM) — When a client has a medical office visit, MCM can only be billed as a multiple encounter when the client is newly diagnosed as pregnant and is referred for MCM assessment or it is determined the client needs nutritional counseling;

(e) Physical or Occupational Therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT, then it would only constitute a single encounter;

(f) Immunizations — if no other medical office visit occurs on the same date of service;

(g) Tobacco cessation if no other medical or addition encounter occurs on the same date of service.

(11) The billing guidelines provided in the AI/AN billing rules for those clinics reimbursed using a per encounter rate methodology are limited to specific CPT/HCPCS codes when reporting an encounter that may not be consistent with national coding standards. This does not apply to ICD-9-CM diagnosis coding. Bill DMAP with the procedure codes indicated in each service category for services included in the AI/AN encounter rate. For services that are not included in the encounter rate or under the MOA please refer to the Services Not Eligible Under the MOA section of the AI/AN billing rules for billing instructions.

(12) When billing for a clinic visit, select the most appropriate CPT/HCPCS procedure code ranges shown in Table 146-0080-1.

(13) It is the HSC's intent to cover reasonable diagnostic services to determine diagnoses on the HSC List, regardless of their placement on the HSC List. Table 146-0080-1; Table 146-0080-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05

410-146-0100
Vaccines for Children (VFC)

(1) American Indian/Alaska Native (AI/AN) Health Care Facilities are eligible under the Memorandum of Agreement (MOA) for reimbursement for the administration of vaccines. These services are billed on a CMS-1500 or 837P using diagnoses that meet national coding standards and the appropriate encounter code. Refer to Supplemental Information, found on the Division of Medical Assistance Programs (DMAP) website, for billing instructions.

(2) The Vaccines for Children (VFC) Program was implemented by DMAP on April 1, 1996. Under this federal program certain immunizations are free for clients ages 0 through 18. For more information on how to enroll for the VFC Program, call the Oregon Health Division.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05

410-146-0120
Maternity Case Management Services

(1) American Indian/Alaska Native Health Care Facilities are eligible for reimbursement for Maternity Case Management (MCM) services.

(2) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are eligible for reimbursement for Maternity Case Management (MCM) services. These services are billed using HCPCS code G9012 for each MCM encounter.

(3) Clients records must reflect the all MCM services provided including all mandatory topics. Refer to Medical/Surgical OAR 410-130-0595 for specific requirements of the MCM program.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant and no later than the day prior to delivery. MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation. Clients are not eligible for MCM services if the MCM initial evaluation has not been completed prior to the day of delivery.

(5) Multiple MCM encounters in a single day cannot be billed as multiple encounters. A prenatal visit and a MCM service on the same day can be billed as two encounters only if the MCM service is the initial evaluation visit. After the initial evaluation visit, the nutritional counseling MCM service can be billed on the same day as a prenatal visit.

(6) The MCM program:

(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month post-partum period;

(c) Is an additional set of services over and above medical management, including perinatal services of pregnant clients;

(d) Allows for billing for intensive nutritional counseling services.

(7) MCM case managers are required to notify the:

(a) Prenatal care provider when:

(A) MCM services have been initiated; and

(B) Any time there is a significant change in the health, economic, social, or nutritional factors of the client.

(b) Health Division for all first-born babies.

(8) Note: In situations where multiple providers are seeing one client for MCM services, the case manager must coordinate care to ensure claims are not submitted to the Division of Medical Assistance Programs (DMAP) if services are duplicated.

(9) Four Case Management Visits may be billed per pregnancy. Six additional Case Management Visits may be billed if the client is identified as High Risk.

(10) DMAP recognizes Community Health Representatives (CHR) may be eligible to provide MCM services under the supervision of licensed health care practitioners as outlined in OAR 410-130-0595, may provide specific services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0130
Modifiers

(1) The Division of Medical Assistance Programs (DMAP) uses nationally recognized modifiers for many services. The modifiers listed in the American Indian/Alaska Native (AI/AN) billing rules are required.

(2) Refer to OAR 410-146-0080 Billing Codes **Table 146-0080-1** for list of required modifiers.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03

410-146-0140
Tobacco Cessation

(1) AI/AN Health Care Facilities are eligible under the MOA for reimbursement for tobacco cessation services. These services are billed on a CMS-1500 using diagnosis code 305.1 only and either S9075 or G9016 as appropriate.

(2) Follow criteria outlined in OAR 410-130-0190.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

410-146-0160
Administrative Medical Examinations and Reports

(1) Administrative medical examinations and reports are not eligible under the Memorandum of Agreement (MOA). Reimbursement for administrative examinations and reports are through the Division of Medical Assistance Programs (DMAP) fee-for-service program. Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services.

(2) AI/AN Health Care Facilities can be reimbursed for administrative medical examinations and reports when requested by a DHS branch office, or approved by DMAP. The branch office may request an Administrative Medical Examination/Report Authorization (DMAP 729) to establish client eligibility for an assistance program or casework planning.

(3) Administrative medical examinations are billed on a CMS-1500 using V68.89 as the diagnosis only and the DMAP unique procedure code that represents the exam provided.

(4) See the Administrative Examination and Report Billing guide for more detailed information on procedure codes and descriptions.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

410-146-0180
Durable Medical Equipment and Medical Supplies

(1) Durable Medical Equipment (DME) and Medical Supplies are not eligible under the Memorandum of Agreement (MOA). Reimbursement for DME services are through the Division of Medical Assistance Programs (DMAP) fee-for-service program. Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services.

(2) If an AI/AN Pharmacy is also supplying DME and Medical Supplies the pharmacy must also enroll as a DMAP DME provider. Follow the guidelines in the DMEPOS guide for billing and prior authorization of these items and services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01

410-146-0200
Pharmacy

(1) Pharmacy services are not eligible under the Memorandum of Agreement (MOA). Reimbursement for pharmacy services are through the Division of Medical Assistance Programs (DMAP) fee-for-service program.

(2) Do not use the American Indian/Alaska Native (AI/AN) Health Care Facility encounter code or rate for these services. AI/AN pharmacy providers use the Pharmacy guide for a complete listing of all rules and policies.

(3) Follow criteria outlined in the following:

(a) Not Covered Services — OAR 410-121-0147;

(b) Brand Name Pharmaceuticals — OAR 410-121-0155;

(c) Drugs and Products Requiring Prior Authorization — OAR 410-121-0040;

(d) Prior Authorization Procedures — OAR 410-121-0060;

(e) Clozapine Therapy — OAR 410-121-0190;

(f) Notation on Prescription — OAR 410-121-0144.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 59-2002, f. & cert. ef. 10-1-02

410-146-0220
Death With Dignity

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) All Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (DMAP), even if the client is in a managed care plan.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 22-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 28-1999, f. & cert. ef. 6-4-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 59-2002, f. & cert. ef. 10-1-02

410-146-0240
Transportation

(1) American Indian/Alaska Native (AI/AN) Health Care Facilities can be reimbursed for medically appropriate transportation services provided to clients who are eligible for medical assistance and receive health services through an AI/AN Health Care Facility.

(2) Transportation is outside of the Memorandum of Agreement (MOA) encounter rate and must be billed to the Division of Medical Assistance Programs (DMAP) fee-for-service on a CMS-1500 billing form with a diagnosis code. Enrolled AI/AN Health Care Facilit ies provid ing medical transportation will not be enrolled as a transportation provider. When billing for an approved transportation service use the AI/AN Health Care Facility provider number.

(3) Use the HCPCS code listed in the AI/AN billing guide that represents the transportation service provided. Do not use the AI/AN Health Care Facility encounter code or rate but rather the HCPCS or DMAP unique procedure code and rate listed for each service. Non-emergency ambulance, air ambulance, commercial air, bus, or train requires advance arrangement and prior approval through the local Seniors and People with Disabilities Division (SPD) (formerly SDSD) or Children, Adults and Families (CAF) (formerly AFS) branch office.

(4) Reimbursement for transportation is based on the following conditions:

(a) The car/van or wheelchair car/van is owned or leased by the AI/AN Health Care Facility;

(b) The individual providing the service is an employee of the AI/AN Health Care Facility;

(c) The service to be provided is the most cost effective method that meets the medical needs of the client;

(d) The service to be provided at the point of origin and/or destination is a medical service covered under DMAP or the MOA.

(5) The following information must be documented in the client's record or a single ledger that contains all medical transportation services for all clients of the facility:

(a) Trip information including date of service, if one way, round trip, or three-way and if transportation needs are ongoing;

(b) Client information, for example, requires wheelchair, walker, cane, needs assistance, requires portable oxygen, etc.

(6) Use the appropriate HCPCS code listed in the AI/AN billing guide to bill for transportation services.

(7) Tribal facility owned or leased car/van (sedan transport):

(a) 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 actual mileage is allowed;

(b) If more than one client is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. No duplicated miles traveled may be billed;

(c) A0170 All inclusive rate — $1.19 per mile.

(8) Tribal facility owned/leased wheelchair car/van (sedan transport):

(a) If a client is able to transfer from wheelchair to car/van use the car/van all-inclusive service. If two DMAP clients are transported by the same mode (e.g., wheelchair van) at the same time, DMAP will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more DMAP clients are transported by mixed mode (e.g., wheelchair van and ambulatory) at the same time, DMAP will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client. Reimbursement will not be made for duplicated miles traveled. If more than one client is transported from a single pickup point to different destinations or from different pickup points to the final destination the total mileage may be billed. The first 10 miles is included in the Base Rate and should be included in the total number of miles on the CMS-1500:

(A) A0130 — Base Rate: $17.72;

(B) T2002 — Mileage (each way): $1.19 per mile. The first 10 miles are included in the Base Rate. When billing mileage, place the total number of miles in Field 24G and the DMAP system will automatically deduct 10 miles;

(C) T2001 — Extra Attendant (each): $17.72.

(b) When billing for transportation use TOS code "D" and the appropriate POS code listed below:

(A) E — Home to Medical Practitioner;

(B) F — Home to Hospital;

(C) G — Home to Nursing Facility;

(D) H — Home to Other;

(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;

(I) N — Hospital to Home;

(J) P — Hospital to Nursing Facility;

(K) Q — Hospital to Other Hospital;

(L) R — Hospital to Other;

(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;

(Q) W — Other to Hospital;

(R) X — Other to Other.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 14-2002, f. & cert. ef. 4-1-02; OMAP 59-2002, f. & cert. ef. 10-1-02

410-146-0340
Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medical Assistance Program coverage, providers must bill Medicare first. Medicare will automatically forward all claims to the Division of Medical Assistance Programs (DMAP) for processing. However, since American Indian/Alaska Native (AI/AN) Health Care Facilities must bill DMAP using the most appropriate code as described in the AI/AN billing guide, some of these claims may not be processed and paid automatically. If your claim cannot be paid and processed automatically, a Remittance Advice instructing you to rebill DMAP on the CMS-1500 claim form will be sent to you.

(2) If an out-of-state Medicare carrier or intermediary was billed, you must bill DMAP using a CMS-1500 claim form, but only after that carrier has made payment determination.

(3) When rebilling on the CMS-1500, bill all services for each encounter under the most appropriate code as directed in the AI/AN billing guide. Enter any Medicare payment received in the "Amount Paid" field or use the appropriate TPR explanation code in Field 9 of the CMS-1500 claim form. See billing instructions for details.

(4) DMAP payment will be based on the allowable cost per encounter, less the actual Medicare payment amount.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02

410-146-0380
OHP Standard Emergency Dental Benefit

(1) The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth.

(2) Services are limited to those procedures listed in Table 146-0380-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

(3) Hospital Dentistry is not a covered benefit for the OHP Standard population except:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(4) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit. Table 146-0380-1.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04

410-146-0400
American Indian/Alaska Native (AI/AN) Urban Health Care Facility Enrollment

(1) The Centers for Medicare and Medicaid (CMS) do not recognize AI/AN Urban Health Care Facilities under the Memorandum of Agreement (MOA) agreement and are not eligible to be reimbursed using the Tribal encounter rate.

(2) AI/AN Urban Health Care Facilities that have a Federally Qualified Health Center (FQHC) status are required to submit financial documentation prior to enrollment. The term "required financial documents" in this rule refers to:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report for Rural Health Clinics (RHC);

(b) Cost Statement Worksheet (DMAP 3032);

(c) A copy of the clinic's trial balance;

(d) Audited financial statements if, the clinic received more than $250,000 total Medicaid funds in a calendar year;

(e) Depreciation schedules;

(f) Overhead cost allocation schedules; and

(g) Complete copy of the grant proposal detailing the clinic's service and geographic scope.

(3) FQHC Enrollment:

(a) To be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, all FQHCs must meet the following criteria:

(A) Centers receiving Public Health Division (PHD) grant funds under authority of Section 330 — Migrant Health Centers, Community Health Centers, or Services to Homeless Individuals, must submit: a copy of the notice of current grant award, an Division of Medical Assistance Programs (DMAP) Provider Application (DMAP 3117), documents showing the clinic's scope of services, and the required financial documents;

(B) For non-federally funded health centers that PHS recommends, and the Centers for Medicare and Medicaid Services (CMS),determines should be designated as an FQHC (i.e., "Look Alikes"), the clinic must submit: a copy of the letter from CMS designating the facility as a "Look Alike" or designating the facility as a non-federally funded health center, a DMAP Provider Application (DMAP 3117), documents showing the clinic's scope of services, and the required financial documents;

(C) For non-federally funded health centers that CMS determines may, for good cause, qualify through waivers of CMS requirements, the clinic must submit: a copy of the letter from CMS designating the facility as a "Look Alike," a DMAP Provider Application (DMAP 3117), documents showing the clinic's scope of services, and the required financial documents. Waivers may be granted for up to two years;

(D) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians/Alaska Natives.

(b) The DMAP Provider Application (DMAP 3117) and the required financial documents will be reviewed by DMAP for compliance with program rules prior to enrollment as an FQHC;

(c) Submit completed Cost Statements (DMAP 3027) one each for medical, dental and mental health. Addiction services are included in mental health costs, Cost Statement Worksheets (DMAP 3032), and the required financial documents to DMAP;

(d) If an FQHC provides mental health services the clinic must submit a copy of their certification from the Addictions and Mental Health Division (AMH);

(e) If an FQHC provides addiction services, the clinic must submit a copy of their certification from AMH;

(f) A list of all MCO contracts;

(g) A list of names of all practitioners working within the FQHC and a list of all individual DMAP provider numbers;

(h) List of all clinics affiliated or owned by the FQHC including any clinics that do not have FQHC or RHC status along with all DMAP provider numbers assigned to these clinics.

(4) If an AI/AN Urban Health Care Facility does not meet these criteria they can enroll with DMAP as an individual clinic for reimbursement on a per service basis, also known as fee-for-service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0420
Reimbursement Methodology

(1) AI/AN Tribal Health Care Facilities that qualify under CMS's Memorandum of Agreement may select one of the following reimbursement methodologies:

(a) Tribal encounter rate that is paid at the rates negotiated between the Centers for Medicare and Medicaid Services (CMS) and IHS, which are published in the Federal Register or Federal Register Notices annually:

(A) Note: If the negotiated rates for the IHS encounter is published in the Federal Register after the effective date of the new rate the Division of Medical Assistance Programs (DMAP) will retroactively reimburse the difference for all claims paid to American Indian/Alaska Native (AI/AN) Health Care Facilities with dates of service on or after the effective date of the new rate;

(B) AI/AN Tribal Health Care Facilities that choose the Tribal encounter rate may be eligible for an Administrative Match contract with DMAP;

(C) AI/AN Tribal Health Care Facilities that choose the Tribal encounter rate are eligible to receive managed care supplemental payments if they have contracts with DMAP managed care organizations.

(b) 100% of reasonable costs:

(A) An encounter rate that is calculated on indirect and direct clinic costs for Medicaid services;

(B) AI/AN Tribal Health Care Facilities that choose the 100% of reasonable costs are not eligible for an Administrative Match contract with DMAP. These costs are included in the indirect and direct costs;

(C) AI/AN Tribal Health Care Facilities that choose the 100% of reasonable costs are eligible to receive managed care supplemental payments if they have contracts with DMAP managed care organizations.

(c) Per service reimbursement also known as fee-for-service:

(A) Fee-for-service rates are posted on www.dhs.state.or.us;

(B) AI/AN Tribal Health Care Facilities that choose the fee-for-service methodology may be eligible for an Administrative Match contract with DMAP;

(C) AI/AN Tribal Health Care Facilities that choose the fee-for-service are not eligible for managed care supplemental payments.

(2) 100% of reasonable costs methodology for specific information refer to OARs 410-147-0380, 410-147-0440, 410-147-0480, 410-147-0520, 410-147-0540.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0440
Managed Care Supplemental Payments

(1) Qualifying AI/AN Tribal Health Care Facilities may receive managed care supplemental payments when the facility has contracts with the Division of Medical Assistance Programs (DMAP) managed care organizations (MCOs).

(2) To receive managed care supplemental payments from DMAP theAI/AN Tribal Health Facility must submit the following:

(a) When submitting claims to MCOs:

(A) The claims must be submitted within the required timelines outlined in the contract with the MCO;

(B) The AI/AN Tribal Health Care Facility number must be used when submitting all claims to the MCOs. MCOs must accept an AI/AN Tribal Health Care Facility number and may not require individual provider numbers from the facility.

(b) When submitting managed care supplemental payment documentation to DMAP:

(A) Total payments for all services including lab and diagnostic imaging received from the MCO excluding any bonus or incentive payments;

(B) The total number of actual encounters, excluding all lab or diagnostic imaging encounters;

(C) All performing provider numbers that any practitioner associated with the AI/AN Tribal Health Care Facility. Association refers to a practitioner that works for the FQHC or RHC and has or had a private practice and billed DMAP for services;

(D) A current list of all MCO contracts. Must be updated annually and submitted to DMAP each October.

(3) MCO Supplemental Payment process:

(a) On a quarterly basis DMAP will send AI/AN Tribal Health Care Facilities all MCO encounter data received by DMAP electronically in a spreadsheet format along with an explanation letter;

(b) AI/AN Tribal Health Care Facility must review the encounter data and determine if it is complete within 30 days. If it is incomplete, the facility needs to:

(A) Add the missing data to the electronic file and return it with any documentation that can support the missing data to DMAP and the MCO; and

(B) Verify that the MCO has the correct provider number for the clinic's claims.

(c) Once the data is reviewed and deemed correct by the AI/AN Tribal Health Care Facility, an interim check will be issued within 30 days for all encounters that DMAP can verify. A letter outlining the settlement and any other pertinent information will accompany the interim check;

(d) The data must be submitted within the timelines provided by DMAP.

(4) The data provided to the AI/AN Tribal Health Care Facility must be carefully reviewed in a timely fashion. If any missing data is not brought to DMAP's attention within the time frames outlined, DMAP will not recalculate an adjustment.

(5) Requests for MCO Supplemental Payments cannot be filed after the end of the required reporting period for that quarter unless DMAP has granted in writing an exception.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

410-146-0460
Compensation for Outstationed Eligibility Workers

(1) Compensation may be provided for clinics that are eligible for an Outstationed Outreach Eligibility Worker (OSEW).

(2) Clinics must submit a budget each December 1st to the Division of Medical Assistance Programs (DMAP) for review of the clinic OSEW costs for approval before any OSEW compensation is made each January 1st.

(3) Expenses allowed for OSEW reimbursement:

(a) Salary for each OSEW. To determine which part of the OSEW expense should be charged to DMAP when OSEW has other duties, calculate the percentage of the OSEW total time spent performing eligibility services and multiply it by the total reasonable expenses of the OSEW. This portion of the wages and benefits may be charged to DMAP;

(b) Case management is not part of the OSEW reimbursement. If an OSEW also does case management, calculate the OSEW expense as outlined above;

(c) Travel necessary for DMAP training on OSEW activities;

(d) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(e) Wages for OSEW;

(f) Reasonable equipment necessary to perform outreach activities; and

(g) Facility costs. Include a description of the facility area used and if its used for any other activity.

(4) Tribal Facilities that have a Medicaid Administrative Match contract that includes OSEW costs are not eligible for separate OSEW payments.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04

DIVISION 147

FQHC AND RHC SERVICES

410-147-0000
Foreword

(1) The Division of Medical Assistance Programs" (DMAP) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage.

(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.

(3) It is the clinic's responsibility to understand and follow all DMAP rules that are in effect on the date services are provided.

(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All provider rules can be found on the DMAP website.

(5) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other provider rules unless specifically directed in rules contained in the FQHC and RHC rules. DMAP General Rules and the Oregon Health Plan (OHP) Administrative Rules are intended to be used in conjunction with all program rules including the FQHC and RHC provider rules.

(6) The Health Services Commission's Prioritized List of Health Services is found in the OHP Administrative Rules (OAR 410-141-0520) and defines the services covered under DMAP.

(7) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.

(8) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: Hist.: AFS 20-1988, f. 3-8-88, cert. ef. 4-1-88; AFS 16-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 29-1991(Temp), f. & cert. ef. 7-1-91; HR 33-1991, f. & cert. ef. 8-16-91, Renumbered from 461-014-0415; HR 12-1992, f. & cert. ef. 4-1-92; HR 24-1992, f. & cert. ef. 7-3-92; HR 13-1996(Temp), f. & cert. ef. 7-1-96; HR 24-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00;OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0000; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0000; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 47-2005, f. 9-9-05, cert. ef. 10-1-05

410-147-0020
Professional Ambulatory Services

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 Division 147), General Rules (OAR 410 Division 120), OHP Administrative Rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520), and the Health Services Commission's (HSC) Prioritized List of Health Services (List).

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:

(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and

(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).

(3) Clinics must bill all services provided using diagnoses that meet national coding standards unless otherwise directed in Oregon Administrative Rule.

(4) Primary Care Manager (PCM) case management services, as defined in OHP Administrative Rules (OAR 410-141-0700) and previously provided under a PCM contract with Division of Medical Assistance Programs (DMAP), are included in the above listing of professional services.

(a) Clinics cannot bill DMAP for PCM case management services for coordinating medical care for a client as a stand-alone service since PCM case management is included in a clinic's all-inclusive Prospective Payment System (PPS) encounter rate;

(b) Clinics will report case management services as an allowed administrative program cost on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions.

(5) Clinics cannot bill sign language and oral interpreter services as a stand-alone service since they are professional services included in a clinic's all-inclusive PPS encounter rate. Clinics must report this service as an allowed administrative program cost on a cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions.

(6) Clinics cannot bill supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job readiness as stand-alone services. These services are included in a clinic's all-inclusive PPS encounter rate. Clinics will report these services as allowed administrative program costs on a cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions.

(7) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and HSC Prioritized List to determine coverage.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0500; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0140; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0040
ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The appropriate diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;
(b) Symptoms;
(c) Conditions;
(d) Problems;
(e) Complaints; or
(f) Other reasons for the encounter/visit.

(2) The Division of Medical Assistance Program (DMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-9-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. DMAP considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for calendar years 2006 and 2007 for the date the service(s) was provided:

(a) Use codes on Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(b) Use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) for physician services and other health care services. These services include, but are not limited to, the following:

(A) Physician services;
(B) Physical and occupational therapy services;
(C) Radiology procedures;
(D) Clinical laboratory tests;
(E) Other medical diagnostic procedures;
(F) Hearing and vision services.

(6) DMAP maintains unique coding and claim submission requirements for Administrative Exams and Death With Dignity services. Refer to OAR 410 Division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services, for specific requirements.

Stat. Auth.: ORS 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; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert, ef, 4-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0020; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0060; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07

410-147-0060
Prior Authorization

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Clients who are not enrolled in a PHP, receive services on an "open card" or "fee-for-service" (FFS) basis. The current month's Medical Care Identification specifies the client's status.

(2) Prior Authorization (PA) is not required for covered services provided within a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to a "fee-for-service" client, with the exception of pharmacy services and hospital dentistry. Refer to OAR 410-147-0280 Drugs, OAR 410 Division 121 Pharmaceutical Services and OAR 410 Division 125, Hospital Services.

(3) Clients who are enrolled in a PHP can receive family planning services, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without PA from the PHP as provided under the terms of Oregon's Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with a PHP, and the PHP denies payment, the Division of Medical Assistance Programs (DMAP) will reimburse for these services per a clinic's encounter rate (see OAR 410-147-0120(12)(b)).

(4) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. It is the FQHC or RHC's responsibility to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP Client enrolled in a PHP. The FQHC or RHC needs to contact the client's PHP for specific instructions.

(5) If a client receives services on "fee-for-service" basis, a PA may be required for certain services. An FQHC or RHC assumes full financial risk in providing services to a "fee-for-service" client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OARs). Some covered services or items require authorization by DMAP before the service can be provided or before payment will be made. See OAR 410-120-1320 Authorization of Payment.

(6) If the service or item is subject to Prior Authorization, the FQHC or RHC must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0640; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0080; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0080
Prepaid Health Plans (PHPs)

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Clinics serving eligible OHP clients who are enrolled in a PHP must secure authorization from the PHP prior to providing PHP-covered services or case management services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or referral from the PHP before providing any services to clients enrolled in a PHP unless the FQHC or RHC have contracted with the PHP to provide PHP-covered services. If an FQHC or RHC has an arrangement or contract with a PHP, the clinic is responsible to follow PHP rules and prior authorization requirements. See OAR 410 Division 141 for OHP Program Rules and; OAR 410-147-0060, Prior Authorization.

(2) The Division of Medical Assistance Programs (DMAP) encourages FQHCs and RHCs to contact each PHP in their local service area for the purpose of requesting inclusion in their panel of providers.

(3) PHPs contracting with FQHCs or RHCs, for the provision of providing services to their clients, are required by 42 USC 1396b(m)(2)(A)(ix) to provide payment to the FQHC or RHC that is not less than the level and amount of payment which the PHP would make for services furnished by a non-FQHC/RHC provider.

(4) Payment for services provided to PHP-enrolled clients is a matter between the FQHC or RHC and the PHP authorizing the services except as otherwise provided in OAR 410-141-0410, OHP Primary Care Managers. If a PHP denies payment to an FQHC or RHC because arrangements were not made with the PHP prior to providing the service, DMAP will not reimburse the FQHC or RHC under the encounter rate, except as outlined in Section (5) of this rule (see OAR 410-141-0120, OHP PHP Provision of Health Care Services).

(5) FQHCs and RHCs can provide family planning services or HIV/AIDS prevention services to eligible OHP clients enrolled in PHPs without authorization or a referral from the PHP. The FQHC and RHC must bill the PHP first. If the PHP will not reimburse for the service, then the clinic may bill DMAP. Refer to ORS 414.153, Authorization for payment for certain point of contact services.

(6) PHPs will execute agreements with publicly funded providers, unless cause can be demonstrated to the DMAP satisfaction why such an agreement is not feasible for authorization of payment for point of contact services in the following categories (refer to ORS 414.153):

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(7) PHPs are responsible to ensure the provision of qualified sign language and oral interpreter services for covered medical, mental health or dental care visits, for their enrolled DMAP Members with a hearing impairment or who are non-English speaking. Services must be sufficient for the FQHC or RHC provider to be able to understand the DMAP Member's complaint; to make a diagnosis; respond to the DMAP Member's questions and concerns; and to communicate instructions to the DMAP Member. See OAR 410-141-0220(7), Oregon Health Plan Prepaid Health Plan Accessibility.

(8) The Provider assumes full financial risk in serving a person not confirmed by DMAP as eligible on the date(s) of service. (See OAR 410-120-1140). It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided;

(b) Whether a client receives services on a fee-for-service (open card) basis or is enrolled with a PHP; and

(c) Whether the service is covered by a third party resource (TPR), a PHP, or if DMAP reimburses on a fee-for-service basis.

(9) DMAP requires the following of a FQHC or RHC under contract with a PHP:

(a) Clinic must maintain reimbursement and documentation records that will permit calculation of supplemental payments according to OAR 410-147-0460. According to OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Record Keeping, a PHP's participating providers shall maintain a clinical record keeping system with sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the DMAP Member. See also OAR 410-120-1360, Requirements for Financial, Clinical and Other Records;

(b) Clinics are subject to ongoing performance review by the PHP. According to OAR 410-141-0200, Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System, PHPs must maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to DMAP Members. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(c) Clinics are subject to program review by DMAP, the Department of Human Services' Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity and:

(A) Compliance with Oregon Revised Statutes, Oregon Administrative Rules and Federal laws and regulations;

(B) Accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation, is used for calculating PHP supplemental payments and compensation for out-stationed outreach workers;

(C) Adequate records are maintained for cost reimbursed services to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported.

Stat. Auth.: ORS 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; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0155; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0100; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0085
Client Copayments

(1) The Division of Medical Assistance Programs (DMAP) Medical Care Identification will indicate which Oregon Health Plan (OHP) clients are responsible for copayments for services.

(2) DMAP requires copayments from clients with certain benefit packages. See OAR 410-120-1230, Client Copayment, and Table 120-1230-1 for specific details.

(3) A client may owe more than one copayment during a 24-hour period. DMAP may require copayments for each medical, dental, mental health or alcohol and chemical dependency encounter on the same date of service. Refer to OAR 410-147-0140, Multiple Encounters.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 90-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0120
Encounter

(1) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) encounters billed to the Division of Medical Assistance Programs (DMAP) must meet the definition in Sections (2) and (3) of this rule and are limited to DMAP Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. An encounter includes all services, items and supplies provided to a client during the course of an office visit except as excluded in Section (11) of this rule. Section (3) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and OAR 410-130-0190, Tobacco Cessation. See

also OAR 410-120-1200(2)(y). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(4) Encounters with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, refer to OAR 410-147-0140 for reporting multiple encounters.

(5) Refer to **Table 147-0120-1** for a list of procedure codes used to report encounters when billing DMAP directly for non-PHP-enrolled, or open card, clients. DMAP will reimburse a clinic at their all-inclusive Prospective Payment System (PPS) encounter rate for the following services when billed as an encounter and include any related medical supplies provided during the course of the encounter. (Refer to individual program administrative rules for service limitations.):

(a) Medical (OAR 410 Division 130);

(b) Diagnostic: DMAP covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, DMAP will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-147-0220);

(d) Dental — Refer to OAR 410-147-0125, Table 147-0120-1, and OAR 410 Division 123;

(e) Vision (OAR 410 Division 140);

(f) Physical Therapy (OAR 410 Division 131);

(g) Occupational Therapy (OAR 410 Division 131);

(h) Podiatry (OAR 410 Division 130);

(i) Mental Health (OAR 309 Division 16);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 415 Divisions 50 and 51). Requires a letter or licensure of approval by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320(3)(j) and (5)(i);

(k) Maternity Case Management (OAR 410-147-0200);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) DMAP considers a home visit for assessment, diagnosis, treatment or Maternity Case Management (MCM) as an encounter. DMAP does not consider home visits for MCM as Home Health Services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and DMAP Administrative Rules.

(6) The following practitioners are recognized by DMAP:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. See the section on Limited Access Permits, ORS 680.200 and OAR 818-035-0065 through 818-035-0100 for more information;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by DMAP in this section and who is authorized to independently diagnose and treat according to OAR 851 Division 45);

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists (refer to OAR 410 Division 130 for service coverage and limitations); and

(n) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(i) Their individual provider's certification or license; or

(ii) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320(3) and (5).

(7) The clinic must not bill for drugs or medication treatments provided during a clinic visit since they are part of the encounter rate. For example, a hypertensive drug or drug sample dispensed by a clinic to treat a client with high blood pressure during an office visit is included in the all-inclusive encounter rate.

(8) DMAP considers medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) used during an office visit to be part of the cost of an encounter. Clinics cannot bill these items separately as fee-for-service charges;

(9) Clinics cannot bill Primary Care Manager (PCM) case management services for coordinating medical care for a client separately as fee-for-service since such services are included in the cost of an encounter. See also OAR 410-147-0020(4), Professional Services.

(10) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies — Code of Federal Regulations 42 § 405.2417), and any other ambulatory services covered by DMAP are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(11) DMAP excludes the following from the definition of an FQHC or RHC encounter:

(a) Laboratory and/or radiology services as stand alone services are not considered a valid clinic encounter. These services are secondary or resulting from the office visit encounter and are therefore included in the originating encounter and cannot be billed separately;

(b) Clinics cannot bill separately for venipuncture for lab tests since it is part of the encounter. DMAP does not deem a visit for lab test only to be a clinic encounter;

(c) Durable medical equipment or medical supplies (e.g. diabetic supplies) not generally provided during the course of a clinic visit.

(d) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program. Clinics cannot bill DMAP or the PHP for samples provided at no cost to the clinic. Prescriptions are not included in the encounter rate and qualified enrolled pharmacy providers must bill DMAP through the pharmacy. Refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(e) Administrative medical examinations and report services (See OAR 410 Division 150);

(f) Death with Dignity services (See OAR 410-130-0670);

(g) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients. (See OAR 410-120-1210, 461-135-1070 and 410-130-0240);

(h) Services provided to Qualified Medicare Beneficiary (QMB) only clients. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information is located in the FQHC and RHC Supplemental Information billing guide;

(i) Targeted Case Management (TCM) services (See OAR 410 Division 138); and

(j) Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act.

(12) OAR 410-120-1210 describes the OHP benefit packages and delivery system. Most OHP clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or "fee-for-service" (FFS) basis. The current month's Medical Care Identification specifies the client's status.

(a) DMAP is responsible for making payment for services provided to open card clients. The provider will bill DMAP the clinic's encounter rate for Medicaid-covered services provided to these clients according to their OHP benefit package. Refer to 410-147-0360, Encounter Rate Determination.

(b) A PHP is responsible to provide, arrange and make reimbursement arrangements for covered services for their DMAP members. Refer to OAR 410-120-0250, and OAR 410 Division 141, OHP Administrative Rules governing PHPs. The provider must bill the PHP directly for services provided to an enrolled client. See also OAR 410-147-0080, Prepaid Health Plans, and 410-147-0460, PHP Supplemental Payment. Clinics must not bill DMAP an encounter for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(i) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(ii) HIV/AIDS prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(13) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances DMAP will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing DMAP. For the purposes of this rule "reasonable efforts" include, but are not limited to:

(a) Asking the client if they have coverage from Medicare, private insurance or another resource;

(b) Using an insurance database such as Electronic Eligibility Verification Services (EEVS) available to the Provider; or

(c) Verifying the client's insurance coverage through the Automated Information System (AIS) or the Medical Care Identification on each date of service and at the time of billing.

(14) When a Provider receives a payment from any source prior to the submission of a claim to DMAP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See OARs 410-120-1280 Billing and 410-120-1340 Payment.

(15) Codes for encounters: Due to the unique billing and payment methodology, and the implementation of the Health Insurance Portability and Accountability Act (HIPAA), DMAP selected specific CPT and HCPCS codes for clinics to report encounters. Providers must bill DMAP with the procedure codes indicated in **Table 147-0120-1** for FQHC and RHC services eligible for reimbursement per a clinic's encounter rate. For services that are not included in the all-inclusive encounter rate, refer to the appropriate DMAP provider rules for billing instructions.

(16) It is the Health Services Commission's (HSC) intent to cover reasonable diagnostic services to determine diagnoses on the HSC Prioritized List of Health Services (List), regardless of their placement on the HSC List. See also Section (5)(b) of this rule.

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

Stat. Auth.: ORS 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; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0390; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0150; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07

410-147-0125
OHP Standard Emergency Dental Benefit

(1) The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Refer to OAR 410-123-1670 OHP Standard Limited Emergency Dental Benefit.

(2) Services are limited to those procedures listed in OAR 410-123-1670, Table 123-1670-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

(3) An FQHC billing Division of Medical Assistance Programs (DMAP) directly for dental services provided to an open card OHP Standard client, must bill the covered service(s) in accordance with Section (2) of this rule, using a dental procedure code as listed in Table 147-0120-1, FQHC/RHC encounter codes.

(4) An FQHC is not limited to the FQHC/RHC encounter procedure codes listed in Table 147-0120-1 when billing a Dental Care Organization (DCO), Medicare, or any other Third Party Resource (TPR).

(5) Hospital Dentistry is not a covered benefit for the OHP Standard population except for covered services authorized in accordance with Section (2) of this rule when provided to:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(6) Any limitations or prior authorization requirements for services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an FQHC or RHC.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0140
Multiple Encounters

(1) An encounter is defined in OAR 410-147-0120.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (Refer to OAR 410-147-0120 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (Section (4) of this rule, and OAR 410 division 130);

(b) Dental (OAR 410-147-0125, Table 147-0120-1, and OAR 410 division 123);

(c) Mental Health (OAR 309 division 016). If a client is also seen for a medical office visit and receives a mental health diagnosis, then providers must report only one encounter;

(d) Addiction and Alcohol and Chemical Dependency (OAR 415 divisions 50 and 51). If a client is also seen for a medical office visit and receives an addiction diagnosis, then providers must report only one encounter;

(e) Ophthalmologic services — fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR 410 division 140);

(f) Maternity Case Management MCM (OAR 410-147-0200);

(g) Physical or occupational therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR 410 division 131); and

(h) Immunizations — if no other medical office visit occurs on the same date of service.

(3) Division of Medical Assistance Programs (DMAP) expects that multiple encounters will occur on an infrequent basis.

(4) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first Medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in Section (2) of this rule.

(5) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(6) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist;

(f) Any time a client receives only a partial service with one provider and partial service from another provider, this would be considered a single encounter.

(7) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service. A recipient may obtain medical, dental or other health services from any provider approved by DMAP, and/or contracts with the recipient's PHP, if the FQHC/RHC is not the recipient's primary care manager.

(8) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0520; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0155; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0160
Modifiers

(1) The Division of Medical Assistance Programs (DMAP) uses HIPAA compliant modifiers for many services. The modifiers listed in the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules represent those that are required.

(2) For a list of all required modifiers: Refer to OAR 410-147-0120 Table 147-0120-1.

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in their individual program Administrative Rules.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0180
Vaccines for Children (VFC) Program

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible clients. Costs associated with vaccines are included in the definition of an encounter and are not billed separately to DMAP.

(2) The VFC program supplies federally purchased free vaccines for immunizing eligible clients ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Department of Human Services Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0540; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0160; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0200
Maternity Case Management Services

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Maternity Case Management (MCM) services. Refer to OAR 410-147-0120 Encounter, and Table 147-0120-1.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to a client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill DMAP directly per the clinic's PPS encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, the provider needs to request the necessary authorizations from the PHP.

(3) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management (MCM) for specific requirements.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes, including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation the day before delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day cannot be billed as multiple encounters.

(6) A medical encounter and an MCM encounter can occur on the same day only under the following two circumstances:

(a) The practitioner can bill a prenatal visit and a MCM service on the same day as separate encounters only if the MCM service is the initial evaluation visit;

(b) After the initial evaluation visit, the practitioner can bill the nutritional counseling MCM service if provided on the same day as a prenatal visit as two separate encounters. See Section (7)(c) of this rule for limitations.

(7) MCM Services limitations:

(a) DMAP reimburses the initial evaluation one time per pregnancy per provider;

(b) Providers may bill DMAP for case management visits four times per pregnancy. In addition, if a client is identified as high risk; the practitioner may bill six additional case management visits;

(c) DMAP reimburses Nutritional Counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(d) DMAP reimburses a Home/Environmental Assessment one time per pregnancy, and is included in the total number of case management visits in Section (7)(b) of this rule.

(8) A client may only participate in a single case management program. DMAP does not allow multiple case management billings. This includes Maternity Case Management (MCM), and any Targeted Case Management (TCM) Program outlined in OAR 410 division 138.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0560; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0180; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0220
Tobacco Cessation

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for tobacco cessation services under the encounter rate. Bill procedure codes G9016 for tobacco cessation counseling and S9075 for tobacco cessation treatment, with diagnosis code 305.1 (Tobacco Use Disorder). Refer to Table 147-0120-1.

(2) Refer to OAR 410-130-0190 for specific requirements and treatment limitations.

(3) Practitioners may not report Tobacco Cessation, a specific DMAP prevention program, as a separate encounter when a medical, dental, mental health or addiction service encounter occurs on the same date of service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01;OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0580; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0200; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0240
Administrative Medical Examinations and Reports

(1) The Division of Medical Assistance Programs (DMAP) does not reimburse Administrative Medical Examinations and Reports at a clinic's encounter rate. DMAP reimburses providers for Administrative Examinations and Reports on a fee-for-service basis.

(2) Refer to OAR 410 division 150, Administrative Examination and Billing Services, for specific requirements. See Administrative Exams Supplemental Information for more detailed information on procedure codes and descriptions.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-620; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0220; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0260
Death With Dignity

(1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.

(2) All claims for Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (DMAP), even if the client is in a managed care plan. Death With Dignity services are not part of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter rate.

(3) Follow criteria outlined in OAR 410-130-0670.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 16-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 27-1999, f. & cert. ef. 6-4-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0035; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0260

410-147-0280
Drugs

(1) The Division of Medical Assistance Programs (DMAP) excludes pharmaceutical or biologicals not generally provided during a clinic visit from the definition of an FQHC or RHC encounter.

(a) Providers cannot bill separately for drugs or medication treatments dispensed by a clinic to treat a client during an office visit since DMAP includes them in the all-inclusive encounter rate for the office visit;

(b) Prescriptions are not included in the encounter rate and a qualified enrolled pharmacy must bill DMAP through the pharmacy program.

(2) Clinics may directly bill DMAP only for contraceptive supplies and contraceptive medications outside of the pharmacy program:

(a) Clinics must bill the Prepaid Health Plan (PHP) first for clients enrolled in a PHP. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill DMAP fee-for-service at the clinic's acquisition cost. See also OAR 410-130-0585, Family Planning Services;

(b) Clinics can directly bill DMAP fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications dispensed by a clinic to a non-PHP-enrolled client. See also OAR 410-130-0585, Family Planning Services.

(3) Refer to OAR 410 division 121, Pharmaceutical Services Program Rulebook for specific information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0600; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0240; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0320
Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (DMAP) enrollment requirements for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Refer also to OAR 410-120-1260 Provider Enrollment.

(a) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians, providers should refer to the program rules for American Indian/Alaska Native (AI/AN) Services, OAR 410 Division 146, for enrollment details;

(b) An FQHC or RHC that operates a retail pharmacy, provides durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS and/or TCM provider. Refer to OAR 410 Division 121, Pharmaceutical; OAR 410 Division 122, DMEPOS; and OAR 410 Division 138, TCM for specific information.

(2) To enroll with DMAP as an FQHC, a health center must comply with one of the following:

(a) Receive Public Health Service (PHS) grant funds under the authority of Section 330;

(b) Have received FQHC Look-Alike designation from the Centers for Medicare and Medicaid Services (CMS), based on the recommendation of the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC).

(3) Eligible FQHCs who want to enroll with DMAP as an FQHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed DMAP Provider Application Form 3117 for an Agency;

(b) Completed Cost Statement(s) (DMAP 3027):

(i) One each for medical, dental and mental health (including addiction, alcohol and chemical dependency). See also OAR 410-147-0360;

(ii) Complete a cost statement for each FQHC-designated site, unless specifically exempted in writing by DMAP to file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers;

(c) Completed copy of the grant proposal submitted to HRSA/BPHC detailing the clinic's service and geographic scope;

(d) Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC;

(e) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports;

(f) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations";

(g) Depreciation schedules;

(h) Overhead cost allocation schedule;

(i) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220, Certificates of Approval for Mental Health Services; 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and OAR 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(j) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(k) A list of all Prepaid Health Plan (PHP) contracts;

(l) A list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the FQHC; and

(m) A list of all clinics affiliated or owned by the FQHC including any clinics that do not have FQHC status along with all DMAP provider numbers assigned to these clinics.

(4) For enrollment with DMAP as an RHC, a clinic must:

(a) Be designated by CMS as an RHC.

(b) Maintain Medicare certification and be in compliance with all Medicare requirements for certification.

(5) Eligible RHCs who want to enroll with DMAP as an RHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed DMAP Provider Application Form 3117 for an Agency;

(b) Copy of Medicare's letter certifying the clinic as an RHC;

(c) Medicare Cost Report for RHC or completed Cost Statement(s) (DMAP 3027). See also OAR 410-147-0360. Complete a cost statement for each RHC-designated site, unless specifically exempted in writing by DMAP to file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(d) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports (only if completing Cost Statement DMAP 3027);

(e) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" (only if completing Cost Statement DMAP 3027);

(f) Depreciation schedules (only if completing Cost Statement DMAP 3027);

(g) Overhead cost allocation schedules (only if completing Cost Statement DMAP 3027);

(h) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220,

Certificates of Approval for Mental Health Services; 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and OAR 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(i) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(j) A list of all Prepaid Health Plan (PHP) contracts;

(k) A list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the RHC; and

(l) A list of all clinics affiliated or owned by the RHC including any clinics that do not have RHC status along with all DMAP provider numbers assigned to these clinics.

(6) The FQHC/RHC Program Manager, upon receipt of the required items as listed in Section (3) of this rule for FQHCs and Section (5) of this rule for RHCs, will review all documents for compliance with program rules, completeness and accuracy.

(7) DMAP prohibits an established, enrolled FQHC or RHC that adds or opens a new clinic site from submitting claims for services rendered at the new site under their FQHC or RHC DMAP provider number, and according to the PPS encounter rate, prior to DMAP's acknowledgment. An FQHC or RHC is required to immediately submit to the attention of the FQHC/RHC Program Manager, DMAP:

(a) For FQHCs only, a copy of the recent HRSA Notice of Grant Award including the new site under the main FQHC's scope;

(b) For RHCs only, a copy of Medicare's letter certifying the new clinic as an RHC;

(c) A recent list of all Prepaid Health Plan (PHP) contracts; and

(d) A recent list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the new FQHC or RHC site.

(8) If an established and enrolled RHC or FQHC changes ownership, the new owner must submit:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated; or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership;

(b) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit all rights to calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will in effect be reassigned to the new ownership;

(c) Notice of a change in tax identification number;

(d) A recent list of all Prepaid Health Plan (PHP) contracts;

(e) A recent list of names and individual DMAP provider numbers for all practitioners contracted with or employed by the FQHC or RHC; and

(f) A recent list of all clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status along with all DMAP provider numbers assigned to these clinics.

(9) FQHCs that are involved with a Sub-recipient must provide documentation. Sub-recipient contracts with an FQHC must enroll as an FQHC and submit the same required documentation as outlined under the enrollment sections of this rule.

Stat. Auth.: ORS 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; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0010; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07

410-147-0340
Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)/Provider Numbers

(1) Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are allowed one clinic number only. Multiple sites are not allowed additional clinic provider numbers unless each site has a different tax identification number.

(2) The Division of Medical Assistance Programs (DMAP) may grant exception to section (1) of this rule upon written request. The request needs to include documentation describing in detail the need for multiple provider numbers and outlining the mechanisms in place to assure no duplication of billings. If DMAP provides multiple clinic numbers and DMAP finds evidence of duplicate billings or failure to use the billing provider number as required, DMAP may terminate the exception for multiple provider numbers upon written notice to the clinic. To request an exception, write to DMAP — Attn: FQHC/RHC Program Manager. Include an explanation about why DMAP should grant the FQHC or RHC an exception.

(3) Once a clinic enrolls as a FQHC or RHC, DMAP may terminate all individual provider numbers for FQHC/RHC practitioners the same date as the FQHC/RHC clinic number is issued unless documentation is provided for individual providers that have separate practice outside of the FQHC or RHC.

(4) If DMAP grants an exception to section (1) of this rule, DMAP will issue the FQHC or RHC a billing provider number for the main administrative site and a separate performing provider number for each clinic site. If the main administrative site also includes a clinic at that same site, that clinic will have two numbers:

(a) A billing provider number; and

(b) A clinic site provider number. When granted multiple provider numbers, clinics must enter the billing provider number in Field 33 and the clinic site provider number in Field 24K of the CMS-1500 when submitting claims to DMAP. The main administrative office with a clinic site must list the billing provider number in Field 33 and their clinic provider number in Field 24K.

(5) If an FQHC or RHC has several clinic sites and one or more of the clinics are not designated as an FQHC or RHC, the non-FQHC or non-RHC (each individual clinic) must apply for:

(a) A billing provider number; and

(b) Performing provider numbers for each practitioner.

(6) The FQHC/RHC must submit a written request regarding the circumstances of the need for a practitioner to have an individual provider number.

(7) Upon enrollment and each October thereafter, FQHCs and RHCs must submit to DMAP all provider numbers associated with FQHC/RHC practitioners and/or any non-FQHC and non-RHC clinics numbers.

(8) To request an exception for individual provider numbers, write to DMAP — Attn: FQHC/RHC Program Manager. Include an explanation of the circumstances regarding the individual provider numbers.

(9) If an FQHC or RHC operates a retail pharmacy or provides durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS), i.e., diabetic supplies, the clinic must apply for a pharmacy provider number and/or apply for a DME provider number. Providers may only use these numbers when billing for either retail pharmacy or DMEPOS services. The clinic must meet all pharmacy or DME enrollment requirements and must use the rules from the appropriate program billing rules. These services are not included in the encounter rate.

(10) DMAP will not issue clinic provider number(s) until after the encounter rate is established.

(11) Managed Care Organizations (MCO) are required to report all MCO encounters using the FQHC/RHC clinic number and not individual provider numbers.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04

410-147-0360
Encounter Rate Determination

(1) The Division of Medical Assistance Programs (DMAP) will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:

(a) DMAP will enroll a clinic as an FQHC or RHC effective the date DMAP determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with DMAP and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled providers can submit claims to DMAP for providing specific care, item(s), or service(s) to DMAP clients. A clinic or individual provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with DMAP, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical,

Dental and Mental Health (including Addiction, Alcohol and Chemical Dependency) Services.

(a) Effective October 1, 2004, for FQHCs only, DMAP will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with DMAP:

(i) Medical;

(ii) Dental; and

(iii) Mental Health, to include addiction, alcohol and chemical dependency services.

(b) FQHCs enrolled with DMAP prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate calculated if the clinic adds a service category listed in either Section (2)(a)(ii) or (iii) of this rule. Refer also to Section (16) of this rule.

(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.

(a) DMAP will accept an uncertified Medicare Cost Report;

(b) If the clinic's Medicare Cost Report, provided to DMAP, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. DMAP will include these costs when determining the PPS encounter rate.

(c) DMAP will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;

(d) An RHC can submit the DMAP cost statement form 3027 as a substitute to the Medicare Cost Report.

(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by DMAP. If exempted from this requirement by DMAP, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.

(6) FQHCs and RHCs cannot include costs associated with non-covered Medicaid services. DMAP does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.

(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid covered services provided at clinic sites serving DMAP clients when completing the Cost Statement (DMAP 3027). For RHCs only, the Medicare Cost Report can only include financial documents for Medicaid-covered services provided at clinic sites that see DMAP clients. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve DMAP clients in the Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs.

(8) At any time, if DMAP determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, DMAP may:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate(s); and

(b) Impose sanctions as defined in OARs 410-147-0560 and 410-120-1400.

(9) Effective January 1, 2001, DMAP determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid covered services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.

(10) Clinics existing in 1999 and 2000, and enrolled with DMAP as a FQHC or RHC as of January 1, 2001, receive payment from DMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.

(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from DMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC. Coinciding with enrollment as an FQHC or RHC with DMAP, a clinic will have a PPS encounter rate:

(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or

(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.

(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).

(13) For established, enrolled clinics with a change of ownership, the new owner can submit:

(a) A Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by DMAP to determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic's tax identification number;

(c) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.

(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to DMAP for review.

(15) DMAP may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health (including addiction, and alcohol and chemical dependency) services. A separate PPS encounter rate will be calculated by DMAP for the added service element if:

(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;

(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;

(c) The FQHC is certified by the Addictions and Mental Health Division (AMH) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by Addictions and Mental Health Division (AMH), former OMHAS to provide addiction, and alcohol and chemical dependency services;

(i) Certification by AMH of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements

(iii) A letter of licensure or approval by AMH is required for FQHCs providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320(3)(j) and (5)(i);

(16) If an FQHC meets the criteria as outlined in Section (15) of this rule for the addition of Dental or Mental Health (including addiction, and alcohol and chemical dependency) services, after the initial encounter rate determination,DMAP will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

(17) When an FQHC shares the same space for multiple services, then DMAP will use square footage to determine the percent of the indirect cost associated with each encounter rate.

(18) A clinic may be exempt from this requirement if an FQHC has minimal utilization for a particular service such as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to the DMAP FQHC Program Manager for consideration.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0362
Change in Scope of Services

(1) As required by 42 USC § 1396a(bb)(3)(B), the Division of Medical Assistance Programs (DMAP) must adjust Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) Prospective Payment System (PPS) encounter rates based on any increase or decrease

in the scope of FQHC or RHC services, as defined by 42 USC §§ 1396d(a)(2)(B–C).

(2) The Centers for Medicare and Medicaid Services (CMS) defines a "change in scope of services" as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS' broad definition of change in scope of services allows DMAP the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the elements "type," "intensity," "duration," and "amount" and procedures for implementing these adjustments. This rule defines the DMAP policy for implementing FQHC and RHC PPS rate adjustments based on a change in scope of services.

(3) A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC §§ 1396d(a)(2)(B–C).

(4) A change in the cost of a service is not considered in and of itself a change in the scope of services. A FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers' services.

(5) The following examples are offered as guidance to FQHCs and RHCs to facilitate understanding the types of changes that may be recognized as part of the definition of a change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

(a) A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples of eligible changes in scope of services include, but are not limited to:

(A) Changes within medical, dental or mental health (including addiction, alcohol and chemical dependency services) service areas (e.g. vision, physical/occupation therapy, internal medicine, oral surgery, podiatry, obstetrics, acupuncture, or chiropractic);

(B) Services that do not require a face-to-face visit with a FQHC or RHC provider will be recognized (e.g. laboratory, radiology, case-management, supportive rehabilitative services, and enabling services.)

(b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of services does not constitute an eligible change. Examples of eligible changes include but are not limited to:

(A) A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center;

(B) The addition or removal of specialty providers (e.g., pediatric, geriatric or obstetric specialists) with a corresponding change in scope of services provided by the health center (e.g. delivery services);

(i) If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services;

(ii) If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services;

(c) A change in service intensity or service delivery model attributable to a change in the types of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the health center;

(d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services. (e.g. the addition of a radiology department);

(e) A change in applicable technologies or medical practices:

(A) Maintaining Electronic Medical Records (EMR);

(B) Updating or replacing obsolete diagnostic equipment (which may also necessitate personnel changes); or

(C) Updating practice management systems;

(f) A change in overall health center costs due to changes in state or federal regulatory or statutory requirements. Examples include but are not limited to:

(A) Changes in laws or regulations affecting health center malpractice insurance;

(B) Changes in laws or regulations affecting building safety requirements; or

(C) Changes in laws or regulations relating to patient privacy.

(6) The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as described in sections (3)-(5):

(a) A change in office hours;

(b) Adding staff for the same service-mix already provided;

(c) Adding a new site for the same service-mix provided;

(d) A change in office location or office space; or

(e) A change in the number of patients served.

(7) Threshold Change in Cost per Visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over the course of several years (e.g. health centers would use the cost report for the year in which all changes were implemented and the 5% cost/visit was met, as described in sections (13) and (14) of this rule). A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a health center, as defined in sections (3)–(5) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

(8) If a FQHC or RHC has experienced an increase or decrease in the health center's scope of services, as described in sections (3)–(5) of this rule, and that meets the threshold requirement of section (7) of this rule, the FQHC or RHC must submit to DMAP a written application as outlined below. DMAP may also initiate a review of whether a change in scope of services has occurred at a health center:

(a) A written narrative describing the specific changes in health center services, and how these changes relate to a change in the health center's overall picture of services;

(b) An estimate of billable Medicaid encounters for the forthcoming 12-month period so the financial impact to DMAP can be accounted for;

(c) A cost statement. All costs and expenses reported must be in agreement with the principles of reasonable cost reimbursement as found at 42 CFR 413, HCFA Publication 15-1 (Provider Reimbursement Manual), and any other regulations mandated by the Federal government. Any situations not covered will be based on Generally Accepted Accounting Principals (GAAP). See Change in Scope Cost Report Instructions;

(d) Certification by the Addiction and Mental Health Division (AMH) of a health center's outpatient mental health program is required if mental health services are provided by nonlicensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements; and

(e) A letter of licensure or approval by AMH is required for health centers providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320(3)(j) and (5)(i); and

(f) The clinic is responsible for providing complete and accurate copies of the above documentation. Health centers may submit a maximum of one change in scope application per year.

(9) Upon receipt of a health center's written change in scope of services request, the FQHC/RHC Program Manager will:

(a) Review all documents for completeness, accuracy and compliance with program rules. An incomplete application will result in a delay in the DMAP review until the complete application is received; and

(b) Respond to the health center with a decision within 90 days of receipt of a complete application.

(10) Providers may appeal this decision in accordance with the provider appeal rules set forth in OAR 410-120-1560.

(11) Approved Change in Scope of Service requests will result in PPS rate adjustments:

(a) A separate mental health or dental PPS encounter rate will be calculated if a FQHC or RHC adds dental or mental health (including addiction, and alcohol and chemical dependency) services, and costs associated with these service categories were not included in the original cost statements used to determine the baseline PPS encounter rate;

(b) If costs associated with dental or mental health services were included in the original cost statements, whether negligible or significant, health centers have the option of having an adjusted single encounter rate, or requesting a separate dental or mental health rate.

(12) The new rate will be effective beginning the first day of the quarter immediately following the date DMAP approves the change in scope of services adjustment (e.g. January, April, July, or October 1):

(a) DMAP will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;

(b) It is a health center's responsibility to request a timely change in scope of service rate adjustment.

(13) For changes occurring on or after October 1, 2008, the effective date of this policy, FQHCs and RHCs are required to:

(a) For anticipated changes, health centers should submit prospective costs for DMAP to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by DMAP. Health centers may later request a subsequent rate adjustment based on actual costs;

(b) For gradual or unanticipated changes, health centers must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met, or beginning in the calendar year of the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met. For example, a health center implements a change in scope of services in 2008, but the additional costs incurred do not meet the 5% threshold criteria. In 2009 the health center implements additional scope of service changes. Additional costs incurred in 2009 together with the costs incurred for 2008 meet the 5% threshold. The health center would report costs for 2009;

(c) Health centers may submit both actual costs (for prior changes) as well as projected costs (for anticipated changes). Prior to submitting both actual and projected costs, health centers should work with the DMAP FQHC/RHC Program Manager to confirm the appropriate time periods of costs to submit.

(14) For changes that occurred prior to the effective date of this policy, October 1, 2008, FQHCs and RHCs are required to:

(a) Submit cost reports for either:

(A) The first year of actual costs beginning the date on which a change in the cost per visit threshold is met; or

(B) The calendar year or the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met;

(b) For changes that occurred over multiple and overlapping time periods, FQHC/RHCs will submit actual costs for the time period beginning when all changes were in effect. For example, if changes occurred in 2003 and 2004, health centers would submit their 2004 cost report that would include costs for changes implemented in both 2003 and 2004;

(c) Rate adjustments calculated using costs from prior fiscal years will be adjusted by the Medicare Economic Index (MEI) to present.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07

410-147-0365
Rural Health Clinic (RHC) Alternate Payment Methodology (APM) for Obstetrics (OB) Care Delivery Procedures

(1) A Medicare certified RHC, as defined below, may be eligible for an obstetrics (OB) alternate payment methodology (APM) encounter rate for delivery procedures. The OB APM delivery encounter rate includes additional OB delivery-related costs incurred by a clinic as a cost-based payment in addition to the Prospective Payment System (PPS) medical encounter rate. The OB APM is contingent, and becomes effective, upon federal approval of the State Plan Amendment. The intent of the OB APM is to maintain access to OB care, including delivery services, in frontier and remote rural areas and to compensate eligible clinics for professional costs uniquely associated with OB care, not to exceed 100% of reasonable cost.

(2) To be eligible for the OB APM delivery encounter rate, a Medicare certified RHC must meet all Division of Medical Assistance Programs (DMAP) requirements applicable to an RHC, qualify as either "frontier" or "remote rural" as defined in section (2)(a) and (b) of this rule, be located in a service area with unmet medical need defined in section (2)(c), and must request to participate in writing pursuant to participation requirements specified in sections (3) and (5).

(a) Frontier RHC is defined as located in a frontier county as designated by the Oregon Office of Rural Health;

(b) Remote rural RHC is defined as located in a remote rural service area as designated by the Oregon Office of Rural Health;

(c) A frontier or remote rural RHC must be located in a service area of unmet medical need as determined by the Oregon Office of Rural Health for the year in which the written request for OB APM was made.

(3) If the frontier or remote rural RHC qualifies under section (2) of this rule and other requirements outlined by DMAP, the clinic must provide DMAP all required documentation necessary to qualify for the OB APM delivery encounter rate.

(a) An eligible RHC must submit a written request to DMAP for the OB APM delivery encounter rate. The RHC is responsible for providing all documentation necessary for DMAP to conduct the calculations described in this rule. Failure to provide necessary documentation with the request to participate may result in a delay of the calculation and effective date of the OB APM delivery encounter rate.

(b) RHCs that meet the requirements in section (2) of this rule prior to Federal approval of the State Plan Amendment (SPA) may bill, using the OB APM delivery encounter rate, effective the date of Federal approval of the SPA provided DMAP has determined the clinic's OB APM delivery encounter rate.

(c) RHCs that meet the requirements in section (2) of this rule after the Federal approval date of the SPA may bill, using the OB APM delivery encounter rate, effective the date DMAP determines the clinic's OB APM delivery encounter rate.

(4) Care status changes:

(a) DMAP reserves the right to request periodic review of utilization, cost reporting and to re-evaluate OB care access including delivery services in a community to determine the continued need to pay an OB APM delivery encounter rate for frontier and remote rural RHCs;

(b) Prior to making any changes in the RHC's status and rates, DMAP will re-evaluate the following:

(A) If OB care access including delivery services in a community has changed;

(B) If the RHC no longer meets the requirements for the OB APM:

(i) An RHC's agreement with the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) is terminated, or

(ii) The location of an RHC does not qualify as an unmet medical need service area as determined by the Oregon Office of Rural Health for five consecutive years;

(C) The stability of new providers supplying additional OB care access including delivery services;

(c) DMAP will give the RHC 90 days notice of change in status and rate;

(d) If DMAP determines that an RHC no longer meets the OB APM requirements, the RHC may request, within 30 days from notification, that DMAP review any additional supporting documentation regarding the determination.

(5) Determining OB APM Delivery Encounter Rate: The frontier or remote rural RHC requesting an OB APM delivery encounter rate, and meeting the DMAP requirements, will have an OB APM delivery encounter rate which is the sum of a clinic's PPS medical encounter rate and an OB cost-based payment. The OB payment is calculated from costs uniquely associated with OB delivery services and which were not used in the calculation of a clinic's PPS medical encounter rate as outlined in the State Plan, Attachment 4.19B:

(a) Qualification of the OB APM delivery encounter rate is not considered a change of scope;

(b) The Medicare Economic Index (MEI) adjustment, as required by the PPS, will apply to the OB APM delivery encounter rate once established;

(c) DMAP will use the information listed below to determine the eligible RHC's initial OB payment. With the written request for an OB APM delivery encounter rate, both an existing and new clinic must provide:

(A) Total number of delivery encounters;

(B) Malpractice premiums for all physicians and certified nurses performing OB deliveries for the current and next year; and

(C) On-call time coverage;

(d) Delivery encounters include vaginal and cesarean delivery professional services provided by the RHC:

(A) Clinics performing deliveries prior to written request for an OB APM delivery encounter rate must provide the most recent full year of claims data for deliveries; and

(B) Clinics that have not previously provided delivery services must provide a reasonable projection of delivery encounters for the forecasted year;

(C) Clinics with actual or projected delivery encounters less than 100, will have their OB payment calculated using a base number of 100 OB delivery encounters;

(e) DMAP will calculate an additional projected cost of malpractice (liability) premiums to be included in the OB cost-based payment, out-

side of costs included and which have already been accounted for in the PPS medical encounter rate, as follows:

(A) For both an existing and new clinic, DMAP will calculate malpractice premiums that are based on the average costs for the current and next year based on the date the clinic applies for the OB APM delivery encounter rate, as projected by the RHC's malpractice carrier. Costs are the premiums the clinic or individual actually pays, accounting for any reductions or credits;

(B) For existing clinics, DMAP will determine the malpractice premiums reported for physicians and certified nurses performing OB deliveries when the RHC initially enrolled with DMAP and the PPS medical encounter rate was calculated. Premium amounts used in the initial PPS medical encounter rate calculation will be adjusted by the MEI for each subsequent year of enrollment, up to the year of written request for an OB APM delivery encounter rate. The premium(s) adjusted by MEI is an amount included in the current PPS medical encounter rate;

(C) For new clinics, DMAP will determine the actual malpractice premiums for OB physicians and certified nurses performing OB deliveries for the current year;

(D) DMAP will subtract the premiums calculated in section (5)(e)(B) or (C) of this rule, and accounted for in the calculation of the clinic's PPS medical encounter rate, from the average cost of OB malpractice premiums in section (5)(e)(A), to calculate the projected portion of OB malpractice premiums to be included in calculating the OB payment;

(f) DMAP will calculate the cost of physician on-call time for OB care by multiplying a clinic's adjusted OB on-call hours of coverage by the fixed rate of $20.00 per hour. A clinic's adjusted OB on-call coverage hours will be calculated as follows:

(A) Reducing total clinic coverage hours per year by the clinic's daily office hours, and;

(B) Reduced by physician vacation hours, and;

(C) Calculated at 60 percent of adjusted on-call time;

(g) The OB payment will be the sum of the difference of averaged malpractice premiums and current actual premiums in section (5)(e) of this rule, and the cost of on-call coverage in section (5)(f), divided by the total number of OB care delivery encounters in section (5)(d);

(h) The OB APM delivery encounter rate is the sum of the OB payment in section (5)(g) of this rule and the PPS medical encounter rate.

(6) After DMAP has calculated the initial OB APM delivery encounter rate DMAP will inform the RHC.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 18-2005(Temp), f. 3-15-05, cert. ef. 3-18-05 thru 9-1-05; OMAP 26-2005, f. 4-20-05, cert. ef. 6-1-05; OMAP 48-2005(Temp), f. & cert. ef. 9-15-05 thru 2-15-06; OMAP 64-2005, f. 11-29-05, cert. ef. 1-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07

410-147-0380
Accounting and Record Keeping

(1) General Requirements:

(a) The following rules and regulations apply to clinics reimbursed under the Federally Qualified Health Center (FQHC) and Rural Health Clinic Program;

(b) In cases of conflict between the rules contained in section (2) and (3) of this rule, section (2) will prevail over section (3);

(c) FQHCs and RHCs must use the cost principles contained in OMB Circular A-87 or A-122 to determine reasonable costs. Use the circular appropriate to your clinic;

(d) Must adhere to acceptable accounting standards.

(2) Rules and Regulations:

(a) FQHC and RHC Administrative Rules;

(b) The Division of Medical Assistance Programs (DMAP) General Rules;

(c) Oregon Health Plan (OHP) Administrative Rules;

(d) All other applicable DMAP provider rules.

(3) Cost Principles for State and Local Governments, OMB Circular A-87 and A-122.

(4) Each FQHC and RHC shall:

(a) Maintain internal control over and accountability for all funds, property and other assets;

(b) Maintain complete client documentation;

(c) Adequately safeguard from duplicate billings or other routine billing errors;

(d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;

(e) Prepare Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs in conformance with:

(A) Generally accepted accounting principles;

(B) The provisions of the FQHC and RHC Administrative Rules; and

(C) All other applicable rules listed in sections (2) and (3).

(f) Maintain for a period of not less than five years from the end of the fiscal the year:

(A) Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs;

(B) Cost Statement Worksheet (DMAP 3032);

(C) A copy of the clinic's trial balance;

(D) Audited financial statements;

(E) Depreciation schedules;

(F) Overhead cost allocation schedules; and

(G) Financial and clinical records for the period covered by the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs.

(g) Maintain adequate records to thoroughly explain how the amounts reported on the Cost Statement (DMAP 3027) were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;

(h) Adequately document expenses reported as allowable costs in the records of the clinic or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee stating the purpose of the trip or activity, the dates, name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over $25;

(i) Prepare special work papers or reports to support or explain data reported on the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs for current or previous periods at DMAP's request. These work papers/reports must be completed within 30 days of the DMAP request. An extension of up to 30 days may be granted if the request is made before the end of the original 30 day period. Extensions must be requested in writing;

(j) Ensure that the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs is reconcilable to the audited financial records and encounters must be reconcilable to the Uniform Data Set (UDS) form or other reasonable data DMAP may request. If the Cost Statement (DMAP 3027) or Medicare Cost Report for RHCs cannot be reconciled, the UDS numbers will be used or other appropriate data sets as determined by DMAP;

(k) Do not submit financial documentation to DMAP for FQHC or RHC sites that:

(A) Are not designated as an FQHC or RHC, and/or;

(B) Do not serve Medical Assistance Program clients.

Stat. Auth.: ORS 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; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0080; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03

410-147-0400
Compensation for Outstationed Outreach Activities

(1) This rule provides reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices. Reasonable compensation may be provided to eligible Federally Qualified Health Centers (FQHCs) for outreach activities performed by Outstationed Outreach Workers (OSOW) that is equal to 100% of direct costs:

(a) The Division of Medical Assistance Programs (DMAP) will calculate an OSOW rate based on reasonable direct costs described in Section (6) of this rule, and reported by a clinic per Section (3) of this rule;

(b) The OSOW rate will be added to the clinic's current base medical Prospective Payment System (PPS) encounter rate.

(2) An FQHC must have a current Outreach Agreement with the State of Oregon, Department of Human Services (DHS), Division of Medical Assistance Programs (DMAP) to be eligible for compensation under this rule.

(3) Clinics must submit a cost statement for the preceding fiscal year no earlier than October 1, and no later than October 31, of each year to DMAP for review of the clinic's OSOW direct costs for approval before any OSOW compensation is added to the PPS encounter rate:

(a) Any change to the OSOW rate, based on the October cost statement submission, will be effective January 1st of the following year;

(b) If, it is determined that the OSOW rate is inflated, the clinics OSOW rate will be adjusted effective immediately.

(4) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percent of time spent performing OSOW services and maintain adequate documentation to support the percentage of time claimed. The percent must be used to calculate personnel expenses incurred by an FQHC as outlined in Section (6)(c) of this rule and that are directly attributed to outreach activities performed by the employee.

(5) Clinic locations with limited operating hours, or that limit access to the general public during their regular operating hours must calculate the actual time an OSOW meets face-to-face with the general public for receipt and the initial processing of applications. For example, if a clinic employs an OSOW at a satellite school-based health center (SBHC), and the SBHC can only be accessed by the general public outside of the school's normal hours of operation, use the percent of time an OSOW is available to meet face-to-face with potential applicants when reporting compensation as outlined in Section (6)(c) of this rule.

(a) Clinics must display a notice in a prominent place that advises potential applicants when an outstation outreach worker will be available;

(b) The notice must include a telephone number that applicants may call for assistance.

(6) Direct cost expenses allowed for OSOW reimbursement:

(a) Travel expenses incurred by the FQHC for DMAP training on OSOW activities;

(b) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(c) Personnel costs for OSOWs:

(A) Wages;

(B) Taxes;

(C) Fringe Benefits provided to OSOW;

(D) Premiums paid by the FQHC for Private Health Insurance.

(d) Reasonable equipment necessary to perform outreach activities. Do not include expenses for replacing equipment if the original cost of the equipment was reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(e) Rent or space costs. Do not include rent or space costs if 100% of facility costs were reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(7) DMAP excludes indirect costs relating to OSOW activities from calculation of the OSOW rate. Excluded indirect costs include and are not limited to the following:

(a) Any costs included in the initial calculation of a clinic's Prospective Payment System (PPS) encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs; and

(d) Operating expenses including utilities, building maintenance and repair, and janitorial services.

(8) A Public Health Department designated as an FQHC or a School Based Health Center (SBHC) within the scope of an FQHC designation cannot participate in the Medicaid Administrative Claiming (MAC) program.

(9) If a clinic fails to submit the OSOW budget by November 1 of the required year, a clinic may not be eligible for compensation of OSOW costs as of January 1 for the coming year.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0330; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0420
Rebasing

(1) Determination of encounter rates effective January 1, 2001 as directed by the Balanced Budget Act (BBA) of 1997 and the Budget Refinement Act of 1999 Prospective Payment System (PPS) was changed for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) clinics. PPS eliminates annual cost reports and retrospective settlements except for managed care organization (MCO) Supplemental Payments.

(2) As directed by the BBA and PPS, the federal government will notify states when clinics can re-base clinic rates. No specific date has been determined by the federal government at this time.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03

410-147-0440
Medicare Economic Index (MEI)

Effective January 1, 2001, as directed by the Balanced Budget Act of 1997, the Budget Refinement Act of 1999 Prospective Payment System (PPS), and BIPA all encounter rates must be adjusted annually by the Medicare Economic Index (MEI) for the current year. The encounter rate will be adjusted by the MEI effective January 1st of the current year.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02

410-147-0460
Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (DMAP) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP).

(2) The PHP Supplemental Payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP(s) for treating the PHP enrollee and the payment to which the FQHC/RHC would be entitled if they had billed DMAP directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.

(3) In accordance with federal regulations the Provider must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP. Refer to OAR 410-147-0120(13).

(4) When any other coverage is known to the provider, the provider must bill the other resource(s) prior to billing the PHP. When a Provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120-1280 Billing and 410-120-1340 Payment.

(5) Supplemental payment by DMAP for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third Party Resource(s) (TPR).

(6) DMAP will calculate the PHP Supplemental Payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in Section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed DMAP directly per their PPS encounter rate.

(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with dates of service January 1, 2006 and after, using the Managed Care Data Submission Template developed by DMAP to report all PHP encounter and payment activity.

(8) To facilitate DMAP processing PHP supplemental payments, the FQHC or RHC must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The FQHC or RHC clinic number must be used when submitting all claims to the PHPs;

(b) To DMAP:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template Coversheet;

(C) Payments are to be reported at the detail line level on the Managed Care Data Submission Template Worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (Medical, Dental, Mental Health, or Alcohol and Chemical Dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the FQHC or RHC or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) All individual DMAP performing provider numbers assigned to practitioners associated with the FQHC or RHC. "Associated" refers to a practitioner who is either subcontracted or employed by the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain their individual performing provider number under one of the two situations:

(i) The practitioner maintains a private practice; or

(ii) The practitioner is also employed by a non-FQHC or RHC site.

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to DMAP no later than October 31 of each year.

(9) PHP Supplemental Payment process:

(a) DMAP will process PHP Supplemental Payments on a quarterly basis:

(A) Quarterly processing of PHP Supplemental Payments includes a final reconciliation for the reported time period;

(B) For an FQHC or RHC approved by DMAP to participate in a pilot project, PHP Supplemental Payments will be processed at the discretion of DMAP in collaboration with health centers;

(b) Upon processing a clinic's data and the PHP Supplemental Payment, DMAP will:

(A) Send a check to the clinic for PHP Supplemental Payment calculated from clinic data DMAP was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by DMAP;

(c) The FQHC or RHC is responsible for reviewing the data DMAP was unable to process for accuracy and completeness. The clinic has 30 days, from the date of DMAP's cover letter under Section (9)(b) of this rule, to make any corrections to the data and resubmit to DMAP for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by DMAP prior to expiration of the 30 days, and must:

(A) Be requested in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing DMAP the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of DMAP's receipt of the re-submitted data, DMAP will:

(A) Review the data and issue a check for all encounters DMAP verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The FQHC or RHC should submit data to DMAP within the timelines provided by DMAP.

(10) Clinics must carefully review in a timely fashion the data that DMAP was unable to process and returns to the FQHC or RHC. If clinics do not bring any incomplete, inaccurate or missing data to DMAP's attention within the time frames outlined, DMAP will not process an adjustment.

(11) DMAP encourages FQHCs and RHCs to request PHP Supplemental Payment in a timely manner.

(12) Clinics must exclude from a clinic's data submission for PHP supplemental payment, clinic services provided to a PHP-enrolled client when the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family Planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP Supplemental Payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP Supplemental Payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to DMAP. (See also OAR 410-147-0060).

(13) If a PHP denies payment to an FQHC or RHC for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-147-0120, for the reason that all services, items and supplies are non-covered by the plan, DMAP is not required to make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(14) If an FQHC or RHC has been denied payment by a PHP because the clinic does not have a contract or agreement with the PHP, DMAP is not required to make a supplemental payment to the clinic. DMAP is only required to make a PHP supplement payment when the FQHC or RHC has a contract with a PHP.

(15) DMAP will not reimburse some Medicaid covered services that are only reimbursed by PHPs, and are not reimbursed by DMAP. DMAP will not make PHP supplemental payment for these services, as DMAP does not reimburse these services when billed directly to DMAP.

(16) It is the responsibility of the FQHC or RHC to refer PHP-enrolled clients back to their PHP if the FQHC or RHC does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The Provider assumes full financial risk in serving a person not confirmed by DMAP as eligible on the date(s) of service. See OAR 410-120-1140. It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an "open card" or "fee-for-service" basis.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07

410-147-0480
Cost Statement (DMAP 3027) Instructions

(1) The Division of Medical Assistance Programs (DMAP) requires Federally Qualified Health Centers (FQHC) to submit Cost Statements (DMAP 3027).

(2) Rural Health Clinics (RHC) can choose to submit either their Medicare Cost Report or the Cost Statement (DMAP 3027). If the RHC files a Medicare Cost Report, DMAP may request additional information.

(3) DMAP reimburses some services, items and supplies fee-for-service, outside of a FQHC or RHC's Prospective Payment System (PPS) encounter rate. For this reason, clinics must exclude the costs for the following items from the cost statement:

(a) Contraceptive supplies and contraceptive medications. Refer to OAR 410-147-0280;

(b) Pharmacy. Requires separate enrollment, refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(c) Durable Medical Equipment and Supplies. Requires separate enrollment, refer to OAR 410 Division 122, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); and

(d) Targeted Case Management (TCM) services. Requires separate enrollment, refer to OAR 410-147-0610, and 410 Division 138, Targeted Case Management for specific information.

(4) Payment for services provided by FQHCs and RHCs is in accordance with 42 USC 1396a(bb). In general, a Prospective Payment System (PPS) encounter rate is calculated on a per visit basis that is equal to the average of reasonable and allowable costs incurred by a clinic for furnishing services included in the State Plan under Title XIX and XXI of the Social Security Act. The rate is calculated by dividing the total costs incurred by an FQHC or RHC for furnishing services by the total number of clinic encounters as defined in OAR 410-147-0500. A clinic must submit Cost Statement (DMAP 3027) to DMAP:

(a) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinic services. Refer to OAR 410-147-0360;

(b) For new clinics. Refer also to OAR 410-147-0360; or

(c) If there is a change of ownership, the new owner can submit the Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated. See also OAR 410-147-0320(8).

(5) The Cost Statement (DMAP 3027) must include all documents required by OAR 410-147-0320.

(6) Each section must be completed if applicable.

(7) Page 1 — Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, the DMAP provider number, the name of the persons or organizations having legal ownership of the FQHC or RHC; and all provider and health care practitioners as defined on the DMAP 3027 Cost Statement.

(b) The Cost Statement (DMAP 3027) must be prepared, signed and dated by both the FQHC or RHC accountant and an authorized responsible officer.

(8) Page 2 — Part A — FQHC or RHC Practitioner Staff and Visits:

(a) FTE Personnel: List the total number of staff by position;

(b) Encounters: List the number of on-site and off-site encounters by staff. Refer also to OAR 410-147-0500, Total Encounters for Cost Reports. Exclude the following types of encounters from your total encounters:

(A) Outstationed Outreach Workers;

(B) Administration; and

(C) Support staff, or any staff members who do not meet the criteria of OAR 410-147-0120(6) or the qualification or certification requirements under a clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320.

(9) Pages 3–4 — Reclassification and Adjustment of Trial Balance of Expenses:

(a) Record the expenses for covered health care costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs:

(A) Covered health care (program) costs include all necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Whether DMAP allows the costs is subject to the regulations prescribing the treatment of specific items under the Medicaid program. Refer also to OAR 410-147-0020 Professional Services. Covered health care (program) and direct health care costs include but are not limited to:

(i) Personnel costs, including Medical record and medical receptionist costs;

(ii) Administrative costs;

(iii) Employee pension plan costs;

(iv) Normal standby costs;

(v) Medical practitioner salaries; and

(vi) Malpractice insurance costs;

(B) Non-reimbursable program costs are costs that are not related to patient care and which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs that are not necessary include costs that usually are not common or accepted occurrences in the field of the provider's activity. Non-reimbursable program costs include, but are not limited to:

(i) Women, Infants and Children (WIC);

(ii) Community Services/Housing Projects. Refer to OAR 410-120-1200;

(iii) Environmental external maintenance costs (e.g. landscaping, pesticide application);

(iv) Research;

(v) Public Education; and

(vi) Outside services;

(C) Allowable overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs:

(i) Administrative costs;

(ii) Billing department expenses;

(iii) Audit costs;

(iv) Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

(v) Space costs (rent and utilities); and

(vi) Liability insurance costs;

(D) Non-reimbursable overhead costs:

(i) Entertainment;

(ii) Fines and penalties;

(iii) Fundraising;

(iv) Goodwill;

(v) Gifts and contributions;

(vi) Political contributions;

(vii) Bad debts;

(viii) Other interest expense;

(ix) Advertising;

(x) Membership dues for public relations purposes, including country or fraternal club memberships;

(xi) Cost of personal use of motor vehicles;

(xii) Cost of travel incurred in connection with non-patient care related purposes; and

(xiii) Costs applicable to services, facilities, and supplies furnished by a related organization (Related Party Transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity. Refer to OAR 410-147-0540;

(b) Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used;

(c) Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC Administrative rules on allowable costs. A schedule of any reported reclassification of trial balance expense, whether an increase or decrease, must include:

(A) A reference to the line number on either page 3 or 4;

(B) A description of the reclassification or adjustment;

(C) The amount of the debit or credit; and

(D) The total for each debit and credit;

(d) Net expenses must equal the combined reclassified trial balance taking into account the adjustment amount on each detail line;

(e) Enter the totals from each column in the "Total" fields.

(10) Page 5 — Determinations — Determination of Overhead Applicable to FQHC and RHC Services:

(a) Parts A and B: Enter all totals from the previous pages of the Cost Statement (DMAP 3027) as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate;

(b) Part C: If applicable, complete by entering the wages for Outstationed Outreach Workers on line C1, divide the wages by the number of billable DMAP encounters to determine the rate per encounter. See also OAR 410-147-0400.

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; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0400; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07

410-147-0500
Total Encounters for Cost Reports

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively.

(2) In general, the Division of Medical Assistance Programs (DMAP) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter.

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ALL:

(a) Encounters for all clients regardless of payor;

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, Third Party Payor or other party, but otherwise have an associated cost for providing the service whether billed to the client (e.g. uninsured, signed waiver on file) or absorbed by the clinic; and;

(c) Encounters regardless of line placement on the Health Services Commission's Prioritized List of Health Services. For the purpose of

reporting encounters according to this rule, encounters are not subject to the HSC Prioritized List, or service limitations and benefit reductions implemented by the Division of Medical Assistance Programs (DMAP).

(4) FQHCs and RHCs must report all encounters furnished to all client populations irrespective of coverage or payor source. Examples of client populations include, but are not limited to:

(a) Oregon Health Plan (OHP) clients (includes both fee-for-service and prepaid health plan (PHP) clients). Refer to OAR 410-147-0120 for more information regarding OHP encounters;

(b) Citizen/Alien-Waived Emergency Medical (CAWEM) clients. Refer also to OAR 410-120-1210(3)(f).

(c) Family Planning Expansion Program (FPEP) Title X, clients;

(d) Uninsured and/or self-pay clients;

(e) Medicare clients;

(f) Third party or private pay insurance clients;

(g) County- and/or clinic-pay clients (services paid or funded by the county or clinic); and

(h) Clients funded by federal, state, local or other grants.

(5) FQHCs and RHCs must exclude from the total number of reported encounters:

(a) Encounters attributed to non-allowable costs:

(A) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract;

(B) Services performed and reimbursed under separate enrollment. e.g. Targeted Case Management;

(C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC; and

(E) Health services provided as part of a large-scale "free to the public" or "nominal fee" effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair);

(b) Encounters for specific services outlined in 42 USC 1396d(a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services is an allowed administrative program cost and should be reported on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to:

(A) Case management services for coordinating health care for a client;

(B) Enabling services, including but not limited to, sign language and oral interpreter services;

(C) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness;

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis);

(E) Prescription refills; and

(F) Services provided without the client present, except for telephone contacts as specified in this rule section (6)(c).

(6) FQHCs and RHCs are required to include encounters for services furnished by practitioners recognized by DMAP in OAR 410-147-0120(6). Examples of encounters that may be overlooked but should be included are:

(a) Encounters below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement;

(b) Encounters outside of the clinic by primary care practitioners (e.g. services furnished in a hospital or residential treatment setting);

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), OAR 410-130-0595, programs. See also OAR 410-120-1200(2)(y);

(d) Medication management-only encounters by a behavioral health practitioner;

(e) Encounters by Registered and Licensed Practical Nurses:

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of home health agencies (OAR 410-147-0120(10));

(B) Administration of immunizations/vaccinations encounters;

(C) "99211" encounters; and

(D) Maternity Case Management (MCM) encounters.

(7) Global procedures require attention for accurate reporting of encounters:

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter;

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-0040(5) ICD-9-CMm Diagnosis and CPT/HCPCs Procedure Codes, for more information;

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information:

(A) Services within a surgical package and "included" in a given CPT surgical code are reported as a single encounter. Refer to OAR 410-130-0380, Surgical Guidelines, for more information; and

(B) The initial consultation or evaluation of the problem by the provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter.

(8) A surgical procedure furnished to an OHP client and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CAWEM client. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC, may be eligible as multiple encounters if medically necessary.

(9) When two or more services are provided on the same date of service:

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or

(b) With similar diagnoses, a clinic must report one encounter.

(10) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027):

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Stat. Auth.: ORS 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; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0380; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07

410-147-0520
Depreciation

OMB Circular A-87 and A-122, Section 13 is applicable with the following exception: depreciation and amortization must be calculated on a straight line basis less the estimated salvage value. The clinic must use the American Hospital Association guidelines "Estimated Useful Lives of Depreciable Hospital Assets" for determining asset lives when computing depreciation. For assets not covered by the guidelines and with costs of more than $500 individually and $500 aggregate, the lives established by the clinic are subject to approval by Division of Medical Assistance Programs (DMAP). Depreciation and amortization schedules must be maintained.

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; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0260

410-147-0540
Related Party Transactions

(1) A "related party" is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:

(a) "Common ownership" exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;

(b) "Control" exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(2) Division of Medical Assistance Programs (DMAP) allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent that they:

(a) Relate to Title XIX and Title XXI client care;

(b) Are reasonable, ordinary, and necessary; and

(c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.

(3) The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.

(4) Clinics must disclose a related party who is enrolled as a provider with DMAP with a separate DMAP provider number.

(5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by DMAP. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(6) DMAP will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC Administrative Rules.

(7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

Stat. Auth.: ORS 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; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0280; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0560
Sanctions

(1) In addition to the Sanctions in the Division of Medical Assistance Programs' (DMAP) General Rules, the following apply to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC):

(a) Failure to comply with DMAP rules specified in the FQHC and RHC Administrative Rules may result in a reduction to the current encounter rate by 50 percent or $40 per encounter, whichever is less;

(b) 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. For Managed Care Organization (MCO) Supplemental Payments, cost settlement will be based on the reduced encounter rate as specified in section (1) of this rule.

(c) Continued noncompliance of more than 120 days after the encounter rate is reduced, as described in section (1)(a) of this rule, may result in loss of any MCO Supplemental Payments and/or disenrollment from DMAP. The FQHC or RHC will not be permitted to re-enroll without first demonstrating to the DMAP satisfaction:

(A) That it is complying with and will continue to comply with all DMAP rules;

(B) Has established acceptable procedures to assure appropriate billing;

(C) Has provided appropriate staff training and established procedures for training staff;

(D) Has established acceptable procedures to assure the adequate maintenance of all financial records;

(E) Has established procedures to ensure appropriate electronic billing.

(2) If multiple clinic numbers are provided and DMAP finds evidence of duplicate billings or failure to use the billing provider number as required, the exception for multiple provider numbers will be terminated upon written notice to the clinic. Contact the DMAP FQHC and RHC Program Manager for details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0395

410-147-0610
Targeted Case Management (TCM)

(1) Targeted Case Management (TCM) services are provided and reimbursed through a separate program requiring enrollment as a TCM provider.

(2) Refer to OAR 410 division 138, Targeted Case Management, for specific requirements.

(3) If an FQHC or RHC is participating in a TCM program, the clinic must notify the Division of Medical Assistance Programs (DMAP) in writing and must include a description of the TCM program. With the exception of maternity case management (MCM) services authorized by OAR 410-147-0200, costs for TCM services cannot be included in a clinic's cost statement and cannot be billed as an encounter under the FQHC or RHC per a clinic's encounter rate, or billed to a prepaid health plan (PHP).

(4) A client may only participate in a single TCM program. DMAP does not allow multiple TCM billings. This includes Maternity Case Management (MCM).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0620
Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medicaid coverage under the Oregon Health Plan (OHP), coordinated by the Division of Medical Assistance Program (DMAP), providers must bill Medicare first.

(2) All claims submitted by Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) to DMAP for clients who have both Medicare and DMAP coverage must be billed on a CMS-1500 claim form or by 837P transmission. See also Billing for Medicare/Medicaid Clients in the FQHC and RHC Supplemental Information.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill DMAP using a CMS-1500 claim form or 837P transmission, but only after that carrier has made payment determination.

(4) When billing on a CMS-1500 claim form or 837P transmission for a client with both Medicare and DMAP coverage:

(a) Bill all services provided to an OHP beneficiary using a procedure code listed in Table 147-0120-1, FQHC/RHC Encounter Codes;

(b) Bill the clinic's encounter rate; and

(c) Enter the total Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resources (TPR) explanation. Refer to CMS-1500 or 837P detailed billing instructions.

(5) Claims for Qualified Medicare Beneficiary (QMB)-only clients must be billed on CMS-1500 claim form or 837P transmission. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information and instructions are located in the FQHC and RHC Supplemental Information billing guide:

(a) The total charged amount must equal the total Medicare allowed/covered charges, minus any reductions or contract adjustments. FQHCs and RHCs are not to bill their encounter rate for services provided to Qualified Medicare Beneficiary (QMB)-only clients;

(b) FQHC and RHCs must bill each service, treatment or item provided to a QMB-only beneficiary on the CMS-1500 claim form or 837P transmission identical to how Medicare was billed.

(c) For claims to process payment correctly, FQHCs and RHCs billing multiple services need to apply the total charge calculated, according to section (a) above, to the first detail line and zero charge all subsequent lines.

Stat. Auth.: ORS 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; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0040; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07

DIVISION 148

HOME ENTERAL/PARENTERAL NUTRITION AND IV SERVICES

410-148-0000
Foreword

(1) The Home Enteral/Parenteral Nutrition and IV Services rules are a user's manual designed to assist providers in preparing health claims for medical assistance program clients. The Home Enteral/Par-

enteral Nutrition and IV Services provider rules are to be used in conjunction with the General Rules for Oregon Medical Assistance Programs, the Oregon Health Plan Administrative Rules, the Pharmaceutical Services Administrative Rules, and other relevant provider rules and supplemental information.

(2) The Home Enteral/Parenteral Nutrition and IV Services provider rules include procedure codes with restrictions, and limitations. The Home EPIV code and fee schedule, which is not a part of these rules, is not an exhaustive list of OHP covered service codes. Please consult the Prioritized List of Health Services for the Oregon Health Plan and the DMAP Maximum Allowable Table.

(3) The Division of Medical Assistance Programs (DMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

(4) Providers should always follow the DMAP Administrative Rules in effect on the date of service.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0600 OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0020
Home Enteral/Parenteral Nutrition and IV Services

(1) The Division of Medical Assistance Programs (DMAP) will make payment for medically appropriate goods, supplies and services for home enteral/parenteral nutrition and IV therapy on written order or prescription. (a) The order or prescription must be dated and signed by a licensed prescribing practitioner, legible and specify the service required, the ICD-9-CM diagnosis codes, number of units and length of time needed.

(b) The prescription or written physician order for solutions and medications must be retained on file by the provider of service for the period of time specified in DMAP General Rules.

(c) An annual assessment and a new prescription are required once a year for ongoing services.

(d) Also covered are services for subcutaneous, epidural and intrathecal injections requiring pump or gravity delivery.

(2) All claims for Enteral/Parenteral Nutrition and IV services require a valid ICD-9-CM diagnosis code.

(a) It is the provider's responsibility to obtain the actual diagnosis code(s) from the prescribing practitioner. Reimbursement will be made according to covered services on funded lines of the Health Services Commission's Prioritized List of Health Services, and these rules.

(3) DMAP requires one initial nursing service visit to assess the home environment and appropriateness of enteral/parenteral nutrition or IV services in the home setting and to establish the client's treatment plan.

(a) This nursing service visit for assessment purposes does not require payment authorization.

(b) The nursing service assessment visit is not required when:

(A) The only service provided is oral nutritional supplementation;

(B) The services are performed in an Ambulatory Infusion Suite of the Home Infusion Therapy provider.

(4) Nursing service visits specific to this Home Enteral/Parenteral and IV services program are provided in the home, or an Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS) and will be reimbursed by DMAP only when prior authorized, and performed by a person who is licensed by the Oregon State Board of Nursing to practice as a Registered Nurse. All registered nurse delegated or assigned nursing care tasks must comply with the Oregon State Board of Nursing, Nurse Practitioner Act and Administrative Rules regulating the practice of nursing.

(5) Payment for services identified in the Home Enteral/Parenteral Nutrition and IV Services provider rules will be made only when provided in the client's place of residence (i.e., home or nursing facility) or an Ambulatory Infusion Suite (AIS).

Stat. Auth.: ORS 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 461-016-0290; HR 9-1992, f. & cert. ef. 4-1-92; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0640; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 64-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07

410-148-0040
Requirements for Home Enteral/Parenteral Nutrition and IV Services

(1) Home Enteral/Parenteral Nutrition and IV Services:

(a) Home enteral/parenteral nutrition and IV services must include training and/or education of client or support person on nutritional supplement and /or equipment operation;

(b) When enteral/parenteral nutrition and IV services are initiated in a hospital setting, reimbursement for training is included in the hospital reimbursement and will not be made separately;

(c) Reimbursement for enteral/parenteral and IV services training when done in the home is included in the payment for the nursing visit(s);

(d) Per diem reimbursement includes: administrative service, pharmacy professional and cognitive services, including drug admixture, patient assessment, clinical monitoring, and care coordination, and all necessary infusion related supplies and equipment. Enteral/parenteral formula, drugs and nursing visits are not included in per diem rates and must be billed separately.

(2) Home enteral nutrition:

(a) Home enteral nutrition is considered medically appropriate to maintain body mass and prevent nutritional depletion, which occurs with some illnesses or pathological conditions;

(b) Home enteral therapy may be administered orally or by enteral tube feeding, i.e., nasogastric, jejunostomy or gastrostomy delivery systems.

(3) Home parenteral nutrition:

(a) Is considered medically appropriate for treatment of gastrointestinal dysfunction such as severe short bowel syndrome, chronic radiation enteritis, severe Crohn's disease, or other conditions where adequate nutrition by the oral and enteral routes is not possible:

(b) Initiation of home parenteral nutrition services must include client or support person education on catheter care, infusion technique, solution preparation, sterilization technique, and equipment operation;

(c) Parenteral nutrition is appropriate only when oral or enteral feeding is inadequate or contraindicated.

(4) Home intravenous (IV) services:

(a) Home intravenous (IV) services are covered by the Division of Medical Assistance Programs (DMAP) for the administration of antibiotics, analgesics, chemotherapy, hydrational fluids or other intravenous medications in a client's residence, (i.e., home or nursing facility) or an Ambulatory Infusion Suite (AIS).

(b) In addition, the provision of all goods and services needed for maintaining venous or arterial access and required monitoring is covered.

Stat. Auth.: ORS 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; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0660; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07

410-148-0060
Authorization

(1) 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 payment authorization in the Pharmaceutical Services Guide. Contact First Health Services for those items that require prior authorization.

(2) Approval for payment for the above home enteral/parenteral nutrition and/or IV services entities will be made when considered to be "medically appropriate."

(3) Authorization of payment is required for those services that require authorization even though the client has other insurance that may cover the service. Authorization of payment is not required for Medicare covered services.

(4) For services requiring authorization, providers must contact the Division of Medical Assistance Programs (DMAP) or the Medically Fragile Children's Unit for authorization within five working days following initiation of services. Authorization will be given based on med-

ical appropriateness, appropriateness of level of care given, cost and/or effectiveness.

(5) How to Obtain Payment Authorization:

(a) Services for clients identified as Medically Fragile Children's Unit clients will be authorized by the Department of Human Service's (DHS) Medically Fragile Children's Unit;

(b) Request oral nutrition supplements from First Health Services, Managed Access Program;

(c) All other authorization may be obtained by contacting, either by phone or in writing, the DMAP — Medical Unit;

(d) Payment authorization does not guarantee reimbursement.

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

Stat. Auth.: ORS 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 461-016-0090; HR 26-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0220; HR 9-1992, f. & cert. ef. 4-1-92; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0680; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03

410-148-0080
Equipment Rental/Purchase/Repair

(1) The following equipment shall be authorized, if medically appropriate and when cost effective, on a rental basis only:

(a) IV infusion pumps;

(b) Enteral formulae pumps.

(2) The equipment provider is responsible for providing working equipment including replacement if repairs are necessary.

(3) Pump rental payment will not be made beyond the purchase price, but no more than 15 consecutive months when the period of use extends beyond 15 consecutive months:

(a) Consecutive months are defined as "any period of continuous use where no more than a 60-day break occurs";

(b) Division of Medical Assistance Programs (DMAP) considers that the maximum rental period toward purchase price is — 15 consecutive months of pump rental. The purchase price has been met at the earlier of the purchase price or 15 consecutive months;

(c) Having met the purchase price as described in (2)(b), the pump becomes property of the client, and the patient is responsible for all maintenance and repairs.

(A) DMAP can still allow for medically necessary repairs on equipment that the patient owns.

(B) The provider may bill DMAP for maintenance and servicing of the pump (as long as that maintenance and servicing is not covered under any manufacturer/supplier warranty) when a period of at least six months has elapsed since the final month of pump rental. Payment for the maintenance service will only be made one time during every six-month period.

(C) For a purchased pump, a rental pump may be prior authorized for up to one month during equipment repair for a client requiring medically necessary, continuous service.

(4) All other equipment for home enteral/parenteral nutrition and IV services will be authorized as either purchase or based on length of need and medical appropriateness.

(5) All rental or purchase of equipment, full services warranty, pick-up, delivery, set-up, fitting and adjustments are included in the reimbursement. Individual consideration may be given in specific circumstances upon written request to DMAP.

(6) Repair of rental equipment is the responsibility of the provider.

(7) DMAP will not make payment for rental of pumps that are supplied by any manufacturer at no cost to the provider.

Stat. Auth.: ORS 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; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0700; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 64-2004, f. 9-10-04, cert. ef. 10-1-04

410-148-0090
Standard Benefit Package

(1) Some procedure codes/services are not covered for the Standard Benefit Package population. See General Rules 410-120-1210 for additional information.

(2) The OHP Standard benefit package includes limited Home Enteral/Parenteral and IV services:

(a) Drugs that are usually self-administered by the patient such as oral pill form or self-injected medications, are not covered;

(b) Oral nutrition services and supplies are not covered, except when the nutritional supplement meets the criteria specified in 410-148-0260(3), and is the sole source of nutrition for the client;

(c) Nursing assessment and nursing visits must be directly related to administration of the home enteral/parenteral nutrition and intravenous services pursuant to Oregon's Nurse Practices Act (OAR 851-001-0000). Home Health and Private Duty Nursing are not covered services under the Standard benefit package (General Rules 410-120-1210), except nursing assessment and nursing visits under this limited Home Enteral/Parenteral and IV benefit are covered.

Stat. Auth. ORS 409

Stat. Implemented: ORS 414.065

Hist.: OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 17-2005, f. 3-11-05, cert. ef. 4-1-05

410-148-0095
Client Copayments

Copayments may be required for non-American Indian/Alaska Native clients for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 91-2002, f. 12-24-02, cert. ef. 1-1-03

410-148-0100
Reimbursement

(1) Drug ingredients (medications) shall be reimbursed as defined in the Pharmaceutical Services Guide.

(2) The following service/goods will be reimbursed on a fee-for-service basis according to the Division of Medical Assistance Programs (DMAP) Maximum Allowable Fees found in the Pharmaceutical Services Guide on the DMAP website: www.dmap.hr.state.or.us/providern-fo/:

(a) Enteral Formula;

(b) Oral Nutritional Supplements which are medically appropriate and meet the criteria specified in 410-148-0260(3);

(c) Parenteral Nutrition Solutions;

(3) Reimbursement for services will be based on the lesser of the amount billed, the DMAP maximum allowable rate. When the service is covered by Medicare, reimbursement will be based on the lesser of the amount billed, Medicare's allowed amount, or the DMAP maximum allowable rate.

(4) Reimbursement for supplies that require authorization or services/supplies that are listed as Not Otherwise Classified (NOC) or By Report (BR) must be billed to DMAP at the providers' Acquisition Cost, and will be reimbursed at such rate.

(a) For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item. Submit documentation identifying acquisition cost with your authorization request;

(b) Per diem, as it relates to reimbursement, represents each day that a given patient is provided access to a prescribed therapy. This definition is valid for per diem therapies of up to and including every 72 hours.

(c) Per diem reimbursement includes, but is not limited to:

(A) Professional Pharmacy services:

(i) Initial and ongoing assessment/clinical monitoring;

(ii) Coordination with medical professionals, family and other caregivers;

(iii) Sterile procedures, including IV admixtures, clean room upkeep and all biomedical procedures necessary for a safe environment;

(iv) Compounding of medication/medication set-up.

(B) Infusion therapy related supplies:

(i) Durable, reusable or elastomeric disposable infusion pumps;

(ii) All infusion or other administration devices;

(iii) Short peripheral vascular access devices;

(iv) Needles, gauze, sterile tubing, catheters, dressing kits, and other supplies necessary for the safe and effective administration of infusion therapy.

(C) Comprehensive, 24-hour per day, seven days per week delivery and pickup services (includes mileage).

(5) Reimbursement will not be made for the following:

(a) Central Catheter insertion or transfusion of blood/blood products in the client's home;

(b) Central Catheter insertion in the Nursing Facility;

(c) Intradialytic parenteral nutrition in the client's home or Nursing Facility;

(d) Oral Infant formula that is available through the WIC program;

(e) Oral nutritional supplements that are in addition to consumption of food items or meals.

(f) Tocolytic pumps for pre-term labor management;

(g) Home Enteral/Parenteral Nutrition or IV services outside of the client's place of residence (i.e. home, nursing facility or AIS).

Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0720; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 64-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07

410-148-0120
Reimbursement Limitations for Clients in a Nursing Facility

(1) The Division of Medical Assistance Programs (DMAP) will not reimburse for the following services/supplies for clients residing in a nursing facility:

(a) Nursing service visits (including assessment visit). Refer to Seniors and People with Disabilities (SPD) administrative rule covering All-Inclusive Rate;

(b) Supplies and items covered in the nursing facility All-Inclusive Rate. Refer to the Supplemental Information section of the Home Enteral/Parenteral Nutrition and IV Services provider website (http://www.dhs.state.or.us/policy/healthplan/guides/homeiv/) for a listing of those supplies and items;

(c) Oral nutritional supplements that are in addition to consumption of food items or meals.

(2) DMAP will reimburse for the following:

(a) Oral nutritional supplements are covered by DMAP for nursing facility clients when medically appropriate, i.e., the client cannot consume food items or meals;

(b) Tube fed enteral nutrition formula, when medically appropriate;

(c) Patient controlled pump for pain control medication (CADD).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0730; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0140
Billing Information

(1) For medications:

(a) Those pharmacies billing electronically shall bill through First Health Services point-of-sale. For more information on Point-of-Sale, contact the First Health Service Help Desk;

(b) The 5.1 Universal Claim Form may be used only by those pharmacies and EPIV providers billing manually for any medications and home IV drug ingredients that are not billed through Point-of-Sale;

(c) Providers who bill by paper will be required to complete a new 5.1 Universal Claim Form.

(2) For home enteral/parenteral and IV services other than medications:

(a) Home enteral/parenteral nutrition and IV services identified with a five-digit HCPCS or CPT must be billed on the CMS-1500 using the billing instructions found in the Home Enteral/Parenteral Nutrition and IV Services supplemental materials;

(b) See rule 410-148-0160 for billing clients with Medicare coverage;

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0740; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03

410-148-0160
Billing for Clients Who Have Both Medicare and Basic Health Care Coverage

(1) The Divisin of Medical Assistance Programs (DMAP) may be billed directly for services provided to a client when the provider has established and clearly documented in the client's record that the service provided does not qualify for Medicare reimbursement.

(2) When the service qualifies for Medicare reimbursement, bill as follows:

(a) When billing for Home Enteral/Parenteral Nutrition Services:

(A) Bill in the usual manner to the local or designated Medicare Intermediary;

(B) After Medicare makes a payment determination, bill DMAP on the DMAP 505 form following the billing instructions and using the procedure codes listed for the Home Enteral/Parenteral Nutrition and IV Services in the fee schedule and supplemental materials;

(b) When billing for Home IV services:

(A) Bill the local Medicare Intermediary in the usual manner;

(B) After Medicare makes payment determination, bill DMAP following the billing instructions and using the procedure codes listed for the Home Enteral/Parenteral Nutrition and IV Services fee schedule and supplemental materials.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 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; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0750; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03

410-148-0260
Home Enteral Nutrition

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Enteral Nutrition Formula. Use B4150 through B4156 when billing for tube fed nutritional formulae. If the product dispensed is not shown in HCPCS description, select a category equivalent when billing the Division of Medical Assistance Programs (DMAP).

(3) Oral Nutritional Supplements:

(a) Prior authorization is required on all oral supplements;

(b) Oral nutritional supplements can be billed through the on-line Point of Sale pharmacy system, or by paper using the 5.1 Universal Claim Form. Use the product's NDC when billing;

(c) If the product dispensed is not shown in one of the listed categories, select a category that is equivalent when billing DMAP;

(d) Oral nutritional supplements may be approved when the following criteria has been met:

(A) Clients age 6 and above:

(i) Must have a nutritional deficiency identified by one of the following:

(I) Recent low serum protein levels; or

(II) Recent Registered Dietician assessment shows sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods.

(III) The clinical exception to the requirements of (I) and (II) must meet the following:

(III-a) Prolonged history (i.e. years) of malnutrition, and diagnosis or symptoms of cachexia, and

(III-b) Client residence in home, nursing facility, or chronic home care facility, and

(III-c) Where (I) and (II) would be futile and invasive

(ii) And have a recent unplanned weight loss of at least 10%, plus one of the following:

(I) Increased metabolic need resulting from severe trauma; or

(II) Malabsorption difficulties (e.g., short-gut syndrome, fistula, cystic fibrosis, renal dialysis; or

(III) Ongoing cancer treatment, advanced AIDS or pulmonary insufficiency.

(iii) Weight loss criteria may be waived if body weight is being maintained by supplements due to patient's medical condition (e.g., renal failure, AIDS)

(B) Clients under age 6:

(i) Diagnosis of 'failure to thrive';

(ii) Must meet same criteria as above, with the exception of % of weight loss.

(4) Enteral Nutrition Equipment:

(a) All repair and maintenance is subject to rule 410-148-0080;

(b) Procedure Codes:

(A) S5036, Repair of infusion device (each 15 minutes = 1 unit) — PA;

(B) B9998, Enteral Nutrition Infusion Pump Replacement parts will be reimbursed at provider's acquisition cost (including shipping and handling) — PA/BR;

(C) B9000, Enteral Nutrition Infusion Pump, without alarm— rental (1 month = 1 unit) — PA;

(D) B9002, Enteral Nutrition Infusion Pump, with alarm— rental (1 month = 1 unit) — PA;

(E) E0776, IV Pole — Purchase;

(F) E0776, modifier RR, IV Pole — Rental (1 day = 1 unit);

(G) S9342, Enteral Nutrition via pump (1 day = 1 unit) — PA.

(5) Home Infusion Therapy:

(a) S9325, Home infusion, pain management (do not use with code S9326, S9327 or S9328) — PA

(b) S9326, Home infusion, continuous pain management — PA;

(c) S9327, Home infusion, intermittent pain management — PA;

(d) S9328, Home infusion, implanted pump pain management — PA.

(6) Not Otherwise Classified (NOC):

(a) B9998, NOC For Enteral Supplies — PA/BR

(b) S9379, Home infusion therapy, NOC — PA/BR.

Stat. Auth.: ORS 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; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0840; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 52-2006, f. 12-28-06 cert. ef. 1-1-07

410-148-0280

Home Parenteral Nutrition

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Standard Total Parenteral Nutrition (TPN):

(a) Bill using HCPCS codes S9365 through S9368;

(b) Home infusion for stand TPN includes the following drugs and products in the per diem rate:

(A) Non-specialty amino acids (e.g., aminosyn, freeamine, travasol)

(B) Concentrated dextrose (e.g., D10, D20, D40, D50, D60, D70)

(C) Sterile water;

(D) Electrolytes (e.g., CaC12, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4);

(E) Standard multi-trace elements (e.g., MTE4, MTE5, MTE7);

(F) Standard multi-vitamin solutions (e.g., MVI-13).

(c) The following items are not included in the per diem and should be billed separately:

(A) Specialty amino acids for renal failure, hepatic failure or for high stress conditions (e.g., aminess, aminosyn-RF, nephramine, RenAmin, HepatAmine, Aminosyn-HBC, BranchAmin, FreeAmine HBC, Trophamine);

(B) Specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted patients (e.g., Aminosyn 15%, Novamine 15%, Clinisol 15%);

(C) Lipids

(D) Added trace elements, vitamins not from standard multitrace element or multivitamin solution;

(E) Products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran).

(2) Parenteral Nutrition Solutions:

(a) Bill using HCPCS codes B4164 through B5200. See HCPCS book for description.

(b) Note: Reimbursement for compounding, admixture and administrative fees is included in the unit price.

(3) Parenteral Supply Kits/Supplies — Procedure Codes

(4) Parenteral Nutrition Equipment — Procedure Codes — Table 0280-1.

(5) Not Otherwise Classified (NOC) — B9999, NOC For Parenteral Supplies — PA/BR.

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

Stat. Auth.: ORS 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; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0860; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0300

Other Home IV and Enteral/ Parenteral Administration Services

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Catheter Care Kits. All catheter care kit allowable amounts are determined on a per diem basis (1 day = 1 unit):

(a) When performed as a stand alone therapy, or during days not covered under per diem by another therapy, bill using catheter care codes S5497 through S5521;

(b) The following supplies for non-routine catheter procedures may be billed separately from per diem reimbursement:

(A) S5517 Catheter declotting supply kit, 1 day = 1 unit;

(B) S5518 Catheter repair supply kit, 1 day = 1 unit;

(C) S5520 PICC insertion supply kit, 1 day = 1 unit;

(D) S5521 Midline insertion supply kit, 1 day = 1 unit.

(E) E0776 IV Pole — Purchase.

(F) E0776 with modifier RR IV Pole — Rental, 1 day = 1 unit

(3) Home Nursing Visits:

(a) When enteral/parenteral services are performed in the home, only a single provider of skilled home health nursing services may obtain authorization and/or bill for such services for the same dates of service;

(b) Requests made by providers for any intravenous or enteral/parenteral related skilled nursing services, either solely or in combination with any other skilled nursing services in the home are to be reviewed for prior authorization by the Division of Medical Assistance Programs (DMAP) Medical Unit;

(c) Procedure Codes:

(A) 99601, Home infusion/specialty drug administration, per visit (up to 2 hours). Modifier SS is used to indicate — Home infusion services provided in the infusion suite of the IV therapy provider — 1 visit = 1 unit — PA;

(B) 99602, each additional hour. List separately in addition to code for primary procedure). Modifier SS is used to indicate — Home infusion services provided in the infusion suite of the IV therapy provider. Use 99602 in conjunction with 99601 — PA;

(C) T1001, Home Nursing Visit for Assessment — 1 visit = 1 Unit.

(4) Not Otherwise Classified (NOC) — S9379, NOC for Home IV Supplies — PA/BR.

Stat. Auth.: ORS 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; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0880; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04; DMAP 11-2007, f. 6-14-07, cert. ef. 7-1-07

410-148-0320

Billing Quantities, Metric Quantities and Package Sizes

(1) Use the following metric conversions when billing;

(a) Fluid Ounce — 30 ml;

(b) Pint — 480 ml;

(c) Quart — 960 ml;

(d) Gallon — 3,840 ml;

(e) Ounce (solids) — 30 gm;

(f) Pound (solids) — 454 gm.

(2) Use the following units when billing products:

(a) Solid substances (e.g., powders, creams, ointments, etc.), bill per gram;

(b) Solid substances that are reconstituted with a liquid (e.g., dry powder ampules and vials) such as antibiotic vials or piggybacks must be billed in metric quantity of one each;

(c) Tablets, capsules, suppositories, lozenges, packets bill per each unit. Oral contraceptives are to be billed per each table;

(d) Diagnostic supplies (e.g., chemstrips, clinitest tabs), bill per each unit;

(e) Injectables that are prepackaged syringe (e.g., tubex, carpujects), bill per ml;

(f) Medical Supplies (e.g., Testape, Cordran tape) bill in metric quantity of one each;

(g) Prepackaged medications and unit doses must be billed per unit (tablet or capsule). Unit dose liquids are to be billed by ml;

(h) Fractional ml liquid doses (e.g., flu vaccine, pneumovax, etc.) use unique codes and bill per each dose;

(i) Fractional units: If no unique codes are available, round quantity up to the next whole unit (e.g., 3.5 gm to 4.0 gm; 7.2 ml up to 8 ml).

Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0900

DIVISION 149

SENIOR PRESCRIPTION DRUG ASSISTANCE PROGRAM

410-149-0000
Definition of Terms

(1) Critical access pharmacies — Pharmacies in locations where, without this designation, access to the Senior Prescription Drug Assistance Program would otherwise be limited or unavailable.

(2) Department — The Department of Human Services.

(3) Discount price — The total cost to the customer for the prescription drug and the dispensing fee as determined by the Department. It also includes the additional fee charged by critical access pharmacies, if applicable.

(4) Enrollee — Any person who meets the eligibility requirements of the Senior Prescription Drug Assistance Program, pays the enrollment fee, and to whom the Department issues an enrollment card.

(5) Prescription drugs — Drugs that must legally be prescribed by a practitioner authorized to prescribe drugs (legend drugs).

(6) Pharmacy providers — Pharmacies that volunteer to participate in the Senior Prescription Drug Assistance Program and that register with the Department.

(7) SPDAP — The Senior Prescription Drug Assistance Program.

Stat. Auth.: ORS 414.346
Stats. Implemented: ORS 414.340 - 414.348
Hist.: OMAP 5-2003, f. 1-31-03, cert. ef. 2-1-03

410-149-0020
Pharmacy Providers

(1) Registration:

(a) To be a pharmacy provider, under the Senior Prescription Drug Assistance Program (SPDAP), the pharmacy must register with the Department of Human Services (Department), regardless of whether the pharmacy is enrolled with the Department in the Medicaid program;

(b) The registration authorizes the pharmacy to serve enrollees in SPDAP;

(c) To register, the pharmacy must be licensed to do business in Oregon or licensed to do business in a border state if the pharmacy location is within 75 miles of the Oregon border;

(d) To register for the SPDAP, the pharmacy must agree to:

(A) Accept the discount price as payment in full for the cost of the prescription drug;

(B) Keep sufficient documentation of transactions to resolve

disagreements with the customer about the amount charged for the prescription drugs; and

(C) Repay the enrollee directly for overcharges.

(2) Advertising:

(a) A pharmacy provider may advertise that it participates in the SPDAP;

(b) The pharmacy must stop all advertisements pertaining to the program should the Department determine the pharmacy is not abiding by the conditions of the registration and the Department removes the pharmacy from the SPDAP. A pharmacy removed from the SPDAP has due process rights as outlined in OAR 410-149-0080.

(3) Other drug benefit coverage: If a pharmacy is aware that an enrollee has other drug benefit coverage, the pharmacy must notify the Department of the enrollee's other drug benefit coverage. The Department then will take any steps necessary to determine if the enrollee is still eligible for the SPDAP.

(4) Dispensing fee:

(a) Included in the discount price, pharmacies may charge, but are not required to charge, the enrollee a dispensing fee;

(b) The allowable dispensing fee and requirements are the same as set for Medicaid providers;

(c) If a pharmacy is enrolled in the SPDAP and must apply for review of the dispensing fee under ORS 410-121-0160, any change to the dispensing fee due to that review will also change for the SPDAP.

(5) Critical access pharmacies:

(a) Included in the discount price and in addition to the dispensing fee, critical access pharmacies may charge, but are not required to charge, the enrollee an additional fee per prescription;

(b) The purpose of designating pharmacies as critical access pharmacies is to provide incentives for pharmacies to participate in the SPDAP where access to the SPDAP would otherwise be limited or unavailable to enrollees;

(c) To be designated a critical access pharmacy, the pharmacy must provide the Department with sufficient information for the Department to decide if the designation is necessary. This information includes, but may not be limited to:

(A) How many seniors the pharmacy serves in its area;

(B) The distance between the registering pharmacy and the nearest pharmacy serving that senior population; and

(C) How the registering pharmacy believes the designation will increase access to the SPDAP for seniors in its area.

(d) After granting the designation as a critical access pharmacy, the Department, annually, may review the designation to determine if the designation is still necessary;

(e) Pharmacies that apply for the critical access pharmacy designation may appeal the Department 's denial of the designation. The appeal process is outlined in OAR 410-120-1560 through 410-120-1820;

(f) The fee is established as $2 by ORS 414.342 commencing on July 30,2001, and the Department annually will adjust this charge for inflation in April, beginning in April 2003.

(6) Pharmacies may not charge enrollees for costs incurred by the pharmacy for the electronic transmittal of the discount price from the Department to the pharmacy.

Stat. Auth.: ORS 414.346
Stats. Implemented: ORS 414.340 - 414.348
Hist.: OMAP 5-2003, f. 1-31-03, cert. ef. 2-1-03

410-149-0040
Discount Price and Allowable Prescription Drugs

(1) The price for a prescription drug a pharmacy can charge an enrollee, under the Senior Prescription Drug Assistance Program (SPDAP), is the lesser of the following:

(a) The Medicaid program price, as defined in OAR 410-121-0140(9); or

(b) The pharmacy's usual and customary price.

(2) The Department of Human Services (Department) will transmit the Medicaid price of the prescription drugs to the pharmacies using the Point-of- Sale System, as defined by OAR 410-121-0140. The pharmacy is not required to submit any information back to the Department on this system.

(3) The SPDAP is limited to prescription drugs prescribed in the name of and for the use by the enrollee.

(4) No prescription drugs require prior approval from the Department to provide the discount price.

(5) The SPDAP does not include prescriptions for over-the-counter drugs.

(6) Enrollees must use their Medicare benefits rather than their SPDAP enrollment cards for any prescription drugs covered by Medicare. An example includes, but is not limited to, immunosuppressive drug therapy for transplant patients if Medicare paid for the transplant.

Stat. Auth.: ORS 414.346
Stats. Implemented: ORS 414.340 - 414.348
Hist.: OMAP 5-2003, f. 1-31-03, cert. ef. 2-1-03

410-149-0060
Problem Resolution

(1) The following apply when an enrollee notifies the Department of Human Services (Department) that (s)he believes a pharmacy has charged more than the Senior Prescription Drug Assistance Program (SPDAP) price for the prescription drug:

(a) The prescription drug purchase must have occurred in the previous 30 days;

(b) The enrollee must provide proof of the alleged overcharge to the Department. The Department will compare the price paid by the enrollee to the price transmitted to the pharmacy;

(c) If the Department determines the pharmacy overcharged the enrollee, the Department will notify the pharmacy in writing that it must reimburse the enrollee the amount overcharged or offer proof to the Department that the pharmacy did not charge more than the SPDAP price. Within 30 days of the date of the notification, the pharmacy must

reimburse the enrollee and notify the Department of the reimbursement or submit the proof that it charged the SPDAP price.

(2) The following apply when the pharmacy elects, under section (1)(c) of this rule, to submit proof to the Department that it charged the SPDAP price:

(a) If the Department determines the pharmacy charged the SPDAP price, the Department will notify the enrollee of the decision;

(b) If the Department determines the pharmacy charged more than the SPDAP price, the Department will notify the pharmacy in writing of its obligation to reimburse the enrollee. Within 30 days of the date of the notification, the pharmacy must reimburse the enrollee and notify the Department of the reimbursement.

(3) Payment of the reimbursement is the responsibility of the pharmacy.

Stat. Auth.: ORS 414.346
Stats. Implemented: ORS 414.340 - 414.348
Hist.: OMAP 5-2003, f. 1-31-03, cert. ef. 2-1-03

410-149-0080
Provider Sanctions and Due Process Rights

(1) The Department of Human Services (Department) may, at its discretion, remove a pharmacy from the Senior Prescription Drug Assistance Program (SPDAP) if the pharmacy refuses to reimburse an enrollee or to reimburse the enrollee in the allotted time pursuant to OAR 410-149-0060. The Department also may remove a pharmacy from the SPDAP if the pharmacy no longer qualifies under OAR 410-149-0020 (1)(c) or if the pharmacy does not fulfill the agreement under OAR 410-149-0020 (1)(d).

(2) Notification to the pharmacy is outlined in OAR 410-120-1480.

(3) If the Department removes a pharmacy from the SPDAP, the pharmacy may appeal the decision as outlined in OAR 410-120-1560 through 410-120-1820.

Stat. Auth.: ORS 414.346
Stats. Implemented: ORS 414.340 - 414.348
Hist.: OMAP 5-2003, f. 1-31-03, cert. ef. 2-1-03

DIVISION 150

ADMINISTRATIVE EXAMINATION AND BILLING SERVICES

410-150-0000
Purpose

The Administrative Examination and Report rules are provided to use in conjunction with the General Rules of the Division of Medical Assistance Programs (DMAP) to assist providers in completing examinations requested and in preparing claims for administrative evaluations and reports. These rules do not apply to managed care plans.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 67-2003, f. 9-10-03 cert. ef. 10-1-03

410-150-0020
Definitions

(1) Administrative Medical Examination — An evaluation required by the Department of Human Services (DHS) to assist in determining eligibility and for casework planning for various assistance programs. An evaluation must be written and must contain a diagnosis, prognosis, and supporting objective findings. Functional impairments and expected duration of impairment must be included.

(2) Administrative Medical Reports — Copies of existing records from a specified date. Progress notes, laboratory tests, x-ray reports, special test results and copies of other pertinent records must be included.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00

410-150-0040
Request Requirements

(1) A copy of a completed DMAP 729 Administrative Medical Examination/Report Authorization is the authorization needed to perform an administrative examination, complete a form, or send copies of records.

(a) Only an employee of the Department of Human Services (DHS) or Oregon Youth Authority (OYA), or the Division of Medical Assistance Programs (DMAP) may complete an DMAP 729.

(b) Keep a copy of the DMAP 729 for seven years.

(2) There are a series of DMAP 729s that may or may not be requested to be completed. Always follow the instructions on the DMAP 729.

(3) Examinations are only to be completed by the provider type listed on the various Procedure Code Tables in these rules.

[ED. NOTE: Forms referenced rule are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

410-150-0060
Additional Testing

If testing is needed for medical diagnosis, instruct the ancillary service provider to bill using diagnosis code V68.89 and the appropriate CPT or HCPCS procedure codes. For psychiatric/psychological testing, contact the branch office.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00

410-150-0080
Billing Instructions for Administrative Examinations

(1) Medical and ancillary services providers must bill on a CMS-1500.

(2) Hospital services must be billed on a UB-92.

(3) Copies of records by a copy service provider must be billed on a CMS-1500.

(4) Do not attach the DMAP 729 or any documents to the CMS-1500. Send the examination or copies of the reports to the branch office shown on the DMAP 729.

(5) For Administrative Examination billing, the following are required on the appropriate billing form:

(a) The procedure code specified on the DMAP 729;

(b) The description as it appears on the DMAP 729;

(c) The correct type of service (TOS) per Procedure Code Tables; and

(d) The diagnosis V68.89.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 67-2003, f. 9-10-03 cert. ef. 10-1-03

410-150-0120
Procedure Code Table — Medical and Ancillary Services Providers

Table — 150-0120 identifies the codes available for Administrative Examinations and Reports.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 7-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 47-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 15-2002, f. & cert. ef. 4-1-02; OMAP 60-2002, f. & cert. ef. 10-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 67-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 24-2006, f. 6-12-06, cert. ef. 7-1-06

410-150-0160
Procedure Code Table — Hospital Providers

Table — 150-0160.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 47-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 15-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03

410-150-0200
Billing Instructions — Licensed Polygrapher

(1) Billing for licensed polygrapher services must be in writing on a CMS-1500.

(2) A polygraph does not qualify as a health care service and is therefore not subject to Health Insurance Portability and Accountability Act (HIPAA) regulations.

(3) Do not attach the DMAP 729 or any documents to the CMS-1500. Send the test results to the requesting branch office address shown on the DMAP 729.

(4) Send completed CMS-1500 claim form to the Division of Medical Assistance Programs (DMAP).

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 67-2003, f. 9-10-03 cert. ef. 10-1-03

410-150-0240
Procedure Code Table — Licensed Polygrapher

Table — 0240.
[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00

410-150-0300
Procedure Code Table — Copy Services

Table — 150-0300. (Table rewritten.)
[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 15-2002, f. & cert. ef. 4-1-02; OMAP 67-2003, f. 9-10-03 cert. ef. 10-1-03