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## STATUTORY MINOR CORRECTION

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### DMAP 27-2022

CHAPTER 410

OREGON HEALTH AUTHORITY

HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: 410-120-1570 Statutory Minor Correction CWM

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AGENCY ATTESTS THE FOLLOWING CHANGES HAVE BEEN MADE, ACCORDING TO ORS 183.335(7):

Changing the name of a program, office or division within an agency as long as the change in name does not have a substantive effect on the functions of the program, office or division

AMEND: 410-120-1570

RULE TITLE: Claim Re-Determinations

RULE SUMMARY: Changing the name of a program from Citizen/Alien Waived Emergency Medical (CAWEM) to Citizenship Waived Medical (CWM)

RULE TEXT:

- (1) If a provider disagrees with an initial claim determination made by the Division of Medical Assistance Program (Division), the provider may request a review for re-determination of the denied claim payment.
- (2) This rule does not apply to determinations that:
  - (a) Result in a "Notice of Action" that must be provided to the OHP client. If the decision under review requires any notice to the OHP client under applicable rules (OAR 410-120-1860, 410-414-0263), the procedures for notices and hearings must be followed; or
  - (b) Are made by a CCO or PHP regarding services to a CCO or PHP member. The provider must contact the CCO or PHP in accordance with 410-120-1560.
- (3) How to request a redetermination review:
  - (a) To request a review, the provider must submit a written request to the Division Provider Services Unit within 180 days of the original claim adjudication date.
  - (b) The written request must include all information needed to adjudicate the claim or support changing the original claim determination, including but not limited to:
    - (A) A detailed letter of explanation identifying the specific re-determination denial issue and/or alleged error;
    - (B) All relevant medical records and evidence-based practice data to support the position being asserted on review;
    - (C) The specific service, supply or item being denied, including all relevant codes;
    - (D) Detailed justification for the re-determination of the denied service; and
    - (E) A copy of the original claim and a copy of the original denial notice or remittance advice that describes the basis for the claim denial under re-determination;
    - (F) Any information and/or medical documentation pertinent to support the request and to obtain a resolution of the re-

determination review dispute.

(4) A provider requesting a re-determination review must demonstrate one or more of the following reasons that would allow coverage in the particular case:

- (a) A below-the-line condition/treatment pair is justified under the co-morbid rule OAR 410-141-0480(8);
- (b) A treatment that is part of a covered complex procedure and/or related to an existing funded condition;
- (c) A service not listed on the HSC Prioritized List that may be covered under OAR 410-141-0480(10);
- (d) A service that satisfies the Citizenship Waived Medical (CWM) emergency service criteria;
- (e) Medical documentation of applicable evidence-based practice literature that is consistent with the condition or service under review;
- (f) A service that satisfies the prudent layperson definition of emergency medical condition;
- (g) A service intended to prolong survival or palliate symptoms, due to expected length of life consistent with the HSC Statement of Intent for Comfort/Palliative Care;
- (h) A service that should be covered where denial was due to technical errors and omissions with the Oregon Health Services Commission's (HSC) Prioritized List of approved Health Services
- (i) Misapplication of a fee schedule;
- (j) A denied duplicate claim that the provider believes were incorrectly identified as a duplicate;
- (k) Incorrect data items, such as provider number, use of a modifier or date of service, unit changes or incorrect charges;
- (l) Errors with the Medicaid Management Information System (MMIS), such as a code is missing in MMIS that the Oregon Health Services Commission (HSC) has placed on the Prioritized List of Health Services;
- (m) Services provided without the required prior-authorization, except for those authorizations subject to provision outlined in OAR 410-120-1280(2)(a)(C);
- (n) A covered diagnostic service.

(5) The Division will review all re-determination requests as follows:

- (a) The review is based on the Division review of supplied documentation and applicable law(s);
- (b) The Division may request additional information from the provider that it finds relevant to the request under review;
- (c) The Division does not provide a face-to-face meeting with providers as part of the re-determination review process.
- (d) The Division will notify a provider requesting review that the re-determination request has been denied if:
  - (A) The provider did not submit a timely request;
  - (B) The required information is not provided at the same time the request is submitted; and/or
  - (C) The provider fails to submit any additional requested information within 14 business days of request.
- (7) The Division's final decision under this rule is the final decision on appeal. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Division's final decision under this rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065