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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 55-2023
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
06/30/2023 3:14 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Healthier Oregon pathway to OHP benefits expansion to include members of all ages.

EFFECTIVE DATE: 07/01/2023 THROUGH 12/27/2023

AGENCY APPROVED DATE: 06/30/2023

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NEED FOR THE RULE(S):

House Bill 3352 requires the Authority to implement the Healthier Oregon program to all eligible members on July 1, 2023.

JUSTIFICATION OF TEMPORARY FILING:

(1) The Healthier Oregon program will not expand to cover all eligible members.
(2) Newly eligible members for Oregon Health Plan through the Healthier Oregon pathway.
(3) Current Oregon Administrative Rules restrict enrollment to Healthier Oregon by age. New members and current members ages 26-54 would not be eligible for benefits
(4) Temporary rules are filed to keep OHA in alignment with House Bill 3352, which requires Healthier Oregon to expand to all eligible members.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

HB 3352
https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3352
SB 5525 OHA Budget Bill – Enrolled
https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/SB5525
SB 5525 OHA Budget Report
https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/275791

RULES:
410-120-0000, 410-120-1210, 410-120-1280, 410-121-0147, 410-123-1540, 410-125-0230, 410-134-0000, 410-134-0001, 410-134-0002, 410-134-0003, 410-134-0004, 410-136-3020, 410-200-0240

AMEND: 410-120-0000

RULE TITLE: Acronyms and Definitions

RULE SUMMARY: Changes to Citizenship Waived Medical to end date the program and Healthier Oregon program definitions, renumbering.

RULE TEXT:

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-3500 Acronyms and Definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 administrative rules; or contact the Division.

(1) “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.

(2) “Action” means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a Coordinated Care Organization (CCO) member, refer to OAR 410-141-3500.

(3) “Acupuncturist” means an individual licensed to practice acupuncture by the relevant state licensing board.

(4) “Acupuncture Services” means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(5) “Acute” means a condition, diagnosis, or illness with a sudden onset and that is of short duration.

(6) “Acquisition Cost” means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.

(7) “Addictions and Mental Health Division” means the Division within the Authority’s Health Systems Division that administers mental health and addiction programs and services.

(8) “Adequate Record Keeping” means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

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

(10) “Advance Directive” means an individual’s instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(11) “Adverse determination” means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

(12) “Adverse Event” means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.

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

(14) “All-Inclusive Rate” or “Bundled Rate” means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division’s Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.

(15) “Allied Agency” means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, Area Agencies on Aging (AAAs), and

federally recognized American Indian tribes).
(16) “Alternative Care Settings” means sites or groups of practitioners that provide care to members under contract with a Managed Care Entity (MCE), including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.
(17) “Ambulance” means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.
(18) “Ambulatory Payment Classification” means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).
(19) “Ambulatory Surgical Center (ASC)” means a facility licensed as an ASC by the Authority.
(20) “American Indian/Alaska Native (AI/AN)” means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.
(21) “American Indian/Alaska Native (AI/AN) Clinic” means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).
(22) “Ancillary Services” means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.
(23) “Anesthesia Services” means administration of anesthetic agents to cause loss of sensation to the body or body part.
(24) “Appeal” means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.
(25) “Area Agency on Aging (AAA)” means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.
(26) “Atypical Provider” means an entity able to enroll as a Billing Provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.
(27) “Audiologist” means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.
(28) “Audiology” means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.
(29) “Automated Voice Response (AVR)” means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.
(30) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.
(31) “Behavioral Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.
(32) “Behavioral Health Case Management” means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.
(33) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.
(34) “Benefit Package” means the package of covered health care services for which the client is eligible.
(35) “Billing Agent or Billing Service” means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

(36) “Billing Provider (BP)” means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.
(37) “Buying Up” means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)
(38) “By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care shall facilitate evaluation.
(39) “Case Management Services” means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.
(40) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.(41) “Traditional Health Worker” means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon. OAR 950-060-0010(19)
(42) “Child Welfare (CW)” means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.
(43) “Children's Health Insurance Program (CHIP)” means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.
(44) “Chiropractor” means an individual licensed to practice chiropractic by the relevant state licensing board.
(45) “Chiropractic Services” means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.
(46) “Citizenship Waived Medical (CWM)” means Emergency-Only Health Benefits for individuals who prior to June 30, 2023, met the financial and non-financial eligibility requirements for an HSD Medical Program, except they did not meet citizenship or non-citizen status requirements (OAR 410-200-0240).
(47) “Claimant” means an individual who has requested a hearing.
(48) “Client” means an individual found eligible to receive OHP health services.
(49) “Clinical Nurse Specialist” means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.
(50) “Clinical Social Worker” means an individual licensed to practice clinical social work pursuant to state law.
(51) “Clinical Record” means the medical, dental, or mental health records of a client or member.
(52) “Co-morbid Condition” means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.
(53) “Comfort Care” means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.
(54) “Community Health Worker” means an individual who:
(a) Has expertise or experience in public health;
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the

health care needs of its residents and achieve wellness;
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;
(f) Provides health education and information that is culturally appropriate to the individuals being served;
(g) Assists community residents in receiving the care they require;
(h) May give peer counseling and guidance on health behaviors; and
(i) May provide direct services such as first aid or blood pressure screening.
(55) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.(56) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V); and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission (HERC), constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.
(57) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:
(a) A client or member or their representative;
(b) A member of an MCE after resolution of the MCE's appeal process;
(c) An MCE member's provider; or
(d) An MCE.
(58) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.
(59) "Contiguous Area Provider" means a provider practicing in a contiguous area.
(60) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.
(61) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).
(62) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)
(63) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.
(64) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:
(a) Ancillary Services OAR 410-120-0000 (22);
(b) Diagnostic Services OAR 410-120-0000 (82);
(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations(CFR) 42 CFR part 438, subpart k;
(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Waiver.
(65) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.
(66) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care

providers.
(67) “Date of Receipt of a Claim” means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.
(68) “Date of Service” means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.
(69) “Declaration for Mental Health Treatment” means a written statement of an individual’s decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.
(70) “Dental Emergency Services” means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.
(71) “Dental Therapist” means a person licensed to practice dental therapy within the scope of practice as defined under state law.
(72) “Dentist” means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.
(73) “Denturist” means an individual licensed to practice denture technology pursuant to state law.
(74) “Denturist Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.
(75) “Dental Hygienist” means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.
(76) “Dental Hygienist with an Expanded Practice Permit” means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.
(77) “Dentally Appropriate” means health services, items, or dental supplies:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence;
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply;
(d) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE’s judgement;
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.
(78) “Department of Human Services (Department or DHS)” means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.
(79) “Department Representative” means an individual who represents the Department and presents the Department’s position in a hearing.
(80) “Diagnosis Code” means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.
(81) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-10-CM.
(82) “Diagnostic Services” mean those services required to diagnose a condition, including but not limited to: radiology,

ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.
(83) “Division (Division)” means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.
(84) “Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)” means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.
(85) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)” mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.
(86) “Electronic Data Interchange (EDI)” means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.
(87) “EDI Submitter” means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.
(88) “Electronic Verification System (EVS)” means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.
(89) “Emergency Department” means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.
(90) “Emergency Medical Condition” means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis, but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.
(91) “Emergency-Only Health Benefits” means Emergency Medical Conditions defined in OAR 410-134-0003(2)(a)(C)(i)(I-VIII) and OAR 410-134-0003(2)(b)(C)(ii) eligible for Medicaid match. (42 CFR 440.255)
(92) “Emergency Medical Transportation” means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.
(93) “Emergency Services” means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a client’s discharge from a facility or transfer to another facility.
(94) “Evidence-Based Medicine” means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically

relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings.
(95) “False Claim” means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result, or has resulted, in an overpayment.
(96) “Family Planning Services” means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.
(97) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:
(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;
(b) Is qualified to participate in 340B discount purchasing as an HTC;
(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has an identification number that is listed in the HTC directory on the CDC website;
(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and
(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.
(98) “Federally Qualified Health Center (FQHC)” means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.
(99) “Fee-for-Service Provider” means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.
(100) “Fraud” means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.
(101) “Fully Dual Eligible” means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.
(102) “General Assistance (GA)” means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.
(103) “Grievance” means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested.
(104) “Health Care Interpreter” Certified or Qualified have the meaning given those terms in ORS 413.550.
(105) “Health Care Professionals” means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.
(106) “Healthcare Common Procedure Coding System (HCPCS)” means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes;

however, the Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.
(107) “Health Evidence Review Commission” means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.
(108) “Health Insurance Portability and Accountability Act of 1996 (HIPAA)” means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
(109) “Health Maintenance Organization (HMO)” means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.
(110) “Health Plan New/non-categorical client (HPN)” means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.
(111) “Healthier Oregon” means Emergency-Only Health Benefits defined OAR 410-120-0000(91) and State Funded Supplemental Health Benefits OAR 410-120-0000(238) provide benefits equal to OHP for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD or OSIPM Medical Program, except that they do not meet citizenship status requirements (OAR 410-200-0240 and 461-101-0010).
(112) “Hearing Aid Dealer” means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.
(113) “Home Enteral Nutrition” means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.
(114) “Home Health Agency” means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.
(115) “Home Health Services” means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.
(116) “Home Intravenous Services” means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.
(117) “Home Parenteral Nutrition” means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.
(118) “Hospice” means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.
(119) “Hospital” means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short-term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(120) “Hospital-Based Professional Services” means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for the Division.
(121) “Hospital Dentistry” means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).
(122) “Hospital Laboratory” means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital’s cost report to Medicare and to the Division.
(123) “Indian Health Care Provider” (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
(124) “Indian Health Program” means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.
(125) “Indian Health Service (IHS)” means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.
(126) “Indian Managed Care Entities” (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service.
(127) “Indigent” means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).
(128) “Individual Adjustment Request Form (OHP 1036)” means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.
(129) “Inpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)
(130) “Institutional Level of Income Standards (ILIS)” means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.
(131) “Institutionalized” means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.
(132) “International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)” means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.
(133) “Joint fair hearing request” means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.
(134) “Laboratory” means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment

of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).
(135) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their 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.
(136) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.
(137) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.
(138) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.
(139) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:
(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).
(140) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.
(141) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).
(142) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.
(143) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.
(144) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.
(145) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.
(146) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).
(147) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

(148) “Medical Transportation” means transportation to or from covered medical services.
(149) “Medically Appropriate” means health services, items, or medical supplies that are:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;
(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE’s judgment;
(e) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.
(150) “Medically Necessary” means health services and items that are required by a client or member to address one or more of the following:
(a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;
(b) The ability for a client or member to achieve age-appropriate growth and development;
(c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
(d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;
(e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.
(151) “Medicare” means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;
(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division’s Pharmaceutical Services program administrative rules in chapter 410, division 121.
(152) “Medicare Advantage” means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.
(153) “Medicheck for Children and Teens” means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under the age of 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.
(154) “Member” means an OHP client enrolled with a pre-paid health plan or coordinated care organization.
(155) “National Correct Coding Initiative (NCCI)” means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.
(156) “National Drug Code or (NDC)” means a universal number that identifies a drug. The NDC number consists of 11

digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages shall display less than 11 digits, but the number assumes leading zeroes.
(157) “National Provider Identification (NPI)” means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.
(158) “Naturopathic physician” means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.
(159) “Naturopathic Services” means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.
(160) “Non-covered Services” means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:
(a) OAR 410-120-1200 Excluded Services and Limitations; and
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;
(c) OAR 410-141-3820 OHP Benefit Package of Covered Services;
(d) OAR 410-141-0520 Prioritized List of Health Services; and
(e) Any other applicable Division administrative rules.
(161) “Non-Emergent Medical Transportation Services (NEMT)” means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.
(162) “Non-Paid Provider” means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).
(163) “Nurse Anesthetist, C.R.N.A.” means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.
(164) “Nurse Practitioner” means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.
(165) “Nurse Practitioner Services” means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.
(166) “Nursing Facility” means a facility licensed and certified by the Department and defined in OAR 411-070-0005.
(167) “Nursing Services” means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.
(168) “Nutritional Counseling” means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.
(169) “Occupational Therapist” means an individual licensed by the State Board of Examiners for Occupational Therapy.
(170) “Occupational Therapy” means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.
(171) “Ombudsman Services” means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.
(172) “Oregon Health ID” means a card the size of a business card that lists the client’s name, client ID (prime number), and the date it was issued.
(173) “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income

populations and Medicaid and CHIP services under the State Plan.
(174) “Optometric Services” means services provided within the scope of practice of optometrists as defined under state law.
(175) “Optometrist” means an individual licensed to practice optometry pursuant to state law.
(176) “Oregon Health Authority (Authority)” means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.
(177) “Oregon Youth Authority (OYA)” means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.
(178) “Out-of-State Providers” means any provider located outside the borders of the State of Oregon:
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;
(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.
(179) “Outpatient Hospital Services” means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division’s Hospital Services administrative rules chapter 410, division 125.
(180) “Overdue Claim” means a valid claim that is not paid within 45 days of the date it was received.
(181) “Overpayment” means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.
(182) “Overuse” means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.
(183) “Paid Provider” means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.
(184) “Payment Authorization” means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.
(185) “Peer Review Organization (PRO)” means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.
(186) “Peer Support Specialist means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be:
(a) A self-identified individual currently or formerly receiving addictions or mental health services;
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;
(c) A self-identified individual in recovery from problem gambling.
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(187) “Peer Wellness Specialist” including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual’s peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.
(188) “Person Centered Care” means care that reflects the individual patient’s strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient’s goals, and

shall assist the patient in achieving the goals.
(189) “Personal Health Navigator” means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient’s particular circumstances and considering the patient’s needs, lifestyle, combination of conditions, and desired outcome.
(190) “Pharmaceutical Services” means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.
(191) “Pharmacist” means an individual licensed to practice pharmacy pursuant to state law.
(192) “Physical Capacity Evaluation” means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.
(193) “Physical Therapist” means an individual licensed by the relevant state licensing authority to practice physical therapy.
(194) “Physical Therapy” means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.
(195) “Physician” means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.
(196) “Physician Assistant” means an individual 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.
(197) “Physician Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.
(198) “Podiatric Services” means services provided within the scope of practice of podiatrists as defined under state law.
(199) “Podiatrist” means an individual licensed to practice podiatric medicine pursuant to state law.
(199) “Post-Payment Review” means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.
(201) “Practitioner” means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.
(202) “Prepaid Health Plan (PHP)” means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO)
(203) “Primary Care Dentist (PCD)” means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.
(204) “Primary Care Provider (PCP)” means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.
(205) “Prior Authorization (PA)” means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.
(206) “Prioritized List of Health Services” means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.
(207) “Private Duty Nursing Services” means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health

care facility.
(208) “Provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.
(209) “Provider Organization” means a group practice, facility, or organization that is:
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)
(210) “Psychiatric Emergency Services (PES)” means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.
(211) “Public Health Clinic” means a clinic operated by a county government.
(212) “Public Rates” means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.
(213) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary as defined by the Social Security Act and its amendments.
(214) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.
(215) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.
(216) “Quality Improvement Organization (QIO)” means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.
(217) “Radiological Services” means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.
(218) “Recipient” means an individual who is currently eligible for medical assistance (also known as a client).
(219) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).
(220) “Recoupment” means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.
(221) “Referral” means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.
(222) “Remittance Advice (RA)” means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.
(223) “Rendering provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider

of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.
(224) “Request for Hearing” means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.
(225) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.
(226) “Retroactive Medical Eligibility” means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.
(227) “Ride” means non-emergent medical transportation services for a client either to or from a location where covered services are provided. “Ride” does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.
(228) “Rural” means a geographic area that is ten or more map miles from a population center of 30,000 people or less.
(229) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.
(230) “School Based Health Service” means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.
(231) “Self-Sufficiency” means the division in the Department of Human Services that administers programs for adults and families.
(232) “Service Agreement” means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.
(233) “Sliding Fee Schedule” means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.
(234) “Social Worker” means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.
(235) “Speech-Language Pathologist” means an individual licensed by the Oregon Board of Examiners for Speech Pathology.
(236) “Speech-Language Pathology Services” means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.
(237) “State Facility” means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.
(238) “State Funded Supplemental Health Benefits” means benefits defined in OAR 410-134-0003(2)(a)(C)(ii)(I-VII).
(239) “Subparts (of a Provider Organization)” means for NPI application, subparts of a health care provider organization may meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.
(240) “Subrogation” means right of the state to stand in place of the client in the collection of Third Party Resources (TPR).
(241) “Substance Use Disorder (SUD) Services” means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(242) “Supplemental Security Income (SSI)” means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.
(243) “Surgical Assistant” means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.
(244) “Suspension” means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds shall be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.
(245) “Targeted Case Management (TCM)” means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.
(246) “Termination” means a sanction prohibiting a provider's participation in the Division’s programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds shall be made for services provided after the date of termination. Termination is permanent unless:
(a) The exceptions cited in 42 CFR 1001.221 are met; or
(b) Otherwise stated by the Authority at the time of termination.
(247) “Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer” means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.
(248) “Transportation” means medical transportation.
(249) “Service Authorization Request” means a member’s initial or continuing request for the provision of a service including member requests made by their provider or the member’s authorized representative.
(250) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.
(251) “Type B AAA” means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.
(252) “Type B AAA Unit” means a Type B AAA funded by Oregon Project Independence (OPI), Title III—Older Americans Act, and Title XIX of the Social Security Act.
(253) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.
(254) “Urban” means a geographic area that is less than ten map miles from a population center of 30,000 people or more.
(255) “Urgent Care Services” means health services that are medically appropriate and immediately required to prevent serious deterioration of a client’s health that are a result of unforeseen illness or injury.
(256) “Usual Charge (UC)” means the lesser of the following unless prohibited from billing by federal statute or regulation:
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.
(257) “Utilization Review (UR)” means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.
(258) “Valid Claim” means an invoice received by the Division or the appropriate Authority or Department office 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 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).
(259) “Valid Preauthorization” means a document the Authority, a PHP, or CCO receives requesting a health service for a member who may be eligible for the service at the time of the service, and the document contains:
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.
(260) “Vision Services” means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.
(261) “Volunteer” (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: 414.065

AMEND: 410-120-1210

RULE TITLE: Medical Assistance Benefit Packages and Delivery System

RULE SUMMARY: Changes to end date the Citizenship Waived medical program.

RULE TEXT:

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

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

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

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

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

(C) Coverage includes:

(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);

(ii) Ancillary services, (OAR 410-141-3820);

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

(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;

(v) Hospice;

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

(D) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123 and 200);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).

(b) OHP with Limited Drugs:

(A) Benefit package identifier: BMM, BMD;

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

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

(D) Limitations:

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

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

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

(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D shall cover those indications).
(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.
(c) Qualified Medicare Beneficiary (QMB)-Only:
(A) Benefit Package identifier code MED;
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.
(d) Citizenship Waived Medical (CWM): Benefit package defined in OAR 410-134-0003(3), ending June 30, 2023. Refer to OAR 410-134-0004 for billing guidance.
(e) Compact of Free Association (COFA) Dental Program:
(A) Benefit Package identifier code DEN;
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;
(C) Coverage is state funded and includes the types and extent of Dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.
(f) Veteran Dental Program:
(A) Benefit Package identifier code DEN and DNT;
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;
(C) Coverage is state funded and includes the types and extent of dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.
(5) Division clients are enrolled for covered health services to be delivered through one of the following means:
(a) Coordinated Care Organization (CCO):
(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or dental care.
(b) Fee-for-service (FFS):
(A) These clients are not enrolled in a CCO;
(B) Subject to limitations and restrictions in the Division's individual program rules, the client may receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered

service and shall receive a fee for the service provided.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690

AMEND: 410-120-1280

RULE TITLE: Billing

RULE SUMMARY: Changes to end date the Citizenship Waived medical program, renumbered.

RULE TEXT:

(1) A provider enrolled with the Authority or providing services to a client in an MCE under the Oregon Health Plan (OHP) may not seek payment from the client for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by the Authority under this rule.

(2) Identification of eligibility and third-party liability. The provider shall:

(a) Verify the client's eligibility for medical assistance and benefit package prior to rendering service pursuant to OAR 410-120-1140;

(b) Make "reasonable efforts" to identify third-party resources as described in section (10)(b) of this rule; and

(c) Ask the client at the point of service and verify prior to billing if the client has medical assistance, is applying for medical assistance, enrolled with an MCE or has other third-party liability.

(3) If a provider's patient is a medical assistance recipient, the provider must:

(a) Comply with the provisions in sections (10) through (12) of this rule regarding third-party resources;

(b) Submit a claim to the Authority or MCE, if no third-party resources are available or the provider has complied with section (2)(a) of this rule;

(c) Delay any billing or collection action against the patient for 90 calendar days from submitting the claim to the Authority or MCE, except as authorized in section (4) of this rule;

(d) If no payment is received from the Authority or MCE within 90 calendar days from the date the claim was submitted:

(A) Verify the patient's eligibility for the date of service;

(B) If the patient was not eligible for medical assistance on the date of service, proceed with the provider's normal billing and collection process; or

(C) If the patient was eligible for medical assistance on the date of service, and the provider does not have a completed agreement to pay form (3165, 3166, 4109), the provider is not allowed to bill the client, collect payment from the client, or assign an unpaid claim to a collection agency or similar entity pursuant to ORS 414.066, except as authorized by section (5) of this rule.

(4) For Medicaid covered services, the provider must not:

(a) Bill the Authority more than the provider's Usual Charge (OAR 410-120-0000(254)) or the reimbursement specified in the applicable Authority program rules;

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

(c) Bill the client for services or treatments that have been denied due to provider error, except as authorized under section (5) of this rule. Examples of provider error could be things such as required documentation not submitted for a prior authorization, or a prior authorization not submitted.

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

(a) The client did not inform the provider of their Oregon Health plan I.D., MCE I.D. card, or third-party insurance card, or gave a name that did not match OHP I.D. at the time of or after a service was provided; therefore, the provider may not bill the appropriate payer for reasons including but not limited to the lack of prior authorization, or because the time limit to submit the claim for payment has passed. The provider shall verify eligibility at the time of service pursuant to OAR 410-120-1140 and prior to billing or collection pursuant to OAR 410-120-1280, and document attempts to obtain coverage information prior to billing the client;

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

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

(d) Citizenship Waived Medical (CWM) recipients prior to June 30, 2023, that received services that are not part of the CWM emergency only benefits; see OAR 410-134-0003(3) for coverage and limitations. See OAR 410-134-0004 for coverage and billing guidance.
(i) Members receiving CWM benefit plan before June 30, 2023; before providing the non-covered service, the client must have signed the provider-completed Agreement to Pay OHP 3165, 3166, or 4109.
(ii) CWM clients who are limited English proficient, the provider must have provided translation or interpretation services to ensure the client understood the Agreement to Pay.
(e) The client has requested a continuation of benefits during the contested case hearing process, and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 pursuant to section (5)(h) of this rule before providing these services;
(f) The client has requested to privately pay for services denied as not meeting the prior authorization, HERC or other criteria. Refer to non-covered services in this rule section (5)(h);
(g) The client has requested to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all the following:
(A) The requested service is a covered service, and the appropriate payer (the Authority, MCE, or third-party payer) may pay the provider in full for the covered service; and
(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer (Authority or MCE) may pay for the service, and that the provider may not bill the client for an amount greater than the amount the appropriate payer may pay; and
(C) That the client knowingly and voluntarily agrees to pay for the covered service; and
(D) The provider documents in writing, signed by the client or the client's representative, indicating that:
(i) The provider gave the client the information described in section (5)(g)(A-C) of this rule; and
(ii) The client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and
(iii) The client agreed to privately pay for the service by signing an agreement incorporating all the information described above; and
(iv) The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Authority or to the client's MCE or third-party payer that is subject to the agreement.
(h) Non-covered services by the Authority, or MCE (non-covered services include services denied under prior authorization. Refer to OAR 410-120-0000 for a definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165, 3166, or 4109) or a facsimile containing all of the information and elements of the 3165 or 3166 as shown in Table 3165, 3166, or 4109 of this rule. The completed OHP 3165, 3166, 4109 or facsimile is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client’s signature. For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy. Providers must make a copy of the completed OHP 3165, 3166 or 4109 form or facsimile available to the Authority or MCE upon request.
(6) Code set requirements:
(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions, and payments. Code Set has the meaning set forth in 45 CFR 162.103, and it includes the codes and the descriptors of the codes. Federal Code Set requirements are mandatory, and the Authority lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;
(b) The Authority shall adhere to the Code Set requirements in 45 CFR 162.1000–162.1011;
(c) Periodically, the Authority shall update its provider rules and tables to conform to national codes. In the event of an alleged variation between an Authority-listed code and a national code, the Authority shall apply the national code in effect on the date of request or date of service;

(d) Only codes with limitations or requiring prior authorization are noted in OAR. National Code Set issuance alone may not be construed as coverage or a covered service by the Authority;
(e) The Authority adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS). This code adoption may not be construed as coverage or as a covered service by the Authority.
(7) Claims:
(a) Upon submission of a claim to the Authority for payment, the provider agrees that it has complied with all Division program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;
(b) A provider enrolled with the Division shall bill using the Authority assigned provider number, or the National Provider Identification (NPI) number if the NPI is available, pursuant to OAR 410-120-1260;
(c) The provider may not bill the Division more than the provider's usual charge (see Definitions) or the reimbursement specified in the applicable Division program rules;
(d) Claims shall be submitted on the appropriate form as described in the individual Division program rules or electronically in a manner authorized in OAR Chapter 943, Division 120;
(e) Medicare shall send crossover claims to the Authority or contracted health plan after adjudication by Medicare. When billing Medicare as the primary payer, claims for all Medicaid/Medicare members shall include all applicable payer information (with Medicare as primary and Medicaid as secondary) so that Medicare can automatically transmit the correct Medicare payment, coinsurance, and deductible information to the Authority or MCE;
(f) Claims must be for services provided within the provider's licensure or certification;
(g) Unless otherwise specified, claims shall be submitted after:
(A) Delivery of service; or
(B) Dispensing, shipment or mailing of the item.
(h) The provider shall submit true and accurate information when billing the Division. Use of a billing provider does not do away with the performing provider's responsibility for the truth and accuracy of submitted information;
(i) A claim is considered a valid claim only if it contains all data required for processing. See the appropriate provider rules and supplemental information for specific instructions and requirements;
(j) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:
(A) Any false claim for payment;
(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;
(C) Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exception of (10)(c)(A-D) of this rule. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Division. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate Third Party Liability (TPL) Explanation Code;
(D) Any claim for furnishing specific care, items, or services that has not been provided.
(k) If an overpayment has been made by the Authority, the provider is required to do one of the following:
(A) Adjust the original claim to show the overpayment as a credit in the appropriate field:
(i) Submit an Individual Adjustment Request (OHP 1036); or
(ii) Adjust the claim on the Provider Web Portal at https://www.or-medicaid.gov;
(B) Refund the amount of the overpayment on any claim;
(C) Void the claim via the Provider Web Portal if the Division overpaid due to an erroneous billing;
(D) If the overpayment occurred because of a payment from a third-party payer refer to section (10)(f) of this rule.
(L) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued improper billing practices and has had an opportunity for a contested case hearing shall be liable to the Division for up to triple the amount of the Division established

overpayment received as a result of the violation.
(8) Diagnosis code requirement:
(a) A primary diagnosis code is required on all claims, using the ICD-10-CM diagnosis code set, unless specifically excluded in individual Division program rules;
(b) The primary diagnosis code shall be the code that most accurately describes the client's condition;
(c) All diagnosis codes are required to the highest degree of specificity;
(d) Hospitals shall follow national coding guidelines and bill using the seventh digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.
(9) Procedure code requirement:
(a) For claims requiring a procedure code the provider shall bill as instructed in the appropriate Division program rules and shall use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;
(b) For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim must be the code that most accurately describes the services provided. Hospitals shall follow national coding guidelines;
(c) When there is no appropriate descriptive procedure code to bill the Division, the provider shall use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;
(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider shall bill the Division using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.
(10) Third-Party Liability (TPL):
(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division shall be the payer of last resort;
(b) Providers shall make reasonable efforts to obtain payment first from other resources. For the purposes of this rule, "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:
(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;
(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing;
(C) Asking the Medicaid recipient at the point of service or prior to billing if they have other health insurance;
(D) If the provider identifies from the client or other source third-party insurance that is unknown to the state or that is different from what is reported in one of the Division verification systems, the provider shall report the coverage to the Health Insurance Group (HIG) using the secure online form at www.reporttpl.org.
(c) Except as noted in section (10)(d)(A)-(E) of this rule, when third-party coverage is known to the provider prior to billing the Division, the provider shall:
(A) Bill all third-party insurance the client is covered by, which could include Personal Insurance Protection (PIP) or Workers Compensation if the claim is related to a personal injury; and
(B) Except for pharmacy claims billed through the Division's point-of-sale system, the provider shall wait 30 days from submission date of a clean claim and have not received payment from the third party; and
(C) Comply with the insurer's billing and authorization requirements; and
(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.
(d) In accordance with federal regulations, the provider shall bill the TPL prior to billing the Division, except under the following circumstances:
(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);
(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;
(C) The covered health services are prenatal and preventive pediatric services;
(D) Services are covered by a third-party insurer through an absent parent where the medical coverage is

administratively or court ordered;
(E) When a negligent third party caused an injury or illness to a client, a provider may choose to bill the Liability Insurance (see Definitions), bill the liable third party, place a lien on a tort settlement or judgement, or bill the Division. The provider may not both place a lien against a settlement and bill the Division:
(i) The provider may withdraw their lien and bill the Division within 12 months of the date of service; however, the provider shall accept the Division payment as payment in full;
(ii) The provider may not return the payment made by the Division in order to place a lien or to accept payment from a liability settlement, judgement, liability insurer, or other source.
(F) In the circumstances outlined in section (10)(d)(A)-(E) of this rule, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall process the claim and, if applicable, pay the Division's allowable rate for these services and seek reimbursement from the liable third-party insurance plan;
(G) In making the decision to bill the Division, the provider shall be cognizant of the possibility that the third-party payer may reimburse the service at a higher rate than the Division and that once the Division makes payment, no additional billing to the third party is permitted by the provider.
(e) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation shall 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 shall be billed to Medicare first;
(f) In the case of known third-party coverage, a provider may bill the Division if payment from the third-party coverage is not received within 30 days. If a payment is received from the third-party coverage after receiving the Division payment, the provider shall do the following within 30 days of receiving the payment:
(A) Submit an Individual Adjustment Request (OHP 1036) that shows the amount of the third-party payment as a credit in the appropriate field; or
(B) Submit a claim adjustment online at https://www.or-medicaid.gov/ProdPortal/ that shows the amount of the third-party payment as a credit in the appropriate field; or
(C) Refund the amount paid by the Division. The amount refunded shall be the lesser of the third-party payment or the amount paid by the Division. The check to repay the Division shall include the reason the payment is being made and either:
(i) An Individual Adjustment Request that identifies the original claim, name and number of the client, date of service, and items or services for which the repayment is made; or
(ii) A copy of the Remittance Advice showing the original Division payment.
(D) Failure to submit the Individual Adjustment Requests within 30 days of receipt of the third-party payment or to refund the Division payment is considered concealment of material facts and is grounds for recovery and sanction;
(E) Any provider who accepts payment from a client or client's representative and is subsequently paid for the service by the Division shall reimburse the client or their representative the full amount of their payment.
(g) If the third-party coverage is not known by the Division or the provider at the time the Division makes payment, a provider may not return the Division payment in order to bill the third-party coverage if the third-party coverage becomes known after the Division payment;
(h) The Division may make a claim against any third-party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursuing alternate resources includes but is not limited to requesting the provider to bill the third party and to refund the Division in accordance with this rule;
(i) For services provided to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment, except as noted in OAR 410-141-3565, and the provider shall honor that request. Claims submitted to Medicare shall include the Medicaid information necessary to enable electronic crossover to the Authority or contracted health plan. Under federal regulation, a provider may not charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite

being requested to do so;
(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals shall be timely pursued, and Medicare denial must be obtained prior to submitting the claim for payment to the Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.
(11) Full use of alternate resources:
(a) The Division shall generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;
(b) Except as provided in section (12) of this rule, alternate resources may be available:
(A) Under a federal or state worker's compensation law or plan;
(B) For items or services furnished by reason of membership in a prepayment plan;
(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity such as:
(i) Armed Forces Retirees and Dependents Act (CHAMPVA);
(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); or
(iii) Medicare Parts A and B.
(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or
(E) Through other reasonably available resources.
(12) Exceptions:
(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 410-146-0020, Indian Health Services facilities and Tribal facilities operating under Public Law 93, Section 638 agreement are payers of last resort and are not considered an alternate resource or TPL;
(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service-related conditions and as such are not considered an alternate or TPL.
(13) Table 120-1280 – TPR codes.
(14) Table – OHP Client Agreement to Pay for Health Services, OHP 3165, 3166 or 4109.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065, 414.066

Table 120-1280 – Third Party Resource (TPR) Explanation Codes

Use in Field "9" on the CMS-1500

Single Insurance Coverage Use when the client has only one insurance policy in addition to DMAP coverage.	
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Cancelled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Client
RP	Requested Information Not Received by Insurance from Policy holder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance mandated under administrative/court order through an absent parent not paid within 30 days
OT	Other (if above codes do not apply, include detailed information of why no TPR payment was made)
Multiple Insurance Coverage Use when the client has more than one insurance policy in addition to DMAP coverage.	
MP	Primary Insurance Paid-Secondary Paid
SU	Primary Insurance Paid - Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid - Secondary Service Not Covered
SC	Primary Insurance Paid - Secondary Patient Not Covered
ST	Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
SL	Primary Paid - Secondary Lapsed or Not in Effect
SP	Primary Paid - Secondary Payment Went to Patient
SH	Primary Paid - Secondary Payment Went to Policyholder
SA	Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
SE	Primary Paid - Secondary Denied - Service Not Considered Emergency
SF	Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Paid - Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed information of why no TPR payment was made)

OHP Client Agreement to Pay for Health Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay for service(s) not covered by the Oregon Health Plan (OHP), the Oregon Health Authority (OHA) or OHA-contracted managed care entities (MCEs).

Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the person providing the service)* ☐ Prescribing provider

☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider:

② Services requested. These include, but are not limited to, treatment, equipment, supplies and medications.

Service codes *(CDT/CPT/HCPCS/NDC)*:

③ Expected date(s) of service *(if services will occur over several months, please say how often, with start and end dates):*

④ Condition being treated:

⑤ Estimated fees $ To $. *Check one of the following statements about these fees:*

☐ There are no other costs that are part of the service(s).

☐ There may be other costs. You may have to pay for them, too. Other costs may be for (*check all that apply):*

☐ Lab ☐ X-ray ☐ Hospital ☐ Anesthesia ☐ Other:

⑥ ☐ As the rendering or prescribing provider:

- I tried all reasonable covered treatments for your condition.
- I confirmed that the proposed service(s) are not covered for your condition.
- I informed you of covered treatments for your condition, and you chose a treatment that is not covered.

☐ As any other provider *(check one of the following statements):*

☐ I understand that your provider has talked with you about other choices and completed a separate *Agreement to Pay* form.

☐ Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: NPI:

Provider signature: Date:

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand the following, and still choose to get the service(s) listed above:

- The services listed above are not covered for payment by OHP or my plan.
- If I get the services I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- My other options, which are written on the back of this form and were explained by my provider.
- The medically appropriate treatment I can have, including services that OHA or my MCE may pay for.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.

Attention OHP Client – Read this information carefully before you sign.

Before you sign you should be sure each service is not covered by OHP or your coordinated care organization (CCO) or managed care plan. Here are some things you can do:

① ***Check to make sure the service is not covered***

OHA, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and or Hearing***

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.

OHP Client Agreement to Pay for Pharmacy Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000, for the following prescription:

① **Dispensing pharmacy's contact information:**

NPI: Address: Phone number:

② **Prescription information:**

Rx number: Drug name: Quantity/day supply:

NDC: Date dispensed: Billed amount:

③ **Client information:**

Name: Date of birth: Client ID:

The client agrees to pay for this prescription, for one of the reasons listed below. **Please complete ONE of these sections:**

I. Medication is not covered by the Oregon Health Plan

☐ Pharmacy representative:

- I have confirmed that the Oregon Health Plan (OHP) does not cover this prescription.
- I have confirmed that the billed amount listed above is no greater than our usual and customary rate.

☐ Client:

- I understand that because OHP does not cover this prescription, the Oregon Health Authority (OHA) or my coordinated care organization (CCO) cannot pay for it.
- I understand that if I get this prescription, I agree to pay the costs and will not be paid back.
- I have read the back of this form and understand my other options. I still choose to get this prescription.

II. Medication requires prior approval

☐ Pharmacy representative:

- I have confirmed that OHP will only cover this prescription if approved by OHA or the CCO.
- I have confirmed that this prescription does not qualify for an emergency temporary supply.
- I have confirmed that the billed amount listed above is no greater than our usual and customary rate.
- I understand the pharmacy must refund the billed amount to the client if OHP pays for this prescription later.

☐ Client:

- I understand that OHA or my CCO has to approve this prescription before OHP can cover it.
- I understand that if I get this prescription now, I agree to pay the costs.
- I understand that if OHA or my CCO approves the prescription, I can ask the pharmacy to bill OHP.
- I understand that the pharmacy will repay me only if OHP pays for the prescription.
- I have read the back of this form and understand my other options. I still choose to get this prescription.

III. Client wants to pay for a covered medication

☐ Pharmacy representative:

- I have confirmed that OHP will cover this prescription, but the client does not want it billed to OHP.

☐ Client:

- I understand that OHP can cover this prescription. I do not want this prescription billed to OHP.
- I understand that if I get this prescription, I will pay the costs and will not be paid back.
- I understand that I am paying the pharmacy's usual and customary charge, which is higher than what OHP would pay.
- I have read the back of this form and understand my other options. I still choose to get this prescription.

Both the client and pharmacy representative must read and sign the back of this form, and keep a copy for their records. Pharmacies must keep completed forms on file for at least five years.

Attention OHP client – Read this information carefully before you sign.

Before you sign, make sure that the Oregon Health Plan (OHP) does not cover the prescription. If OHP does not cover the prescription, the Oregon Health Authority (OHA) or your coordinated care organization (CCO) cannot pay for it. Here are some things you can do:

Make sure the service is not covered
If the prescription must be approved by OHA or your CCO, you will get a Notice of Action – Benefit Denial (NOABD) if the prescription cannot be approved. This Notice explains why the prescription was not approved. It also explains how you can ask OHA or your CCO to change the decision by asking for an Appeal or Hearing.

- If you did not receive a Notice of Action, ask OHA or your CCO to send you one.
- Read the Notice of Action carefully. It will also give you information about how to ask for an Appeal or Hearing.

If you also have Medicare, you may have other Appeal rights. Call 800-Medicare (800-633-4227) or TTY 711.

If you have Medicare, see if your Medicare Part D plan covers the prescription
If you need help with Medicare Part D, call Oregon's Medicare Medication Assistance (MMA) line at 877-585-0007.

Check to see if there are other ways to get the prescription

- Ask your provider if they have tried all other covered medications that could treat your condition.
- There may be service organizations, free clinics, county health departments, prescription assistance programs, and manufacturer's coupons or discounts that might help you pay for it.
- Will your OHP benefits, or any other health insurance, change soon? If so, try to find out if they will cover the prescription.

Questions?

- Call your CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-699-9075, TTY 711.
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are in OAR 410-120-1280, Billing; 410-120-1360, Requirements for Financial, Clinical and Other Records; and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.

Signatures

Pharmacy representative's signature _____ Date _____

Pharmacy representative's name: _____

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* _____ Date _____

If signed by the client's representative, print their name here: _____

You can get this form in another language, large print, or another way that is best for you. Call 800-699-9075 (TTY 711).

OHP Client Agreement to Pay for Planned Community (Out-of-Hospital) Birth Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay for Planned Community (out-of-hospital) birth services that the Oregon Health Authority (OHA) did not approve for Oregon Health Plan (OHP) coverage by OHA or the member's OHA-contracted coordinated care organization (CCO). OHA did not approve these services because the client's pregnancy is not low-risk as defined in OAR 410-130-0240(4) and Prioritized List Guideline Note 153.

Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the provider who is providing the service)* ☐ Freestanding birth center

☐ Other provider:

②	**Services requested**	**CPT/HCPCS/NDC codes**	**Estimated fees**
☐	Global maternity care (prenatal care, birth, postpartum care)		
☐	Associated supplies		
☐	Birth attendant (second midwife when applicable)		
☐	Newborn exam		
☐	Birth center facility fees		
☐	Other:		

③ Expected date(s) of service *(start/end dates):* Expected due date:

④ Check one of the following statements about the estimated fees:

☐ There are no other costs.

☐ There may be other costs. You may have to pay for them, too. Other costs may be for (*check all that apply):*

☐ Lab ☐ Ultrasound ☐ Hospital ☐ Anesthesia ☐ Other:

⑤ ☐ As the rendering or prescribing provider:

- I submitted all information required to request OHA approval of planned community (out-of-hospital) birth coverage.
- I confirmed that OHA will not cover a planned community (out-of-hospital birth) for this pregnancy.
- I informed you these services would be covered if provided in a hospital setting, but not in a community setting, and you still choose to receive these services outside the hospital setting.
- I cannot bill for more than the amount OHA or the CCO would pay, as required by OAR 410-120-1280.

Provider name:

National Provider Identifier (NPI):

Provider signature: Date:

Client — Keep a copy of this form for your records.

Attention OHP Client — Read this information carefully before you sign.

Before you sign you should be sure each service is not covered by OHP or your CCO. Here are some things you can do:

① ***Check to make sure the service is not covered***

OHA, your CCO or your plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an appeal and or hearing***

Once you have a Notice of Action, you can request an appeal or hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider:

- If they have tried all other covered options available for treating your condition, and
- If there is a hospital, medical school, service organization, free clinic or county health department that might provide this service or help you pay for it.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers — such as hospital, anesthesia, therapy or laboratory services — that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's customer service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand the following, and still choose to get the service(s) listed above:

- Planned community (out-of-hospital birth services) are not covered for this pregnancy by OHP, OHA or my coordinated care organization (CCO). This means that no coverage will be provided and I may be responsible to pay for community birth services out of pocket, at a rate not to exceed what OHA or the CCO would pay if they had provided coverage.
- These services would be covered if provided in a hospital. I still choose to receive these services outside a hospital, knowing that I may have to pay for these services out of pocket.
- If I receive community birth services, I will receive bills for the community birth services provided. I understand that I may have to pay for the services that have been provided.
- I have other options concerning receiving community birth services and/or coverage for these services as explained on the back of this form in sections 1-5 and as explained by my provider.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and is good only for the current pregnancy at the time of the member's signature.

Attention provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.

AMEND: 410-121-0147

RULE TITLE: Exclusions and Limitations

RULE SUMMARY: Changes to end date the Citizenship Waived medical program.

RULE TEXT:

(1) The following items are not covered for payment by the Division of Medical Assistance Programs (Division) Pharmaceutical Services Program:

(a) Drug products for diagnoses below the funded line on the Health Services Commission Prioritized List or an excluded service under Oregon Health Plan (OHP) coverage;

(b) Home pregnancy kits;

(c) Fluoride for individuals over 18 years of age;

(d) Expired drug products;

(e) Drug products from non-rebatable manufacturers, with the exception of selected oral nutritionals, vitamins, and vaccines;

(f) Active Pharmaceutical Ingredients (APIs) and Excipients as described by Centers for Medicare and Medicaid (CMS);

(g) Drug products that are not assigned a National Drug Code (NDC) number;

(h) Drug products that are not approved by the Food and Drug Administration (FDA);

(i) Drug products dispensed for Citizenship Waived Medical (CWM) client benefit type except when prescribed as an emergency medical service as defined by OAR 410-134-0003(3). The CWM benefit plan ends on June 30, 2023.

(j) Drug Efficacy Study Implementation (DESI) drugs (see OAR 410-121-0420);

(k) Medicare Part D covered drugs or classes of drugs for fully dual eligible clients (see OAR 410-121-0149, 410-120-1200 & 410-120-1210).

(2) Effective on or after April 1, 2008, Section 1903(i) of the Social Security Act requires that written (nonelectronic) prescriptions for covered outpatient drugs for Medicaid clients be executed on a tamper-resistant pad in order to be eligible for federal matching funds. To meet this requirement, the Division shall only reimburse for covered Medicaid outpatient drugs only when the written (nonelectronic) prescription is executed on a tamper-resistant pad, or the prescription is electronically submitted to the pharmacy.

(3) Drugs requiring a skilled medical professional for safe administration will be billed by the medical professional's office; unless otherwise specified by the Division.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-123-1540

RULE TITLE: Healthier Oregon Dental Benefits

RULE SUMMARY: Changes to end date the Citizenship Waived medical program, renumbered.

RULE TEXT:

(1) The CWM and CWX benefit plan ends on June 30, 2023, see OAR 410-134-0003(3) for benefit coverage and limitations.

(2) CWM and CWX services delivered before June 30, 2023 are eligible for billing, see OAR 410-134-0004 for billing guidance.

(3) As of July 1, 2023, Healthier Oregon members are eligible for:

(a) Emergency-Only Health Benefits, see OAR 410-120-0000(91), for dental services provided in an emergency department or hospital setting; and

(b) State Funded Supplemental Health Benefits OAR 410-120-0000(238) for dental services equal to OHP coverage. OAR 410-123-1220

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-125-0230

RULE TITLE: Qualified Directed Payments

RULE SUMMARY: Changes to end date the Citizenship Waived medical program

RULE TEXT:

Qualified Directed Payments (QDP) are payments made by the Oregon Health Authority (Authority) to Coordinated Care Organizations (CCOs) from three Quality and Access pools for distinct provider classes: one for Rural Type A and Type B hospitals; one for Public Academic Health Centers; and one for DRG hospitals. Each provider class is defined in §438.6(c) Preprint forms approved by the U.S. Department of health and Human Services Centers for Medicare and Medicaid Services. QDPs are tied to inpatient and outpatient encounters by Medicaid and Children's Health Insurance Program (CHIP) members enrolled in a Coordinated Care Organization except for encounters for eligible Citizenship Waived Medical (CWM) or CWM Plus Services Healthier Oregon benefit plan as defined in 410-134-0003(3)

(1) Type A and Type B hospitals:

(a) The Authority shall make a qualified directed payment only if the Type A or Type B hospital meets criteria established by the Authority for the Type A or Type B hospital Quality and Access program in accordance with applicable federal requirements, which may be updated as needed.

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;

(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access funds;

(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be distributed to each CCO and each Type A and Type B hospital;

(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;

(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

(2) Public Academic Health Centers:

(a) The Authority shall make a qualified directed payment only if the public academic medical center meets criteria established by the Authority for the Public Academic Medical Center Quality and Access program in accordance with applicable federal requirements, which may be updated as needed.

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;

(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;

(e) The Authority shall combine the weekly encounters into a monthly report to assist CCOs in distributing the funds to the appropriate hospital. The report shall be distributed to each CCO and public academic health center;

(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by each public health center for the amount indicated on the report;

(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

(3) Diagnosis Related Grouper (DRG) Hospitals:

(a) The Authority shall make a qualified directed payment only if the DRG Hospital meets criteria established by the Authority for the DRG Hospital Quality and Access Pool program in accordance with applicable federal requirements, which may be updated as needed.

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(c) QDP amounts shall be at two separate rates. One for inpatient encounters and one for outpatient encounters;

(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;
(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be distributed to each CCO and each DRG hospital;
(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.
(4) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

AMEND: 410-134-0000

RULE TITLE: Purpose

RULE SUMMARY: Defines purpose of the Healthier Oregon program Emergency-Only Health Benefits and State Funded Supplemental Health Benefits. Renumbered.

RULE TEXT:
The rules in OAR Chapter 410, division 134 are specific to the Healthier Oregon program Emergency-Only Health Benefits and State Funded Supplemental Health Benefits to provide benefits equal to OHP including:
(1) Emergency-Only Health Benefits described in OAR 410-134-0003(2)(a)(C)(i)(I-VIII) and OAR 410-134-0003(2)(b)(C)(ii);
(2) State Funded Supplemental Health Benefits described in OAR 410-134-0003(2)(a)(C)(ii)(I-VII);
(3) Healthier Oregon benefit for pregnant and post-partum people described in OAR 410-134-0003(2)(b).
(4) Healthier Oregon Cover All Kids Emergency-Only Health Benefits and State Funded Supplemental Health Benefits. OAR 410-134-0003(2)(c).

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.025, 414.065, 414.231, 414.312, 414.430, 414.432, 414.706

AMEND: 410-134-0001

RULE TITLE: Acronyms and Definitions

RULE SUMMARY: Updates to acronyms and definitions, renumbered.

RULE TEXT:

(1) The following acronyms and definitions within this rule specifically are used within the Healthier Oregon program in its entirety.

(a) The Authority incorporates acronyms and definitions in OAR 410-141-3500, OAR 410-120-0000 and OAR 410-200-0015;

(b) The administrative rules for the Department of Human Services (Department) chapter 411, 413, and 461;

(c) Public Health Division chapter 333 division 4 definitions;

(d) Behavioral Health Division chapter 309 division 19 definitions.

(2) Behavioral Health "Crisis" means an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is acutely disrupted, and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care or death OAR 309-019-0105(49).

(3) "Citizenship Waived Medical" (CWM) means Emergency-Only Medical Benefits for individuals who prior to June 30, 2023, met the financial and non-financial eligibility requirements for an HSD Medical Program, except they did not meet citizenship or non-citizen status requirements (OAR 410-200-0240).

(4) "Healthier Oregon Cover All Kids (CAK)" means recipients who are age 18 or younger, and eligible for the Healthier Oregon Cover All Kids program.

(5) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant person, the health of their pregnancy) in serious jeopardy, serious impairment to bodily functions, serious dysfunction, or serious disfigurement that could lead to serious dysfunction, of any bodily organ or part. An emergency medical condition is not based on the final diagnosis, but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. OAR 410-120-0000(90)

(6) "Emergency-Only Health Benefits" means Emergency Medical Conditions defined in OAR 410-134-0003(2)(a)(D)(i-viii) and 410-134-0003(2)(b)(ii) eligible for Medicaid match. OAR 410-120-0000(91), (42 CFR 440.255)

(7) "Heathier Oregon" means Emergency-Only Health Benefits and State Funded Supplemental Health Benefits, provide benefits equal to OHP; for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD or OSIPM Medical Program, except they do not meet citizenship or non-citizen status requirements OAR 410-200-0240 and OAR 461-101-0010.

(8) "Healthier Oregon non-pregnant Adult" means recipients who are not pregnant or within their 12 month post-partum period, age 19 and older, and eligible for the Healthier Oregon program.

(9) "Healthier Oregon Pregnant Adult" means recipients who report pregnancy to the Authority and are within their 12 month post-partum period, age 19 and older, and eligible for the Healthier Oregon program.

(10) "Reproductive Health Equity Act (RHEA)" means state funding, which provides access to reproductive health and abortion services to Oregonians who are able to get pregnant and who maybe eligible for medical assistance if not for 8 U.S.C. 1611 or 1613 OAR 333-004-3010(40).

(11) "State-Funded Supplemental Health Benefits" means benefits defined in 410-134-0003(2)(a)(E)(i-vii).

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 414.025, 414.231, 414.312, 414.430, 414.432, 414.706

SUSPEND: 410-134-0002

RULE TITLE: Determining When A Client Has Medical Assistance

RULE SUMMARY: This section shall be omitted from rule.

RULE TEXT:

(1) The Medical Card has the client's name as listed with the OHP and their alpha-numeric prime number.

(2) Eligibility may change monthly. In some instances, eligibility will change during the month. Eligibility should be verified each time services are provided to assure that the client is eligible for date(s) of service (see OAR 410-120-1140).

(3) Providers must verify the client's eligibility on the date of service, regardless of if the client is anticipated to have PHP, CCO, FFS, or no Medicaid coverage. It is not required but recommended to print the client's eligibility verification to include within the client's chart.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042

AMEND: 410-134-0003

RULE TITLE: Healthier Oregon And State Funded Supplemental Health Benefits

RULE SUMMARY: Defines Healthier Oregon benefit packages, renumbered.

RULE TEXT:

Healthier Oregon Emergency-Only And State Funded Supplemental Health Benefits

(1) The Healthier Oregon benefit package description, benefits package identifier, eligibility criteria, coverage of Emergency-Only Health Benefits and State-Funded Supplemental Health Benefits, funding and coverage are identified in these rules.

(2) Benefit package descriptions:

(a) Healthier Oregon non-pregnant Adult:

(A) Benefit Package identifier BMH;

(B) Eligibility criteria: Eligible recipients are individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD or OSIPM Medical Program, except they do not meet the citizenship and or noncitizen status requirements pursuant to OAR 410-200-0240;

(C) Coverage includes:

(i) Emergency-Only Health Benefits:

(I) Services to treat Emergency Medical Conditions as defined by 42 CFR 440.255 and OAR 410-134-0001(4). The Healthier Oregon Desk Reference located at https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-CWM.aspx defines claims the Authority determines an emergency;

(II) Labor and Delivery;

(III) Behavioral health “Crisis”, as defined in OAR 410-134-0001(2);

(IV) Outpatient dialysis to treat acute renal failure or end stage renal disease (ESRD);

(V) Office visits and labs to prescribe and monitor immunosuppressant medications post kidney transplant;

(VI) Cancer treatment;

(VII) Dental services provided in an emergency department or hospital setting;

(VIII) Covid 19 coverage shall be equal to the coverage available during the Federal Public Health Emergency (PHE) and shall end May 11, 2024.

(ii) State-Funded Supplemental Health Benefits include:

(I) Abortion services;

(II) Sterilization;

(III) Family Planning;

(IV) Organ Transplants OAR 410-124-0010;

(V) Pharmacy benefits equal to OHP Plus coverage and limitations in OAR 410-121-0030 and 410-121-0040;

(VI) Dental services equal to OHP coverage in OAR 410-123-1220;

(VII) OHP Plus coverage and limitations in OAR 410-120-1280.

(b) Healthier Oregon pregnant Adult:

(A) Benefits Package identifier code BMH or BMP;

(B) Eligible clients are pregnant people and people within twelve (12) months following the end of pregnancy who are age 19 and older, not eligible for other Medicaid programs because these individuals do not meet the citizen and immigration status requirement pursuant to OAR 410-200-0215;

(C) Coverage includes:

(i) Emergency-Only Health Benefits OAR 410-134-0003(2)(a)(C)(i)(I-VIII);

(ii) Children Health Insurance Program (CHIP) coverage equal to OHP Plus OAR 410-120-1280;

(iii) State-Funded Supplemental Health Benefits OAR 410-134-0003(2)(a)(C)(ii)(I-VII);

(iv) Post-Partum coverage for twelve (12) months beginning the day after pregnancy ends.

(c) Healthier Oregon Cover All Kids (CAK):

(A) Benefit Package identifier code BMH;
(B) Eligible clients are age 18 or younger, who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, except they do meet the citizenship and or noncitizen status requirements pursuant to OAR 410-200-0240;
(C) Coverage includes:
(i) Emergency-Only Health Benefits OAR 410-134-0003(2)(a)(C)(ii)(I-VIII);
(ii) State-Funded Supplemental Health Benefits OAR 410-134-0003(2)(a)(C)(ii)(I-VII).
(3) Citizenship Waived Medical (CWM) and CWM Plus benefits for members eligible or found retroactively eligible until June 30, 2023. Benefit coverage and limitations can be found under DMAP 65-2002, adopt file 06/30/2022, effective 07/01/2023.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 414.025, 414.231, 414.312, 414.430, 414.432, 414.706

AMEND: 410-134-0004

RULE TITLE: Billing

RULE SUMMARY: Changes reference billing guidance for claims prior to the Citizenship Waived Medical end date, renumbered.

RULE TEXT:
Citizenship Waived Medical (CWM) and CWM Plus services delivered before June 30, 2023 are eligible for billing. CWM and CWM plus billing guidance can be found under DMAP 13-2023, minor correction filed 03/30/2023, effective 03/30/2023.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 414.025, 414.231, 414.312, 414.430, 414.432, 414.706

AMEND: 410-136-3020

RULE TITLE: General Requirements for NEMT

RULE SUMMARY: Changes reference coverage for the Citizenship Waived Medical end date.

RULE TEXT:

(1) The Authority may enroll governmental transportation brokerages (local units of government) or other entities to arrange rides and pay subcontractors for NEMT services. The Authority may limit the enrollment with brokerages to units of local government;

(2) For purposes of the rules (OAR 410-136-3000 through 410-136-3360), "subcontractor" means the individual or entity with which the brokerage subcontracts or employs to drive the client to and from Oregon Health Plan (OHP) covered medical services;

(3) The brokerage shall:

(a) Prior authorize and pay subcontractors for the least costly but most appropriate mode of transport for the client's medical needs to and from an OHP covered medical service. The most appropriate and least costly ride may include requiring the client to share the ride with other clients;

(b) Verify that the client is obtaining OHP covered medical services in the client's local area. "Local area" means an area within the accepted community standard and includes the client's metropolitan area, city, or town of residence;

(c) Verify the client's OHP eligibility and that the client's benefit package includes NEMT services. The brokerage shall verify this through electronic eligibility information;

(d) Assess the client's access to other means of transportation, such as driving their own car or getting a ride from a family member or neighbor;

(e) Verify the client's attendance for continuing requests for rides if the medical provider could not affirm an appointment for a previous ride;

(f) Schedule a ride with an alternate subcontractor if the subcontractor originally assigned is unable to provide the ride; and

(g) Assign rides based on an evaluation of several factors including, but not limited to:

(A) Cost;

(B) The client's need for appropriate equipment and transportation;

(C) Any factors related to a subcontractor's capabilities, availability, and past performance; and

(D) Any factors related to the brokerage's need to maintain sufficient service capacity to meet client needs.

(4) Pursuant to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System, clients receiving the following benefit packages are not eligible for NEMT:

(a) Citizenship Waived Medical (CWM) until the Citizenship Waived Medical program coverage limitations ends in accordance with OAR 410-134-0003(3);

(b) Qualified Medicare Beneficiary (QMB) only.

(5) The brokerage shall maintain records of the reasons for authorizing a ride:

(a) That is not cost effective or not based on the factors specified in section (3) of this rule;

(b) With more than two attendants for an ambulance or stretcher car; or

(c) With more than one attendant for a wheelchair van.

(6) The brokerage shall provide a ride to a client to fill prescription medication only in the following situation:

(a) The client needs to stop on the way home to fill or pick up prescribed medication related to the medical service for which the brokerage provided the ride;

(b) It is medically necessary to fill or pick up the medication immediately; and

(c) The pharmacy is located on the return route or is the closest pharmacy to the return route.

(7) The brokerage may provide a ride to a client to fill prescribed medication under the following situations:

(a) The brokerage asks the client if the prescription service is available through the Authority's contracted postal prescription service, and the client responds that it is not available through that source;

(b) The client has an urgent need to fill or pick up prescribed medication because the postal prescription service mailed the wrong medication, or the client has an unexpected problem caused by the medication; or
(c) The client is transient or without regular access to a mailbox. In this situation, the brokerage may evaluate the need on a case-by-case basis.
(8) The brokerage shall provide rides outside the brokerage's local service area as described in section 3(b) of this rule, under the following circumstances:
(a) The client is receiving an OHP covered medical service that is not available in the service or local area but is available in another area of the state;
(b) The client is receiving a covered service in California, Idaho, or Washington where the service location is no more than 75 miles from the Oregon border; or
(c) No local medical provider or facility shall provide OHP covered medical services for the client.
(9) Brokerages may coordinate to provide a return ride to a client who receives medical services outside the client's local area.
(10) Brokerages shall retroactively authorize and pay for NEMT services that have already occurred only when the brokerage could not prior authorize the service because the brokerage was closed, and the request for authorization is within 30 days of the date of service. The brokerage also must confirm that one of the following circumstances supported the ride:
(a) The eligible client needed urgent medical care;
(b) The eligible client required secured transport pursuant to OAR 410-136-3120, Secured Transports; or
(c) The client was in a hospital, and the hospital discharged or transferred the client.
(11) Notwithstanding section (10) of this rule, a brokerage shall retroactively authorize NEMT services for ambulance transports when:
(a) An ambulance provider responds to an emergency call, but the client's medical condition does not warrant an emergency transport;
(b) The ambulance provider transports the client as a NEMT service; and
(c) The ambulance provider requests retroactive authorization within 30 days of the NEMT service.
(12) Brokerages shall not authorize or pay for rides outside their service areas based only on client preference or convenience.
(13) Brokerages shall provide toll-free call centers for clients to request rides. The following pertain to the brokerage's call center and scheduling of rides:
(a) The call center shall operate at a minimum Monday through Friday from 9:00 a.m. to 5:00 p.m., but the brokerage may close the call center on New Year's Day, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the brokerage requests the closure at least 30 days in advance.
(b) Brokerages shall make all reasonable efforts for clients to have access to available NEMT services 24 hours a day. When the call center is closed, the brokerages shall provide a recording or answering service to refer the client directly to a subcontractor. If no subcontractor is available, the brokerage must provide clients with recorded information about service hours and how to reach emergency services by calling 911;
(c) The brokerage shall allow a client to schedule rides at least 30 days in advance of the medical service; and
(d) The brokerage shall allow a client to request multiple ride requests at one time.
(e) The brokerage shall develop procedures and make reasonable efforts to arrange a ride requested on the day of the medical service when the medical service is:
(A) For an urgent medical condition; and
(B) Due to the urgency of the medical condition, the client scheduled an immediate medical appointment.
(14) The brokerage is not responsible for providing emergency medical transportation services. However, brokerages shall have procedures for referring clients requesting emergency medical transportation services to the appropriate emergency transportation resources and procedures for subcontractors per OAR 410-136-3040, Vehicle Equipment

and Subcontractor Standards.
(15) The Authority shall collaborate with brokerages and CCOs to develop and conduct a statewide client satisfaction survey at least once every two years. The Authority may contract with one or more brokerages to conduct the survey. The Authority shall use the results of the survey to identify and address potential operational deficiencies and to identify and share successes in the NEMT program.
(16) Brokerages shall establish regional advisory groups consisting of representatives from the Authority, DHS, Area Agencies on Aging, consumers, representatives of client advocacy groups from within the service or local area, brokerage subcontractors, and providers of NEMT ambulance services. The role of the group includes, but is not limited to:
(a) Assisting in monitoring and evaluating the NEMT program; and
(b) Recommending potential policy or procedure changes and program improvements to brokerages and the Authority and assisting in prioritizing those changes and improvements.
(17) Brokerages shall have the discretion to use or not use DHS-approved volunteers. DHS shall provide brokerages with a list of approved and trained volunteers. DHS shall supervise the volunteers and assumes all liability for each volunteer as provided by law.
(18) Brokerages or their subcontractors shall not bill eligible clients for any transports to and from OHP covered medical services or any transports where the Authority denied reimbursement.
(19) On a minimum of five percent of the ride requests, brokerages shall contact medical providers to verify appointments and that the appointments are for OHP covered medical services.
(20) Brokerages may purchase tickets for common carrier transportation, such as inter- or intra-city bus, train, or commercial airline when deemed cost effective and safe for the client.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-200-0240

RULE TITLE: Citizenship Waived Medical and Healthier Oregon Benefits

RULE SUMMARY: Changes to end date the CWM program and expand eligibility for Healthier Oregon to all ages, renumbered.

RULE TEXT:

(1) Citizenship Waived Medical (CWM):

(a) CWM benefits provide coverage for emergency services OAR 410-134-0003(3).

(b) Through June 30, 2023, to be eligible for CWM benefits, an individual must:

(A) Be age 26 or older and under age 55; and

(B) Meet all eligibility requirements for a Health Systems Division (HSD) Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).

(2) Citizenship Waived Medical Plus (CWM Plus):

(a) CWM Plus benefits provide full coverage for pregnant individuals.

(b) Individuals receiving CWM Plus benefits shall maintain CWM Plus coverage through the protected eligibility period OAR 410-200-0135.

(c)Through June 30, 2023, to be eligible for CWM Plus benefits, an individual must:

(A) Be age 26 or older and under age 55;

(B) Be pregnant; and

(C) Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).

(3) Healthier Oregon:

(a) Healthier Oregon benefits include Cover All Kids and are equivalent to OHP Plus benefits.

(b) For individuals age 19 and older, to be eligible for Healthier Oregon benefits, an individual must:

(A) Through June 30, 2023:

(i) Be age 19 through age 25; or

(ii) Be age 55 or older; and

(iii) Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).

(B) Effective July 1, 2023, meet all eligibility requirements for an HSD Medical Program, except they do not meet the citizenship and non-citizen status requirements (OAR 410-200-0215), without age restriction.

(c) For individuals age 18 and younger, to be eligible for Healthier Oregon Cover All Kids benefits, an individual must:

(A) Be under the age of 19; and

(B) Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).

STATUTORY/OTHER AUTHORITY: ORS 414.534, ORS 411.060, ORS 411.402, 411.404, 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706