



NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410

OREGON HEALTH AUTHORITY

HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/19/2026 12:14 PM

ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Reorganization and updates to billing rules and the Agreement to Pay form (OHP 3165).

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:

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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026

TIME: 9:00 AM - 9:45 AM

OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS

MEETING URL: [Click here to join the meeting](#)

PHONE NUMBER: 1-669-254-5252

CONFERENCE ID: 1658671365

SPECIAL INSTRUCTIONS:

Meeting ID: 165 867 1365

Passcode: 215425

NEED FOR THE RULE(S):

The Oregon Health Authority is making changes to the billing rules and updates to the Agreement to Pay form (OHP 3165) after receiving feedback from Providers and Members about improvements.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Agreement to Pay form (OHP 3165) <https://sharesystems.dhsoha.state.or.us/DHSForms/Served/he3165.pdf>

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The Oregon Health Authority does not currently collect data that can inform usage rates and impacts of the Agreement to Pay form (OHP 3165) on different community demographics. The Authority does not expect a disproportionate impact to racial equity as a result of this rulemaking or updates to the form.

FISCAL AND ECONOMIC IMPACT:

The Oregon Health Authority does not expect a significant fiscal and economic impact as a result of this rulemaking. There is potential minor impact to Providers, particularly independent Providers, and Members using the Agreement to Pay form (OHP 3165) in the circumstance when the form is not properly used in accordance with the updated rule text and the Provider may be required to refund the Member.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s):

The Oregon Health Authority, Coordinated Care Organizations, Medicaid Fee-for-Service Providers, other enrolled Providers, and OHP Members may be economically impacted by these rules.

(2) Effect on Small Businesses:

(a) Estimate the number and type of small businesses subject to the rule(s):

The Centers for Medicare and Medicaid Services (CMS) and the Oregon Health Authority (OHA) do not currently track the rate of Medicaid enrolled Providers that are also small businesses.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s):

When a Provider uses the Agreement to Pay form (OHP 3165) with a Member, the Provider must keep a copy of the form and document their compliance with OAR 410-120-1350 in the Member's medical record and provide a physical copy of the signed agreement to the Member.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s):

None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-120-1200, 410-120-1280, 410-120-1350, 410-120-1400, 410-120-1460, 410-120-1855, 410-130-0160

AMEND: 410-120-1200

RULE SUMMARY: Update rule citation due to Billing rule changes; changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1200

Excluded Services and Limitations ¶¶

(1) Certain services or items are not covered under any program or for any group of eligible ~~client~~Members. Service limitations are subject to either:¶¶

(a) ~~¶The Health Evidence Review Commission (HERC) OHA Prioritized List of Health Services as referenced in Oregon Administrative Rule (OAR) 410-141-3830 and the individual program chapter 410 OARs; or¶¶~~

(b) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as set forth in chapter 410 Division 151.¶¶

(2) If the ~~client~~Member accepts financial responsibility for a ~~Non-Covered~~Service, payment is a matter between the ~~Provider~~Member and the ~~client~~Member subject to the requirements of OAR 410-120-128350.¶¶

(3) The ~~Health Systems Division (Division) Authority~~ shall make no payment for any expense incurred for services or items that meet any of the following:¶¶

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

(b) Not properly prescribed as required by law or administrative rule by a licensed ~~Practitioner~~ practicing within their scope of practice or licensure;¶¶

(c) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in an extracurricular program or activity not related to the improvement of health and rehabilitation of the ~~client~~Member. Examples include routine drug test used for employment or exams for employment, or life insurance exams; (3)(c) of this rule is not for vaccines, for vaccine eligible coverage see OAR 410-130-0255.¶¶

(d) Provided by friends or relatives of eligible ~~clients or members of his or~~Members or individuals within their household, except when the friend, relative or household member:¶¶

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

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

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

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

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

(g) Related to a ~~Non-Covered~~Service, some exceptions are identified in the individual ~~Provider~~ rules. If the Division determines the provision of a service related to a ~~Non-Covered~~Service is Cost Effective, the related medical service may, at the discretion of the Division and with Division ~~Prior~~Authorization (PA), be covered;¶¶

(h) Considered experimental or investigational, that deviates from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;¶¶

(i) Identified in the appropriate program rules including the Division's Hospital Services program administrative rules, Revenue Codes Section, as ~~Non-Covered~~Services;¶¶

(j) Requested by or for a ~~client~~Member whom the Division has determined to be non-compliant with treatment and

who is unlikely to benefit from additional related, identical, or similar services;¶

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

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

(m) Similar or identical to services or items that shall achieve the same purpose at a lower cost and where it is anticipated that the outcome for the clientMember shall be essentially the same;¶

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

(o) Items or services that are for the convenience of the clientMember and are not ~~m~~Medically or ~~d~~Dentally ~~a~~Appropriate;¶

(p) The collection, processing, and storage of autologous blood or blood from selected donors unless a ~~p~~Physician certifies that the use of autologous blood or blood from a selected donor is ~~m~~Medically ~~a~~Appropriate and surgery is scheduled;¶

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

(r) Outpatient social services except ~~m~~Maternity ~~e~~Case ~~m~~Management services and other social services described as covered in the individual ~~p~~Provider rules;¶

(s) Post-mortem exams or burial costs;¶

(t) Radial keratotomies;¶

(u) Recreational therapy;¶

(v) Telephone calls except for:¶

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

(B) Maternity ~~e~~Case ~~m~~Management as described in OAR 410-130-0595;¶

(C) Telemedicine as described in OAR 410-120-1990; and¶

(D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and substance use disorder procedure code and reimbursement rates published by the ~~Addiction and Ment~~Addiction and Mental Behavioral Health ~~d~~Division.¶

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

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

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

(z) Missed appointments, an appointment that the clientMember fails to keep. Refer to OAR 410-120-1280;¶

(aa) Transportation to meet a clientMember's personal choice of a ~~p~~Provider;¶

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

(cc) Medicare Part D covered prescription drugs or classes of drugs and any cost sharing for those drugs for Medicare-Medicaid Fully Dual Eligible clientMembers, even if the Fully Dual Eligible clientMember is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for ~~b~~Benefit ~~p~~Package;.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065, ORS 414.025

RULE SUMMARY: Remove section (5); add rule text from 410-130-0160 about codes; update attached 3165 form; changing "client" and "recipient" to "Member" or "CCO Member" or "Open Card Member" where appropriate.

CHANGES TO RULE:

410-120-1280

Billing & Codes

(1) A ~~p~~Provider enrolled with the Authority or providing services to a ~~client in a Member in a Coordinated Care Entity (MCE Organization (CCO))~~ under the Oregon Health Plan (OHP) may not seek payment from the ~~client~~Member for any services covered by Medicaid fee-for-service (FFS) or through contracted health care plans; ~~except as authorized by the Authority under this rule. Members may provide private payment for services as described in OAR 410-120-1350.~~

(2) Identification of eligibility and ~~t~~Third-~~p~~Party ~~L~~iability (TPL). The ~~p~~Provider must:

(a) Verify the ~~client~~Member's eligibility for ~~m~~Medical ~~a~~Assistance Programs and ~~b~~Benefit ~~p~~Package prior to rendering service pursuant to OAR 410-120-1140;

(b) Make "reasonable efforts" to identify ~~t~~Third-~~p~~Party ~~r~~Resources as described in section (4)(b) of this rule; and

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

(3) If a ~~p~~Provider's ~~e~~patient is a ~~medical assistance recipient~~Member, the ~~p~~Provider must:

(a) Comply with the provisions in sections (4) through (12) of this rule regarding ~~t~~Third-~~p~~Party ~~r~~Resources;

(b) Submit a claim to the Authority or ~~MCE CCO~~, if no ~~t~~Third-~~p~~Party ~~r~~Resources are available or the ~~p~~Provider has complied with section (2)(a) of this rule;

(c) Delay any billing or collection ~~a~~Action against the ~~client~~Member for ~~ninety (90)~~ calendar days from submitting the ~~v~~Valid ~~e~~Claim to the Authority or ~~MCE CCO~~, except as authorized in section (4) of this rule;

(d) If no payment is received from the Authority or ~~MCE CCO~~ within ~~ninety (90)~~ calendar days from the date a ~~v~~Valid ~~e~~Claim, as defined in (OAR 410-120-0000), was submitted, the Provider must:

(A) Verify the ~~client~~Member's eligibility for the ~~d~~Date of ~~s~~Service;

(B) If the individual was not eligible for ~~m~~Medical ~~a~~Assistance Programs on the ~~d~~Date of ~~s~~Service, proceed with the ~~p~~Provider's normal billing and collection process; or

(C) If the individual was eligible for ~~m~~Medical ~~a~~Assistance Programs on the ~~d~~Date of ~~s~~Service, and the ~~p~~Provider does not have a completed agreement to pay form (OHP 3165, 3166, 4109), the ~~p~~Provider ~~is must not allowed to bill the client~~ bill the individual, collect payment from the ~~client~~individual, 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~~ OAR 410-120-1350.

(4) For Medicaid ~~e~~Covered ~~s~~Services, the ~~p~~Provider must not:

(a) Bill the Authority more than the ~~p~~Provider's Usual Charge ~~(as defined in OAR 410-120-0000)~~ or the reimbursement specified in the applicable Authority program rules;

(b) Bill the ~~client~~Member 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~~Member or the Authority;

(c) Bill the ~~client~~Member for services or treatments that have been denied due to ~~p~~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, or an error in the information or billing codes the provider listed on the claim.

(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 is now unable to 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 to the appropriate payer has passed. The provider shall verify eligibility of the client 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 each attempt 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. The provider shall accept this

payment from the third-party payer as payment in full;¶¶

(d) Citizenship Waived Medical (CWM) Benefits Package recipients prior to June 30, 2023, that received services that are not part of the CWM emergency-only benefits, must have signed the provider-completed Agreement to Pay OHP form 3165, 3166 or 4109. CWM Benefits Package coverage, limitations, and billing guidance found in OAR 410-134-0005.¶¶

(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 agreement to pay form OHP 3165 pursuant to section (5)(h) of this rule before providing these services to the client;¶¶

(f) The client has requested to privately pay for services denied as not meeting the prior authorization, HERC or other criteria. The provider shall provide to the client all required information for a non-covered service 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 client does not have to pay for the requested service because it is covered by the Oregon Health Plan; and¶¶

(B) the provider is not permitted to bill the client more than the amount the appropriate payer may be required to pay; and¶¶

(C) The estimated total cost of the covered service, including all related charges, that the client may have to pay if the client decides to privately pay, which cannot exceed the amount that the appropriate payer (Authority, or MCE, or third-party) may have to pay for the covered service; and¶¶

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

(E) The provider shall document in writing the date and time in the client's medical record that:¶¶

(i) The provider gave the client or the client's authorized representative 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 covered service by signing an agreement to pay form (OHP 3165, 3166, 4109); and¶¶

(iv) The provider must give a copy of the signed and dated agreement to pay form (OHP 3165, 3166, 4109) to the client and keeps a copy of the form in the client's medical record.¶¶

(F) A provider must not submit a claim for payment for covered services to the Authority, the client's MCE, or a third-party payer that is subject to the agreement.¶¶

(h) The service is a non-covered service 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 provider shall provide to the client all of the following:¶¶

(A) The requested service is a non-covered service; and¶¶

(B) The estimated total cost of the non-covered service, including all related charges; and¶¶

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

(D) the provider documents in writing the date and time in the client's record, indicating that:¶¶

(i) The provider gave the client or the client's authorized representative the information described in OAR 410-120-1280 (5)(h)(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 non-covered service by signing an agreement to pay form (OHP 3165, 3166, 4109); and¶¶

(iv) The provider gives a copy of the signed and dated agreement to pay form (OHP 3165, 3166, 4109) to the client and keeps a copy of the form in OAR 410-120-1350. Examples of Provider error could be things such as required documentation not submitted for a Prior Authorization, or a Prior Authorization not submitted, or an error in the client's medical record.¶¶

(E) the client must sign and date the provider-completed agreement to pay form (OHP 3165, 3166, or 4109);¶¶

(i) The completed agreement to pay form (OHP 3165, 3166, 4109) is valid only if the estimated fee for the service or good does not change and the service is scheduled within thirty (30) days of the client's signature. The completed agreement to pay form (OHP 3165, 3166, 4109) is not transferrable to a different service or good. The agreement to pay form (OHP 3165, 3166, 4109) is not valid when this form is used by the provider as a generic agreement by the client to pay for unspecified non-covered services.¶¶

(ii) For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy.¶¶

(iii) Providers must make a copy of the completed agreement to pay form (OHP 3165, 3166 or 4109) available to

the Authority or MCE upon request.¶

(i) For clients agreeing to pay for services under this rule section (5) who are limited English proficient, who are deaf, or hard of hearing, the provider shall provide translation or interpretation services before the client or a financially responsible relative or representative of that client signs the agreement to pay form (OHP 3165, 3166, 4109). This includes but is not limited to providing the following without limitation:¶

(A) Written documents in appropriate languages; and ¶

(B) Interpreter services consistent with OAR 410-120-0001.¶

~~(6) Information or billing codes the Provider listed on the claim.¶~~

(5) 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 ~~p~~Prior ~~a~~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, code guidelines, and parentheticals related to the code. Federal Code Set requirements are mandatory as part of the National Correct Coding Initiative (NCCI), 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 ~~p~~P 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 ~~d~~Date of ~~s~~Service. Providers billing the Authority shall use codes in the appropriate sequence and highest degree of specificity, append the appropriate modifiers, and indicate the appropriate and most specific place of services;¶

(d) Only codes with limitations or requiring ~~p~~Prior ~~a~~Authorization are noted in ~~OAR~~ Oregon Administrative Rule (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 ~~e~~Covered ~~s~~Service by the Authority.¶

~~(7)~~ Claims:¶

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

(b) A ~~p~~P Provider enrolled with the ~~Division~~ Authority shall bill using the Authority assigned ~~p~~P Provider number, or the National Provider Identification (NPI) number-, pursuant to OAR 410-120-1260;¶

(c) The ~~p~~P Provider may ~~not~~ bill the ~~Division~~ Authority more than the ~~p~~P Provider's ~~u~~Usual ~~e~~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~~ Authority program rules or electronically in a manner authorized in OAR ~~C~~chapter 943, ~~D~~division 120;¶

(e) Medicare ~~shall send~~ crossover claims to the Authority or contracted health plan after adjudication by Medicare. When a Provider bills 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 MCECCO;¶

(f) Claims must be for services provided within the ~~p~~P Provider's licensure or certification as required by OAR ~~C~~chapter 410-~~D~~, ~~d~~ivision 120 and program specific rules;¶

(g) Unless otherwise specified, claims shall be submitted after:¶

(A) Delivery of service; or¶

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

(h) The ~~p~~P Provider shall submit true and accurate information when billing the ~~Division~~ Authority. Use of a ~~b~~Billing ~~p~~P Provider does not ~~do away with~~ remove the performing ~~p~~P Provider's responsibility for the truth and accuracy of submitted information;¶

(i) A claim is considered a ~~v~~Valid ~~e~~Claim only if it contains all data required for processing. See the appropriate ~~p~~P Provider rules and supplemental information for specific instructions and requirements;¶

(j) A ~~p~~P Provider or its contracted agency, including ~~b~~Billing ~~p~~P Providers, may not submit or cause to be submitted:¶

(A) Any ~~f~~False ~~e~~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 ~~(40 paragraphs (9)(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~~ Authority. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate ~~Third~~

~~Party Liability (TPL)~~ ~~E~~ Explanation ~~C~~ code;¶

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

(k) If an ~~e~~ Overpayment has been made by the Authority, the ~~p~~ Provider is required to do one of the following:¶

(A) Adjust the original claim to show the ~~e~~ 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 ~~e~~ Overpayment on any claim;¶

(C) Void the claim via the Provider Web Portal if the ~~Division Authority~~ overpaid due to an erroneous billing;¶

(D) If the ~~e~~ Overpayment occurred because of a payment from a ~~Third-Party Payer~~, refer to ~~subsection (402)(f)~~ of this rule.¶

~~(L)~~ 340B covered entities that bill ~~Fee-for-Service (FFS)~~ or a ~~Coordinated Care Organization (CCO) CO~~ shall follow ~~OHA~~ the Authority's 340B policy in order to avoid "duplicate discounts".¶

~~(87)~~ ~~Z~~ Diagnosis code requirement:¶

~~(a) A. The Provider must:~~¶

~~(a)~~ Provide a primary ~~d~~ Diagnosis ~~e~~ Code is required on all claims, using the ICD-10-CM ~~d~~ Diagnosis ~~e~~ Code set, unless specifically excluded in ~~individual Health System Division Authority~~ program rules;¶

~~(b)~~ The primary ~~d~~ Diagnosis ~~e~~ Code shall be the code that most accurately describes the ~~client Member's~~ condition;¶

~~(c)~~ All ~~d~~ Diagnosis ~~e~~ 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.¶

~~(98)~~ Procedure code requirement. ~~The Provider must:~~¶

~~(a)~~ For claims requiring a procedure code, the ~~p~~ Provider shall bill as instructed in the appropriate ~~Division Authority~~ 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;¶

~~(A)~~ Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;¶

~~(B)~~ Effective January 1, 2005, HIPAA regulations prohibit the use of a grace period for codes deleted from CPT or HCPCS. In the past the grace period was from January 1 through March 31;¶

~~(C)~~ Coverage of CPT Category II and Category III codes is subject to the Health Evidence Review Commission's (HERC) OHA Prioritized List of Health Services (Prioritized List). The division may consider reimbursement for any Category III codes that may be determined necessary for the administration of a covered outpatient drug recommended in the Federal Drug Administration (FDA) labeling for that medication.¶

~~(D)~~ Use the most applicable CPT or HCPCS code. Do not fragment coding when services can be included in a single code (see the "Bundled Services" section of OAR 410-130-0160). Do not use both CPT and HCPCS codes for the same procedure. This is considered duplicate billing.¶

~~(b)~~ For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim must be supported by the ~~client Member's~~ medical record and must be the code that most accurately describes the services provided. All Providers, including Hospitals, shall follow national coding guidelines;¶

~~(c)~~ When there is no appropriate descriptive procedure code to bill the ~~Division Authority~~, the ~~p~~ Provider shall use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual ~~p~~ 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 ~~p~~ Provider shall bill the ~~Division Authority~~ using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.¶

~~(402)~~ Third-Party Liability (TPL):¶

~~(a)~~ Federal law (~~42 CFR 433.138~~) requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the ~~Division Authority~~ 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 ~~d~~ Date of ~~s~~ Service by:¶

~~(A)~~ Using an insurance database such as Electronic Verification System (EVS) available to the ~~p~~ Provider;¶

~~(B)~~ Using the Automated Voice Response (AVR) or secure ~~p~~ Provider web portal on each ~~d~~ Date of ~~s~~ Service and at the time of billing;¶

~~(C)~~ Asking the ~~Medicaid recipient member~~ at the point of service or prior to billing if they have other health insurance;¶

~~(D)~~ If the ~~p~~ Provider identifies from the ~~client Member~~ 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 Authority verification systems, the pProvider 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) paragraphs (9)(d)(A)-(E)~~ of this rule, when ~~€Third-pParty~~ coverage is known to the pProvider prior to billing the Division Authority, the pProvider shall:¶

(A) Bill all ~~€Third-pParty~~ insurance the client Member 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 Authority's point-of-sale system, the pProvider shall wait ~~thirty (30)~~ days from submission date of a clean claim and have not received payment from the ~~€Third-pParty~~; 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 pProvider shall bill the TPL prior to billing the Division Authority, except under the following circumstances:¶

(A) The ~~€Covered health-s~~Service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);¶

(B) The ~~€Covered health-s~~Service is provided by institutional services for ~~the mentally and emotionally disturbed individuals experiencing serious mental illness~~;¶

(C) The ~~€Covered health-s~~Services are prenatal and preventive pediatric services;¶

(D) Services are covered by a ~~€Third-pParty~~ insurer through an absent parent where the medical coverage is administratively or court ordered;¶

(E) When a negligent ~~€Third-pParty~~ caused an injury or illness to a client Member, a pProvider may choose to bill the Liability Insurance (~~see Definitions~~), as defined in OAR 410-120-0000, bill the liable ~~€Third-pParty~~, place a lien on a tort settlement or judgement, or bill the Division Authority. The pProvider may not both place a lien against a settlement and bill the Division Authority.¶

(i) The pProvider may withdraw their lien and bill the ~~Division within twelve (Authority within 12)~~ months of the ~~dDate of sService~~; however, the pProvider shall accept the Division Authority payment as payment in full;¶

(ii) The pProvider may not return the payment made by the Division Authority 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) paragraphs (9)(d)(A)-(E)~~ of this rule, the pProvider may choose to bill the primary insurance prior to billing the Division Authority. Otherwise, the ~~Division shall Authority~~ processes the claim and, if applicable, pays the Division Authority's allowable rate for these services and seeks reimbursement from the liable ~~€Third-pParty~~ insurance plan;¶

(G) In making the decision to bill the Division Authority, the pProvider shall be ~~cognizant~~ aware of the possibility that the ~~€Third-pParty pPayer~~ may reimburse the service at a higher rate than the Division Authority and that once the Division Authority makes payment, no additional billing to the ~~€Third-pParty~~ is permitted by the pProvider.¶

(e) The pProvider may bill the Division Authority directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant pProvider rules. Documentation shall be on file in the pProvider's records indicating this is a ~~nNon-€Covered sService~~ for purposes of Third-Party Resources. See the individual pProvider rules for further information on services that shall be billed to Medicare first;¶

(f) In the case of known ~~€Third-pParty~~ coverage, a pProvider may bill the Division Authority if payment from the ~~€Third-pParty~~ coverage is not received within ~~thirty (30)~~ days. If a payment is received from the ~~€Third-pParty~~ coverage after receiving the Division Authority payment, the pProvider shall ~~decomplete~~ the following within ~~thirty (30)~~ days of receiving the payment:¶

(A) Submit an Individual Adjustment Request (OHP 1036) that shows the amount of the ~~€Third-pParty~~ 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-pParty~~ payment as a credit in the appropriate field; or¶

(C) Refund the amount paid by the Division Authority. The amount refunded shall be the lesser of the ~~€Third-pParty~~ payment or the amount paid by the Division Authority. The check to repay the Division Authority 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 Member, ~~dDate of sService~~, and items or services for which the repayment is made; or¶

(ii) A copy of the Remittance Advice showing the original Division Authority payment.¶

(D) Failure to submit the Individual Adjustment Requests within ~~thirty (30)~~ days of receipt of the ~~€Third-pParty~~ payment or to refund the Division Authority payment is considered concealment of material facts and is grounds for recovery and ~~sSanction~~;¶

(E) Any pProvider who accepts payment from a ~~client or client Member or Member's rRepresentative~~ and is subsequently paid for the service by the Division Authority shall reimburse the client Member or their

~~Representative the full amount of their payment.~~

(g) If the ~~Third-Party~~ coverage is not known by the ~~Division Authority~~ or the ~~Provider~~ at the time the ~~Division Authority~~ makes payment, a ~~Provider~~ may not return the ~~Division Authority~~ payment in order to bill the ~~Third-Party~~ coverage if the ~~Third-Party~~ coverage becomes known after the ~~Division Authority~~ payment;

(h) The ~~Division Authority~~ may make a claim against any ~~Third-Party Payer~~ after making payment to the ~~Provider~~ of service. The ~~Division Authority~~ 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 Authority~~ in accordance with this rule;

(i) For services provided to a Medicare and Medicaid dual eligible client, ~~the Division Member, the Authority~~ 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 by the Provider, and Medicare denial must be obtained by the Provider prior to submitting the claim for payment to the ~~Division Authority~~. Medicare denial on the basis of a Provider's failure to submit a timely appeal may result in the ~~Division Authority~~ reducing from the amount of the claim any amount the ~~Division Authority~~ determines could have been paid by Medicare.

~~(140)~~ Full use of alternate resources:

(a) The ~~Division Authority~~ shall generally make payment only when other resources are not available for the ~~client Member's~~ medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in section ~~(121)~~ 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.

~~(121) Exceptions~~ Claims billed by the following Provider types are not addressed by this rule. The billing requirements for these Providers are found in:

(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.

~~(132)~~ Table 120-1280 - TPR codes.

~~(14) Table - OHP Client Agreement to Pay form for Health Services, OHP 3165, 3166 or 4109~~ Third Party Resource (TPR) Explanation Codes.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.066, 42 CFR 433.138, 42 CFR 136.61

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-120-1280.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340838>

AMEND: 410-120-1350

RULE SUMMARY: Add section (5) from 410-120-1280 and clarify; changing "client" and "recipient" to "Member" or "CCO Member" or "Open Card Member" where appropriate.

CHANGES TO RULE:

410-120-1350

~~Buying-Up~~ illing Members ¶

~~(1) Providers are not permitted to bill and accept payment from the Division or a managed care plan for a covered service.¶~~

~~(a) When a non-covered service has been provided~~ This rule references OHP Agreement to Pay forms 3165, 3166, and 4109. All forms provided by the Oregon Health Authority are digitally accessible to the public and continuously available at <https://sharedsystems.dhsoha.state.or.us/forms/>.¶

(1) In accordance with ORS 414.066, Providers are prohibited from initiating or soliciting payment from a Member, except for the specific situations outlined by the Authority in section (2) of this rule.¶

(2) Providers may bill a Member or Representative of that Member in the following situations:¶

(a) The Member did not inform the Provider of their Oregon Health plan (OHP) I.D., Coordinated Care Organization (CCO) 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 is now unable to 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 to the appropriate payer has passed. The Provider shall verify eligibility of the Member at the time of service pursuant to OAR 410-120-1140 and prior to billing or collection pursuant to OAR 410-120-1280 and this rule, and document each attempt to obtain coverage information prior to billing the Member;¶

(b) The Member 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 Member for services provided. The Provider shall accept this payment from the Third-Party Payer as payment in full;¶

(d) The Member has requested a continuation of benefits during the Contested Case Hearing process, and the final decision was not in favor of the Member. The Member 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 agreement to pay form OHP 3165 pursuant to section (2)(g) of this rule before providing these services to the Member;¶

(e) The Member requests to privately pay for a Covered Service. In this situation, the Provider may bill the Member if the Provider confirms and documents that the Member knowingly and voluntarily agrees to pay for the Covered Service, and the Provider informs the Member in advance of all the following:¶

(A) The Member does not have to pay for the requested service because it is covered by the Oregon Health Plan (OHP); and¶

~~(b) Additional payment is sought or accepted from the Division client~~ The Provider is not permitted to bill the Member more than the amount the appropriate payer may be required to pay; and¶

(C) The estimated total cost of the Covered Service, including all related charges, that the Member may have to pay if the Member decides to privately pay, which cannot exceed the amount that the appropriate payer (Authority, or CCO, or Third-Party) may have to pay for the Covered Service.¶

(f) Buying-Up, as defined in OAR 410-120-0000, is when payment from the Member is obtained in addition to the Authority or CCO payment for a Non-Covered Service;¶

(A) The Authority or CCO payment for a Covered Service cannot be credited toward the Non-Covered Service.¶

(B) Providers are not permitted to bill and accept payment from the Authority or a CCO;¶

(i) When a Non-Covered Service has been provided; and¶

(ii) Additional payment is sought or accepted from the Member.¶

~~(2C) Examples include, but are not limited to, charging the client~~ Member an additional payment to obtain a gold crown (non-covered) instead of the stainless steel crown (covered) or charging an additional client payment to obtain eyeglass frames not on the Division or managed care plan contract.¶

~~(3) If a client wants to purchase a non-covered service or item, the client~~ Member payment to obtain eyeglass frames not on the Division or managed care plan contract.(D) The Provider shall provide Members seeking to Buy-Up with the same required information for a Non-Covered Service as described in subsection (2)(g) of this rule, prior to rendering the service.¶

(g) The Member requests to privately pay for a Non-Covered Service. The service is a Non-Covered Service by the Authority, or CCO (Non-Covered services include services denied under Prior Authorization. Refer to OAR 410-

120-0000 for a definition of Non-Covered Services). In this situation, before providing the Non-Covered Service the Provider must confirm that the Member knowingly and voluntarily agrees to pay for the Non-Covered Service, and the Provider must provide the Member with the following:

(A) Confirmation the requested service is a Non-Covered Service; and

(B) The estimated total cost of the Non-Covered Service, including all related charges.

(3) When seeking payment from a Member due to circumstances described in subsections (2)(d) - (g) of this rule, the Provider shall confirm in the Member's medical record and document in writing the date in the Member's medical record that:

(a) The Provider signed the form and gave the Member or the Member's Representative the information described in subsection (2)(e) for Covered Services, or subsection (2)(g) for Non-Covered Services, of this rule prior to rendering the service; and

(b) The Member had an opportunity to ask questions, obtain additional information, and consult with the Member's caseworker or Representative; and

(c) The Member signed the form at the same time as the Provider and agreed to privately pay for the service by signing an agreement to pay form (OHP 3165, 3166, 4109); and

(d) The Provider gave a physical copy of the signed and dated agreement to pay form (OHP 3165, 3166, 4109) to the Member and included a copy of the form in the Member's medical record.

(4) The completed agreement to pay form (OHP 3165, 3166, 4109) is valid only if the estimated fee for the service or good, or anticipated amount to be paid by the Member or Member's Representative, does not change and the service is scheduled within 30 days of the Member's signature:

(a) The fee for the service or good, or anticipated amount to be paid by the Member or Member's Representative, must be documented as a range that is reasonable and informed by the Usual Charge of the service and must not exceed the highest amount documented.

(b) For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy.

(c) Providers must make a copy of the Member's medical record that confirms and dates the completed agreement to pay form (OHP 3165, 3166 or 4109) and all related requirements available to the Authority or CCO upon request.

(5) This rule must be used in alignment with OAR 410-120-1280:

(a) A Provider must not submit a claim for payment for services to the Authority, a CCO, or a Third-Party Payer that is subject to the agreement.

(b) If a Member wants to purchase a Non-Covered Service or item, the Member must be responsible for full payment.

(c) The Division or managed care plan payment for a covered service cannot be credited toward the non-covered service. Authority or CCO payment for a Covered Service cannot be credited toward the Non-Covered Service.

(6) Prohibited uses of the agreement to pay form. Providers must not:

(a) Use the form to delay, limit or deny a Member access to a Covered Service;

(b) Use the form as a global agreement for unspecified Covered or Non-Covered Services;

(c) Request payment for a service or good that is not listed on the agreement to pay form. The completed agreement to pay form (OHP 3165, 3166, 4109) is not transferrable to a different service or good;

(d) Use the form to request a Member pay for a service previously provided or delivered. The form cannot be retroactively applied to a service or good that has already been provided to a Member;

(e) Request payment from a Member for a missed appointment per OAR 410-120-1280;

(f) Request payment from a Member for concierge, membership, or other fee.

(7) For Members agreeing to pay for services under this rule who are limited English proficient, who are deaf, or hard of hearing, the Provider must offer translation or interpretation services before the Member or a financially responsible relative or Representative of that Member signs the agreement to pay form (OHP 3165, 3166, 4109). If translation or interpretation services are declined by the Member or their Representative, the Provider shall document in the Member's medical record that the services were offered and declined. This includes but is not limited to providing the following:

(a) Written documents in appropriate languages; and

(b) Interpreter services consistent with OAR 410-120-0001.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.066

RULE SUMMARY: Update rule citation due to Billing rule changes; changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-120-1400

Provider Sanctions ¶

(1) The Authority recognizes two classes of Medicaid ~~p~~Provider ~~s~~Sanctions, mandatory and discretionary, outlined in sections (4) and (5) of this rule.¶

(2) The Authority shall impose ~~s~~Sanctions on Medicaid ~~p~~Providers at the discretion of the Authority Director or delegate. Nothing in this rule limits the ability of Authority or the Oregon Department of Human Services (ODHS) to also seek monetary recovery, or pursue remedies specific to a contract with Authority or ODHS, or as otherwise permitted by state or federal law. Authority ~~s~~Sanctions of its contracted ~~m~~Managed ~~c~~Care ~~e~~Entities are governed by OAR 410-141-3530.¶

(3) ~~The~~ Authority may ~~s~~Sanction and ~~s~~Suspend or ~~t~~Terminate a ~~p~~Provider who:¶

(a) ~~i~~s applying for enrollment, re-enrollment or revalidation as an Oregon Medicaid ~~p~~Provider;¶

(b) ~~i~~s enrolled as an Oregon Medicaid ~~p~~Provider; regardless of whether enrollment is continuous or active; or¶

(c) ~~w~~Was an enrolled Oregon Medicaid ~~p~~Provider at the time the sanctionable conduct, ~~a~~Action, conditions or activity occurred.¶

(4) The Authority shall impose mandatory ~~s~~Sanctions and deny enrollment, ~~s~~Suspend or ~~t~~Terminate the enrollment of the ~~p~~Provider from participation in Oregon's ~~m~~Medical ~~a~~Assistance ~~p~~Programs, regardless of whether the ~~p~~Provider was directly enrolled or contracted by Authority or was enrolled or contracted by an Authority designee including but not limited to ODHS:¶

(a) When a ~~p~~Provider, or any person with five (5) percent or more direct or indirect ownership interest in the ~~p~~Provider, or any ~~a~~Agent, affiliate or managing employee of the ~~p~~Provider is, or was in the preceding ~~then~~(10) years, convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act, any other federal program, or related state laws; regardless of whether an ~~a~~Appeal from that judgment is pending;¶

(b) When a ~~p~~Provider, or any person with five (5) percent or more direct or indirect ownership interest in the ~~p~~Provider, or any ~~a~~Agent, affiliate or managing employee of the ~~p~~Provider, is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG) or from Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services; regardless of whether an ~~a~~Appeal from that judgment is pending. The ~~p~~Provider shall also be ~~t~~Terminated or ~~s~~Suspended from participation with the Authority for the duration of exclusion or suspension from the Medicare program or by the OIG;¶

(c) When a ~~p~~Provider fails to disclose ownership or controlling information required under 42 CFR 455.104 that is required to be reported at the time the ~~p~~Provider submits a ~~p~~Provider enrollment application, or when there is a material change in the information that must be reported or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.¶

(d) When a ~~p~~Provider, or any person with a five (5) percent or greater direct or indirect ownership or controlling interest in the ~~p~~Provider, fails to submit sets of fingerprints in a form and manner determined by the Authority within 30 days of CMS or an Authority request;¶

(e) When a ~~p~~Provider, or any person with a five (5) percent or greater direct or indirect ownership or control interest, an agent, affiliate or managing employee of the ~~p~~Provider, fails to submit timely and accurate information, comply with Authority screening methods, or both as required under 42 CFR 455 Subpart E;¶

(f) When a ~~p~~Provider fails to permit access to a ~~p~~Provider location for any site visit under 42 CFR §455.432; unless the Authority determines the ~~t~~Termination is not in the best interest of the Medicaid program. 42 CFR 455.416(f);¶

(g) When a ~~p~~Provider is ~~s~~Suspended or excluded from participation in a state Medicaid or CHIP program for reasons related to professional competence, professional performance, debarment or other reason;¶

(h) If the Authority:¶

(A) Determines that the ~~p~~Provider has falsified any information provided on the application for enrollment; or¶

(B) Cannot verify the identity of the ~~p~~Provider.¶

(i) When a ~~p~~Provider is convicted of fraud related to any federal, state, or locally financed health care program or commits ~~f~~Fraud, receives kickbacks, or commits other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;¶

- (j) When a ~~p~~Provider is convicted of interfering with the investigation of health care ~~f~~Eraud;¶
- (k) When a ~~p~~Provider is convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;¶
- (l) When a ~~p~~Provider, or any person with five (5) percent or more direct or indirect ownership interest in the ~~p~~Provider, or any ~~a~~Agent, affiliate or managing employee of the ~~p~~Provider, is subject to an adverse Legal Action including conviction of a felony crime against persons, financial crime(s) or misdemeanor conviction of patient ~~a~~Abuse or neglect, theft, embezzlement or ~~f~~Eraud;¶
- (m) When there is a credible allegation of ~~f~~Eraud as defined in 42 CFR 455.2 for which an investigation is pending under the Medicaid program, unless good cause not to suspend payments exists, in accordance with 42 CFR §455.23;¶
- (n) When Authority receives a referral from a Medicaid Fraud Control Unit (MFCU), Authority will initiate any available administrative or judicial action to recover improper payments to a ~~p~~Provider and ~~s~~Suspend the ~~p~~Provider to prevent future payments, unless good cause not to suspend payments exists, in accordance with 42 CFR §455.23;¶
- (o) When the ~~p~~Provider's enrollment has been ~~t~~Terminated or revoked for cause by Medicare or another state's Medicaid program and such ~~t~~Termination has been published in the Data Exchange System (DEX), the Authority will terminate the ~~p~~Provider's enrollment in its program pursuant to 42 CFR 455.416(c) and 455.101.¶
- (5) The Authority may impose discretionary ~~s~~Sanctions and deny enrollment, ~~s~~Suspend or ~~t~~Terminate a ~~p~~Provider when the Authority determines that the ~~p~~Provider fails to meet one or more of the Authority's requirements in all applicable administrative rules or the contract between Authority and the ~~p~~Provider governing participation in its ~~m~~Medical ~~a~~Assistance ~~p~~Programs. Conditions that may result in a discretionary ~~s~~Sanction include but are not limited to:¶
 - (a) ~~b~~Breach of the ~~p~~Provider agreement;¶
 - (b) ~~a~~Actions of any state licensing authority for reasons relating to the ~~p~~Provider's professional competence, professional conduct, quality of care, or financial integrity including but not limited to:¶
 - (A) Having the health care license suspended or revoked, or otherwise loses their license; or¶
 - (B) Surrendering their license while a formal disciplinary proceeding is pending before the licensing authority.¶
 - (c) Suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;¶
 - (d) Billing excessive charges (i.e., charges more than the usual charge). Furnishes items or services substantially more than the Authority ~~e~~lient~~M~~ember's needs or more than those services ordered by a medical ~~p~~Provider or more than generally accepted standards or of a quality that fails to meet professionally recognized standards;¶
 - (e) Fails to furnish ~~m~~Medically ~~n~~Necessary services as required by law or contract with the Authority if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the Authority ~~e~~lient~~M~~ember;¶
 - (f) Fails to disclose required ownership information;¶
 - (g) Fails to supply requested records and information on subcontractors, ~~p~~Providers, and suppliers of goods or services;¶
 - (h) Fails to supply requested payment information;¶
 - (i) Fails to provide or disclose requested information or documentation to Authority, within the timeframe listed on the Authority's written request;¶
 - (j) Fails to grant access or to furnish as requested, records, or grant access to facilities upon request of the Authority or designee, ODHS, the Authority's Office of Program Integrity (OPI), OIG, or the State of Oregon's Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU) conducting their regulatory or statutory functions;¶
 - (k) In the case of a ~~h~~Hospital, fails to take corrective ~~a~~Action as required by the Authority, based on information supplied by the Quality Improvement Organization to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Authority;¶
 - (~~l~~) Defaults on repayment of federal or state government scholarship obligations or loans in connection with the ~~p~~Provider's health profession education. The Authority:¶
 - (A) Shall make a reasonable effort to secure payment;¶
 - (B) Shall take into account access of beneficiaries to services; and¶
 - (C) May not exclude a community's sole ~~p~~Physician or source of essential specialized services.¶
 - (m) Submits one or more claims with required data missing or incorrect;¶
 - (n) Fails to comply with the requirements of OAR 410-120-1280, ~~410-120-1350~~, Ch 410, Ch 943, Ch 309 or any other ~~OAR CH Oregon Administrative Rules chapter~~ applicable to the service or good when billing or submitting claims or encounters to Authority.¶
 - (o) Fails to develop, maintain, and retain in accordance with OAR 410-120-1360 and relevant rules Ch 410, Ch 943, Ch 309 or any other ~~OAR CH chapter of rules~~ applicable to the service or good and standards adequate clinical or other records that document the ~~m~~Medical ~~a~~Appropriateness, nature, and extent of the health care provided;¶

- (p) Fails to develop, maintain, and retain in accordance with OAR 410-120-1360 and relevant rules in Ch 410, Ch 943, Ch 309 or any other ~~OAR-CH~~chapter of rules applicable to the ~~p~~Provider and adequate financial records as defined in OAR 410-120-0000 that document charges incurred by a ~~client~~Member and payments received from any source;¶
- (q) Fails to develop, maintain, and retain adequate financial or other records of all assets, liabilities, income, and expenses that support information submitted on a cost report;¶
- (r) Fails to follow generally accepted accounting principles or accounting standards or cost principles sanctioned by recognized authoritative bodies such as the Governmental Accounting Standard Board and the Financial Accounting Standards Board and required by federal or state laws, rules, or regulations applicable to Medicaid;¶
- (s) Submits claims or written orders contrary to generally accepted standards of medical practice of the ~~p~~Provider receiving or requesting payment;¶
- (t) Submits claims or encounters for services that exceed that requested or agreed to by the ~~m~~Member or the responsible relative or guardian or requested by another medical ~~p~~Provider;¶
- (u) Breaches the terms of the ~~p~~Provider contract or the ~~p~~Provider enrollment agreement with the Authority or Oregon Department of Human Services (ODHS). This includes failure to comply with the terms of the ~~p~~Provider certifications on the medical claim form;¶
- (v) Rebates or accepts a fee or portion of a fee or charge for an Authority ~~client~~Member Referral, or collects a portion of a service fee from the ~~client~~Member and bills the Authority for the same service;¶
- (w) Fails to disclose information requested on the ~~p~~Provider enrollment application or as otherwise requested by Authority;¶
- (x) Fails to correct deficiencies in operations after receiving written notice of the deficiencies from the Authority; including deficiencies in licensing or certification procedures;¶
- (y) Submits any claim or encounter for payment for which payment has already been made by the Authority or any other source unless the amount of the payment from the other source is clearly identified;¶
- (z) Threatens, intimidates, or harasses ~~m~~Members or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the ~~p~~Provider and the Authority;¶
- (aa) Fails to properly account for an Authority ~~m~~Member's Personal Incidental Funds, including but not limited to using a ~~client~~Member's Personal Incidental Funds for payment of services that are included in a medical facility's all-inclusive rates;¶
- (bb) Provides or bills for services provided by ineligible or unsupervised or unqualified employees, ~~p~~Providers, or interns;¶
- (cc) Participates in collusion that results in an inappropriate money flow between the parties involved, for example, referring ~~client~~Members unnecessarily to another ~~p~~Provider;¶
- (dd) Refuses or fails to repay in accordance with an accepted schedule an ~~e~~Overpayment established by the Authority, Authority's OPI, MFCU or as ordered by a court;¶
- (ee) Refuses or fails to repay in accordance with an accepted schedule repayment of identified ~~e~~Overpayment or settlement agreements established by Authority, Authority OPI, MFCU or as ordered by a court;¶
- (ff) Fails to report to Authority or ODHS payments received from any other source after the Authority made payment for the service;¶
- (gg) Fails to comply with federal or state statutes and regulations or policies of the Authority or ODHS that are applicable to the ~~p~~Provider;¶
- (hh) Fails to obtain or maintain required ~~p~~Provider credentials or has credentials ~~s~~Suspended or otherwise revoked by the credentialing entity, for any reason;¶
- (ii) Fails to correct subcontractor deficiencies in operations or non-compliance with Medicaid program requirements after receiving written notice of the deficiencies from the Authority;¶
- (jj) Acts to discriminate among ~~m~~Members on the basis of their health status or need for health care services, or on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability; violates ~~m~~Member civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A;¶
- (kk) When a person with five (5) percent or more direct or indirect ownership interest in the ~~p~~Provider, or an ~~a~~Agent, affiliate, supplier or managing employee of the ~~p~~Provider is found to be in violation, independently or in tandem with the ~~p~~Provider, of one or more of the provision of section (4) or (5) of this rule;¶
- ~~(ll)~~ When a MCE ~~or CCO~~ Participating ~~p~~Provider or subcontractor enrolled or seeking enrollment as an encounter only ~~p~~Provider is found to be in violation of one or more of the provision of section (4) or (5) of this rule;¶
- (mm) Submits a bill or invoice or otherwise seeks payment from a ~~m~~Member for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by OAR 410-120-128350. If the ~~m~~Member was eligible for medical assistance on the ~~d~~Date of ~~s~~Service, and the ~~p~~Provider does not have a completed signed agreement to pay form (3165, 3166), the ~~p~~Provider is not allowed to bill the ~~m~~Member, collect payment from the ~~m~~Member, or assign an unpaid claim to a collection agency or similar entity pursuant to ORS

414.066, except as authorized by ~~section (5) of~~ OAR 410-120-128~~350~~. The Authority ~~s~~Sanction of the ~~p~~Provider may include but is not limited to any amount necessary to fully repay the ~~m~~Member for the billed services, fines, fees or other financial penalties imposed on the ~~m~~Member by the ~~p~~Provider or any ~~t~~Third-~~p~~Party collections agency, and any accrued interest.¶

(nn) Failure to comply with Authority or its designee's notice that the ~~p~~Provider is in violation of ORS 414.066 within 30 days or within the time required in the Authority's written notice;¶

(oo) Failure to comply with federal or state statutes and regulations or policies of the Authority that are applicable to the ~~p~~Provider;¶

(pp) No claims have been submitted in an 18-month period. The ~~p~~Provider must reapply for enrollment;¶

(6) A ~~p~~Provider excluded, ~~s~~Suspended, or ~~t~~Terminated from participation in a federal or state medical program, such as Medicare or Medicaid or CHIP, or whose license or certification to practice is ~~s~~Suspended or revoked by a state licensing board or Authority may not submit encounters or claims to the Authority for payment, either personally or through claims submitted by any ~~b~~Billing ~~a~~Agent/service, ~~b~~Billing ~~p~~Provider, or other ~~p~~Provider for any services or supplies provided under the ~~m~~Medical ~~a~~Assistance ~~p~~Programs, except those services or supplies provided prior to the date of exclusion, ~~s~~Suspension, or ~~t~~Termination; unless good cause not to suspend payments exists, in accordance with 42 CFR §455.23.¶

(7) A Provider may not submit encounters or claims for payment to the Authority for payment for any services or supplies provided by an individual ~~p~~Provider or ~~p~~Provider entity that is excluded, ~~s~~Suspended, or ~~t~~Terminated from participation in a federal or state medical program or whose license to practice is suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, ~~s~~Suspension, or ~~t~~Termination; unless good cause not to suspend payments exists, in accordance with 42 CFR §455.23.¶

(8) When any one of the provisions of sections (4) or (5) of this rule are violated, the Authority may ~~s~~Suspend or ~~t~~Terminate the ~~b~~Billing ~~p~~Provider's enrollment agreement or the enrollment agreement of any individual ~~p~~Provider who is in violation. When a ~~p~~Provider is ~~s~~Sanctioned, all other enrolled ~~p~~Providers in which the ~~s~~Sanctioned ~~p~~Provider has ownership or controlling interest of five (5) percent or greater, may also be ~~s~~Sanctioned and ~~s~~Suspended or ~~t~~Terminated.¶

(9) When any of the provisions of section (4) are violated, Authority shall withhold and recover all payments made to the ~~p~~Provider for services furnished after the effective date of the ~~s~~Sanction; unless good cause not to recover payments exists, in accordance with 42 CFR §455.23. When provisions of section (5) are violated, Authority may withhold and recover all payments made to the ~~p~~Provider for services furnished after the effective date of the ~~s~~Sanction.¶

(10) When a ~~p~~Provider ~~s~~Sanctioned as a result of exclusion from participation in federal or another state's health care programs the scope of the ~~p~~Provider ~~a~~Appeal of the Authority's Action is limited to a review of whether the ~~p~~Provider was, in fact, ~~t~~Terminated by the initiating program. The ~~a~~Appeal will not review the underlying reasons for the initiating ~~t~~Termination. The ~~p~~Provider must contact the federal or state agency which issued the initial decision.¶

(11) Authority shall, for any ~~p~~Provider or any person with a relationship with the ~~p~~Provider who meets the circumstances for exclusion listed in 42 CFR 1001.1001, promptly notify the OIG of any action(s) Authority takes on the ~~p~~Provider's application for enrollment in the program and any ~~a~~Action(s) taken to limit the ability of a ~~p~~Provider, whether an individual or entity, to participate in Oregon's Medicaid program, regardless of what such an ~~a~~Action is called. This includes, but is not limited to, ~~s~~Suspension ~~a~~Actions, settlement agreements and situations where the ~~p~~Provider voluntarily withdraws from the program to avoid formal ~~s~~Sanction(s).¶

(12) Authority shall, for any ~~p~~Provider ~~s~~Sanctioned by the Authority under this rule 410-120-1400 list the name(s) of the ~~p~~Provider, NPI, duration and the effective date of the ~~s~~Sanction on the Authority's website.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: 414.025, 414.065

RULE SUMMARY: Update rule citation due to Billing rule changes; changing "client" and "recipient" to "Member" or "CCO Member" or "Open Card Member" where appropriate.

CHANGES TO RULE:

410-120-1460

Type and Conditions of Sanction ¶

(1) The ~~Health Systems Division (Division)~~ Division may impose mandatory Sanctions on a Provider pursuant to OAR 410-120-1400(4), in which case:¶

(a) The Provider shall be either Terminated or Suspended from participation in Oregon's ~~mMedical aAssistance pPrograms~~;¶

(b) If Suspended, the minimum duration of Suspension shall be determined by the Secretary of the Department of Health and Human Services (DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The Authority may Suspend a Provider from participation in Oregon's ~~mMedical aAssistance pPrograms~~ longer than the minimum Suspension determined by the DHHS Secretary.¶

(2) The Division may impose the following discretionary Sanctions on a Provider pursuant to OAR 410-120-1400(5):¶

(a) The Provider may be Terminated from participation in Oregon's ~~mMedical aAssistance pPrograms~~;¶

(b) The Provider may be Suspended from participation in Oregon's ~~mMedical assistance pPrograms~~ for a specified length of time, or until specified conditions for reinstatement are met and approved by Division;¶

(c) The Division may withhold payments to a Provider;¶

(d) The Provider may be required to attend Provider education sessions at the expense of the Sanctioned Provider;¶

(e) The Division may require that payment for certain services are made only after the Division has reviewed documentation supporting the services;¶

(f) The Division may recover investigative and legal costs;¶

(g) The Division may provide for reduction of any amount otherwise due the Provider. The reduction may be up to three times the amount a Provider sought to collect from a ~~client~~ Member in violation of OAR 410-120-1280 or ~~410-120-1350~~; or¶

(h) Any other Sanctions reasonably designed to remedy or compel future compliance with federal, state, or Division regulations.¶

(3) The Division shall consider the following factors in determining the Sanction(s) to be imposed:¶

(a) Seriousness of the offense(s);¶

(b) Extent of violations by the Provider;¶

(c) History of prior violations by the Provider;¶

(d) Prior imposition of Sanctions;¶

(e) Prior Provider education;¶

(f) Provider willingness to comply with program rules;¶

(g) Actions taken or recommended by licensing boards or a Quality Improvement Organization (QIO);¶

(h) Adverse impact on the health of Division ~~client~~ Members living in the Provider's service area; and¶

(i) Any other relevant factors.¶

(4) Immediate Suspension. When a Provider fails to meet one or more of the requirements identified in this rule the Division, at its sole discretion, may immediately Suspend the Provider's Authority assigned billing number to prevent public harm or inappropriate expenditure of public funds:¶

(a) The Provider subject to immediate Suspension is entitled to a ~~eContested eCase hHearing~~ as outlined in OAR 410-120-1600 through 410-120-1700 to determine whether the Provider's authority assigned number shall be revoked;¶

(b) The notice requirements described in section (5) of this rule do not stop the Division's decision of immediate Suspension to prevent public harm or inappropriate expenditure of public funds. Suspension shall start immediately while the notice and ~~eContested eCase hHearing~~ rights are exercised.¶

(5) If the Authority decides to Sanction a Provider, the Division shall notify the Provider of the intent to Sanction by certified mail, personal delivery service or other traceable services such as email with delivery and read receipt. Notices sent certified mail shall be sent to the "mail-to" address on file for the Provider at the time of Sanction. Notices sent via secure email shall be sent to the Providers email if on file or the most current contact on file for the Provider a time of Sanction. The notice of immediate or proposed Sanction shall identify:¶

(a) The factual basis used to determine the alleged deficiencies;¶

- (b) Explanation of actions expected of the Provider;¶
 - (c) Explanation of subsequent actions the Division intends to take;¶
 - (d) The Provider's right to dispute the Division's allegations, and submit evidence to support the Provider's position; and¶
 - (e) The Provider's right to ~~a~~Appeal Division's proposed ~~a~~Actions pursuant to OARs 410-120-1560 through 410-120-1700.¶
 - (6) If the Division makes a final decision to Sanction a Provider, the Division shall notify the Provider in writing at least 15 days before the effective date of ~~a~~Action, except in the case of immediate Suspension to avoid public harm or inappropriate expenditure of funds.¶
 - (7) The Provider may ~~a~~Appeal the Division's immediate or proposed Sanction(s) or other action(s) the Authority intends to take, including but not limited to the following list. The Provider must ~~a~~Appeal these ~~a~~Actions separately from any ~~a~~Appeal of audit findings and ~~e~~Overpayments:¶
 - (a) Termination or Suspension from participation in the Medicaid-funded ~~m~~Medical ~~a~~Assistance ~~p~~Programs;¶
 - (b) Termination or Suspension from participation in the Division's state-funded programs;¶
 - (c) Revocation of the Provider's Division assigned Provider number.¶
 - (8) Other provisions:¶
 - (a) When a Provider has been Sanctioned, all other Provider entities in which the Provider has ownership (five percent or greater) or control of, may also be Sanctioned;¶
 - (b) When a Provider has been Sanctioned, the Division may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon managed care entities, and the National Practitioner Data Base of the findings and the Sanctions imposed;¶
 - (c) At the discretion of the Division, Providers who have previously been Terminated or Suspended may or may not be re-enrolled as Division Providers;¶
 - (d) Nothing in this rule prevents the Authority from simultaneously seeking monetary recovery and imposing Sanctions against the Provider;¶
 - (e) If the Division discovers continued improper billing practices from a Provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices and has had an opportunity for a ~~e~~Contested ~~e~~Case ~~h~~Hearing, that Provider will be liable to the Division for up to triple the amount of the Division's established ~~e~~Overpayment received as a result of such violation.
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 414.025, 414.065

RULE SUMMARY: Update rule citation due to Billing rule changes; changing "client" and "recipient" to "Member" or "CCO Member" or "Open Card Member" where appropriate.

CHANGES TO RULE:

410-120-1855

~~Client~~Members Rights and Responsibilities ¶¶

(1) Division of Medical Assistance Programs (Division) ~~client~~Members shall have the following rights:¶¶

- (a) To be treated with dignity and respect;¶¶
- (b) To be treated by ~~p~~Providers the same as other people seeking health care benefits to which they are entitled;¶¶
- (c) To refer oneself directly to mental health, substance use disorder or family planning services without getting a referral from a Primary Care Practitioner (PCP) or other ~~p~~Provider;¶¶
- (d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;¶¶
- (e) To be actively involved in the development of their treatment plan;¶¶
- (f) To be given information about their condition and ~~e~~Covered and ~~n~~Non-eCovered ~~s~~Services to allow an informed decision about proposed treatment(s);¶¶
- (g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;¶¶
- (h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;¶¶
- (i) To have written materials explained in a manner that is understandable to the ~~Division client~~Member;¶¶
- (j) To receive necessary and reasonable services to diagnose the presenting condition;¶¶
- (k) To receive Division ~~e~~Covered ~~s~~Services that meet generally accepted standards of practice and are ~~m~~Medically ~~a~~Appropriate;¶¶
- (~~l~~) To obtain covered preventive services;¶¶
- (m) To receive a referral to specialty ~~p~~Providers for ~~m~~Medically ~~a~~Appropriate ~~e~~Covered ~~s~~Services;¶¶
- (n) To have a clinical record maintained that documents conditions, services received, and referrals made;¶¶
- (o) To have access to one's own clinical record, unless restricted by statute;¶¶
- (p) To transfer a copy of their clinical record to another ~~p~~Provider;¶¶
- (q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, substance use disorder or mental health treatment, and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 - Patient Self-Determination Act;¶¶
- (r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;¶¶
- (s) To know how to make a Complaint, Grievance or Appeal with the Division and receive a response as defined in OAR 410-120-1860 and 410-120-1865;¶¶
- (t) To request an ~~A~~Addministrative ~~H~~Hearing with the Oregon Health Authority (Authority);¶¶
- (u) To receive a notice of an appointment cancellation in a timely manner;¶¶
- (v) To receive adequate notice of Authority privacy practices.¶¶

(2) Division ~~client~~Members shall have the following responsibilities:¶¶

- (a) To treat the ~~p~~Providers and clinics' staff with respect;¶¶
- (b) To be on time for appointments made with ~~p~~Providers and to call in advance either to cancel if unable to keep the appointment or if the ~~client~~Member expects to be late;¶¶
- (c) To seek periodic health exams and preventive services from their PCP or clinic;¶¶
- (d) To use their PCP or clinic for diagnostic and other care except in an ~~E~~Emergency;¶¶
- (e) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;¶¶
- (f) To use ~~e~~Emergency ~~s~~Services appropriately;¶¶
- (g) To give accurate information, including name that matches the Oregon Health I.D. card for inclusion in the clinical or billing record;¶¶
- (h) To help the ~~p~~Provider or clinic obtain clinical records from other ~~p~~Providers which may include signing an authorization for release of information;¶¶
- (i) To ask questions about conditions, treatments and other issues related to their care that is not understood;¶¶
- (j) To use information to make informed decisions about treatment before it is given;¶¶

- (k) To help in the creation of a treatment plan with the ~~p~~Provider;¶
 - ~~(L)~~ To follow prescribed, agreed-upon treatment plans;¶
 - (m) To tell the ~~p~~Provider that their health care is covered with the Division before services are received, and to show the ~~p~~Provider the Oregon Health I.D.;¶
 - (n) To tell the Department or Authority staff of a change of address or phone number;¶
 - (o) To tell the Department or Authority staff if the ~~Division client~~Member becomes pregnant and to notify the Department worker of the birth of the ~~Division client~~Member's child;¶
 - (p) To tell the Department or Authority staff if any family members move in or out of the household;¶
 - (q) To tell the Department or Authority staff and ~~p~~Provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;¶
 - (r) To pay for ~~n~~Non-~~e~~Covered ~~s~~Services under the provisions described in OAR 410-120-1200 and 410-120-128350;¶
 - (s) To pay the monthly OHP premium on time if so required;¶
 - (t) To assist the Division in pursuing any TPR available and to pay the Division the amount of benefits it paid for an injury from any recovery received from that injury;¶
 - (u) To bring issues, or Complaints or Grievances to the attention of the Division; and¶
 - (v) To sign an authorization for release of medical information so the Authority can get pertinent and needed information to respond to an ~~A~~Administrative ~~H~~hearing request in an effective and efficient manner.
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 414.025, 414.065, 414.066

AMEND: 410-130-0160

RULE SUMMARY: Remove section (2) to be moved into OAR 410-120-1280.

CHANGES TO RULE:

410-130-0160

Codes ¶

(1) ICD-10-CM Diagnosis Codes:¶

(a) Always use the principal ~~d~~Diagnosis ~~e~~Code in the first position to the highest degree of specificity. List additional ~~d~~Diagnosis ~~e~~Codes if the claim includes charges for services that relate to the additional diagnoses. However, it is not necessary to include more than one ~~d~~Diagnosis ~~e~~Code per procedure code;¶

(b) Diagnosis ~~e~~Codes are required on all billings including those from independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers;¶

(c) Always supply the ICD-10-CM ~~d~~Diagnosis ~~e~~Code to ancillary service ~~p~~Providers when prescribing services, equipment, and supplies.¶

(2) ~~CPT and HCPCS Codes:¶~~

~~(a) Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;¶~~

~~(b) Effective January 1, 2005, HIPAA regulations prohibit the use of a grace period for codes deleted from CPT or HCPCS. In the past the grace period was from January 1 through March 31;¶~~

~~(c) The division may consider reimbursement for CPT category III codes included under the following headings: Adaptive Behavior Assessments, Adaptive Behavior Treatment, and Exposure Adaptive Behavior Treatment With Protocol Modification. All CPT category II (codes with fifth character of "F") and all other category III codes (codes with fifth character "T") are not Division of Medical Assistance Programs' (Division) covered services;¶~~

~~(d) Use the most applicable CPT or HCPCS code. Do not fragment coding when services can be included in a single code (see the "Bundled Services" section of this rule). Do not use both CPT and HCPCS codes for the same procedure. This is considered duplicate billing.¶~~

~~(3) The Medical-Surgical Service rules list the HCPCS/CPT codes that require authorization or have limitations. The Health Evidence Review Commission's OHA Prioritized List of Health Services (OAR 410-141-3830) determines ~~e~~Covered ~~s~~Services.¶~~

~~(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT and HCPCS codebook. Use the definitions to verify level of service, especially for office visits. Unless otherwise specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.¶~~

~~(5) Bundled Services: Reimbursements for some services are "bundled" into the payment for another service. The Division does not make separate payment for bundled services and ~~client~~Members may not be billed for bundled services. The Division's Not Covered/Bundled Services rule, OAR 410-130-0220, provides more information regarding bundled services.¶~~

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

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065