CHAPTER 407
DEPARTMENT OF HUMAN SERVICES,
ADMINISTRATIVE SERVICES DIVISION AND DIRECTOR'S OFFICE

DIVISION 120
PROVIDER RULES

MMIS Provider Enrollment and Claiming

407-120-0300
Definitions

The following definitions apply to OAR 407-120-0300 through 407-120-0380:

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Department, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes actions by clients or recipients that result in unnecessary cost to the Department.

(2) "Advance Directive" means a form that allows an individual to have another individual make health care decisions when he or she cannot make decisions and informs a doctor if the individual does not want any life sustaining help if he or she is near death.

(3) "Benefit Package" means the package of covered health care services for which the client is eligible.

(4) "Billing Agent or Billing Service" means a third party or organization that contracts with a provider to perform designated services in order to facilitate claim submission or electronic transaction on behalf of the provider.

(5) "Billing Provider" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Department on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider.

(6) "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 Division of Medical Assistance Programs (DMAP).

(7) "Claim" means a bill for services, a line item of a service, or all services for one client within a bill. Claim includes a bill or an encounter associated with requesting reimbursement, whether submitted on paper or electronically. Under these rules, claim also includes any other methodology for requesting reimbursement that may be established in contract or program-specific rules.

(8) “Client or Recipient” means an individual found eligible by the Department to receive services under the OHP demonstration, medical assistance program or other public assistance administered by the Department. The following OHP categories are eligible for enrollment:

(a) Temporary Assistance to Needy Families (TANF) are categorically eligible families with income under current eligibility rules;

(b) CHIP children under one year of age who have income under 185% Federal Poverty Level (FPL) and do not meet one of the other eligibility classifications;

(c) Poverty Level Medical (PLM) adults under 100% of the FPL are clients who are pregnant women with income under 100% of FPL;

(d) PLM adults over 100% of the FPL are clients who are pregnant women with income between 100% and 185% of the FPL;

(e) PLM children under one year of age have family income under 133% of the FPL or were born to mothers who were eligible as PLM adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(h) OHP adults and couples are clients age 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(i) OHP families are clients, age 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) General Assistance (GA) recipients are clients who are eligible by virtue of their eligibility under the GA program, ORS 411.710 et seq.;

(k) Assistance to Blind and Disabled (AB/AD) with Medicare eligibles are clients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare eligibles are clients without Medicare with income under current eligibility rules;

(m) Old Age Assistance (OAA) with Medicare eligibles are clients with concurrent Medicare Part A or Medicare Parts A and B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare eligibles are clients without Medicare with income under current eligibility rules; or

(p) Children, Adults and Families (CAF) children are clients who are children with medical eligibility determined by CAF or Oregon Youth Authority (OYA) receiving OHP under ORS 414.025, 418.034, and 418.187 through 418.970. These individuals are generally in the care or custody of CAF or OYA who are in placement outside of their homes.

(9) "Client Representative" means an individual who can make decisions for clients who are not able to make such decisions themselves. For purposes of medical assistance a client representative may be, in the following order of priority, an individual who is designated as the client's health care representative under ORS 127-505(12), a court-appointed guardian, a spouse, or other family member as designated by the client, the individual service plan team (for developmentally disabled clients), a Department case manager or other Department designee. To the extent that other Department programs recognize other individuals who may act as a client representative, that individual may be considered the client representative in accordance program-specific rules or applicable contracts.

(10) "Clinical Records" means the medical, dental, or mental health records of a client. These records include the Primary Care Provider (PCP's) records, the inpatient and outpatient hospital records and the Exceptional Needs Care Coordinator (ENCC), complaint and disenrollment for cause records which may be located in the Prepaid Health Plan (PHP's) administrative offices.

(11) "Conviction or Convicted" means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

(12) "Covered Services" means medically appropriate health services or items that are funded by the Legislature and described in ORS chapter 414, including the OHP authorized under ORS 414.705 through 414.750 and applicable Department rules describing the benefit packages of covered services; except as excluded or limited under OAR 410-141-0500, excluded services and limitations for OHP clients; or such other public assistance services provided to eligible clients under program-specific requirements or contracts by providers required to enroll with the Department under OAR 407-120-0300 to 407-120-0380.

(13) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules.

(14) "Department" means the Department of Human Services.

(15) "Diagnosis Code" means the code as identified in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The primary diagnosis code is shown in all billing claims and PHP encounters, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes must be shown to the degree of specificity outlined in OAR 407-120-0340, claim and PHP encounter submission.

(16) "Electronic Data Transaction (EDT)" means the electronic exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, conducted by either web portal or electronic data interchange in accordance with the Department's electronic data transaction rule (OAR 407-120-0100 through 407-120-0200).

(17) "Exclusion" means the Department will not reimburse a specific provider who has defrauded or abused the Department for items or services that provider furnished.

(18) "False Claim" means a claim or PHP encounter that a provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and such inaccurate or misleading information would result, or has resulted, in an overpayment or improper use for per capita cost calculations.

(19) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to himself or some other individual. It includes any act that constitutes fraud or false claim under applicable federal or state law.

(20) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures and supplies. HCPCS consists of the Level 1 – American Medical Association's Physicians' Current Procedural Terminology (CPT), Level II – National Codes and Level III – Local Codes.

(21) "Health Insurance Portability and Accountability Act (HIPAA)" means a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(22) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare, accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry.

(23) “Individual Adjustment Request” means a form (DMAP 1036) used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(24) “Medicaid” means a federal and state funded portion of the medical assistance program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department.

(25) “Medicaid Management Information System (MMIS)” means the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying provider enrollment and client eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

(26) “Medical Assistance Program” means a program for payment of health care provided to eligible Oregonians. Oregon's medical assistance program includes Medicaid services including the OHP Medicaid Demonstration, and CHIP. The medical assistance program is administered and coordinated by DMAP, a division of the Department.

(27) “Medically Appropriate” means services and medical supplies that are required for prevention, diagnosis, or treatment of a health condition that encompasses physical or mental conditions, or injuries and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence based medicine and professional standards of care as effective;

(c) Not solely for the convenience of a client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a client in the provider’s judgment.

(28) “Medicare” means the federal health insurance program for the aged and disabled administered by the Centers for Medicare and Medicaid Services (CMS) under Title XVIII of the Social Security Act.

(29) “National Provider Identification (NPI)” means a federally directed provider number mandated for use on HIPAA covered transactions by individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 Code of Federal Regulations (CFR) 160.103) and who conduct HIPAA covered transactions electronically.

(30) “Non-Covered Services” means services or items for which the Department is not responsible for payment. Non-covered services are identified in:

(a) OAR 410-120-1200, Excluded Services and Limitations;

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) The individual Department provider rules, program-specific rules, and contracts.

(31) “Non-Participating Provider” means a provider who does not have a contractual relationship with the PHP.

(32) “Nursing Facility” means a facility licensed and certified by the Department’s Seniors and People with Disabilities Division (SPD) defined in 411-070-0005.

(33) “Oregon Health Plan (OHP)” means the Medicaid demonstration project that expands Medicaid eligibility to eligible clients. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(34) “Out-of-State Providers” means any provider located outside the borders of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of Oregon.

(35) “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.

(36) “Prepaid Health Plan (PHP)” means a managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with DMAP or Addictions and Mental Health Division (AMH) on a case managed, prepaid, capitated basis under the OHP. PHP's may be a Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), Primary Care Organization (PCO) or Chemical Dependency Organization (CDO).

(37) “Prohibited Kickback Relationships” means remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 CFR 1001.951.

(38) "PHP Encounter" means encounter data submitted by a PHP or by a provider in connection with services or items reimbursed by a PHP.

(39) "Prior Authorization" means payment authorization for specified covered services or items given by Department staff, or its contracted agencies, or a county if required by the county, prior to provision of the service. A physician or other referral is not a prior authorization.

(40) "Provider" means an individual, facility, institution, corporate entity, or other organization which supplies health care or other covered services or items, also termed a performing provider, that must be enrolled with the Department in accordance with OAR 407-120-0300 to 407-120-0380 in order to seek reimbursement from the Department, including services provided, under program-specific rules or contracts with the Department or with a county or PHP.

(41) "Quality Improvement" means the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality improvement includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(42) "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."

(43) "Remittance Advice" means the automated notice a provider receives explaining payments or other claim actions.

(44) "Subrogation" means the right of the state to stand in place of the client in the collection of third party resources, including Medicare.

(45) "Suspension" means a sanction prohibiting a provider's participation in the Department's medical assistance or other programs by deactivation of the assigned provider number for a specified period of time or until the occurrence of a specified event.

(46) "Termination" means a sanction prohibiting a provider's participation in the Department's programs by canceling the assigned provider number and agreement.

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Department at the time of termination.

(47) “Third Party Resource (TPR)” means a medical or financial resource, including Medicare, which, under law, is available and applicable to pay for covered services and items for a medical assistance client.

(48) “Usual Charge” means when program-specific or contract reimbursement is based on usual charge, 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; or

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the FPL, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to TPR are to be considered.

(49) “Visit Data” means program-specific or contract data collection requirements associated with the delivery of service to clients on the basis of an event such as a visit.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0310
Provider Requirements

(1) Scope of Rule. All providers seeking reimbursement from the Department, a PHP, or a county pursuant to a county agreement with the Department for the provision of covered services or items to eligible recipients, must comply with these rules, OAR 407-120-0300 to 407-120-0380, and the applicable rules or contracts of the specific programs described below:

(a) Programs administered by DMAP including the OHP and the medical assistance program that reimburses providers for services or items provided to eligible recipients;

(b) Programs administered by AMH that reimburse providers for services or items provided to eligible AMH recipients; and

(c) Programs administered by SPD that reimburse providers for services or items provided to eligible SPD recipients.

(2) Visit Data.

(a) Some programs require providers to document visit data in connection with service delivery.

(A) Department programs use visit data to monitor service delivery, planning, and quality improvement activities.

(B) Visit data is required to be submitted by a program-specific rule or contract. A provider is required to make accurate, complete, and timely submission of visit data as a material term of provider participation in the applicable Department program.

(b) Visit data is not a HIPAA transaction and does not constitute a claim for reimbursement.

(3) CHIP and Medicaid-Funded Covered Services and Items.

(a) Covered services or items paid for with Medicaid (Title XIX) and CHIP (Title XXI) funds (referred to as the medical assistance program) are also subject to federal and state Medicaid rules and requirements. In interpreting these rules and program-specific rules or contracts, the Department will construe them as much as possible in a manner that will comply with federal and state medical assistance program laws and regulations, and the terms and conditions of federal waivers and the state plans

(b) If a provider is reimbursed with medical assistance program funds, the provider must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid services under the Medicaid Act, Title XIX, 42 United States Code (USC) Section 1396 et. seq., and CHIP services under Title XXI, including without limitation:

(A) Maintaining all records necessary to fully disclose the extent of the services provided to individuals receiving medical assistance and furnish such information to any state or federal agency responsible for administration or oversight of the medical assistance program regarding any payments claimed by an individual or institution for providing Medicaid services as the state or federal agency may from time to time request;

(B) Complying with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B);

(C) Maintaining written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I;

(D) Certifying that the information is true, accurate and complete when submitting claims or PHP encounters for the provision of medical assistance services or items. Submission of a claim or PHP encounter constitutes a representation of the provider's understanding that payment of the claim will be from federal or state funds, or both, and that any falsification or concealment of a material fact may result in prosecution under federal or state laws.

(c) Hospitals, nursing facilities, home health agencies (including those providing personal care), hospices and HMOs must comply with the Patient Self-Determination Act as set forth in Section 4751 of OBRA 1991. To comply with the obligation under the above-listed laws to deliver information on the rights of the individual under Oregon law to make health care decisions, the named providers and organizations must give capable individuals over the age of 18 a copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1993, by the Oregon State Bar Health Law Section. Out-of-state providers of these services should comply with Medicare and Medicaid regulations in their state. Submittal to the Department of the appropriate claim form requesting payment for medical services provided to a Medicaid eligible shall be deemed representation to the Department of the medical provider's compliance with the above-listed laws.

(d) Payment for any service or item furnished by a provider of CHIP or Medicaid-funded services or items may not be made by or through (directly or by power of attorney) any individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or a deduction of a portion of the accounts receivable.

(e) The Department will make medical assistance provider payments only to the following:

(A) The provider who actually performed the service or provided the item;

(B) In accordance with a reassignment from the provider to a government agency or reassignment by a court order;

(C) To the employer of the provider, if the provider is required as a condition of employment to turn over his or her fees to the employer;

(D) To the facility in which the service is provided, if the provider has a contract under which the facility submits the claim;

(E) To a foundation, PHP, clinic, or similar organization operating as an organized health care delivery system, if the provider has a contract under which the organization submits the claim; or

(F) To an enrolled billing provider, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of the provider, if the billing provider's compensation for this service is:

(i) Related to the cost of processing the billing;

(ii) Not related on percentage or other basis to the amount that is billed or collected; and not dependent upon the collection of the payment.

(f) Providers must comply with TPR requirements in program-specific rules or contracts.

(4) Required State and Federal Statutes. When a provider submits a claim for services or supplies provided to a client or a PHP encounter, it is a representation by the provider that the provider has complied with all the requirements of these rules, and if applicable, program-specific rules or contracts.

(5) Program Integrity. The Department uses several approaches to promote program integrity. These rules describe program integrity actions related to provider payments, including provider reimbursement under program-specific rules, county agreements, and contracts. The program integrity goal is to pay the correct amount to a properly enrolled provider for covered services provided to an eligible client according to the program-specific coverage criteria in effect on the date of service.

(a) Program integrity activities include but are not limited to the following:

(A) Medical or professional review including but not limited to following the evaluation of care in accordance with evidence-based principles, medical error identification, and prior authorization processes, including all actions taken to determine the coverage and appropriateness of services or items in accordance with program-specific rules or contract;

(B) Provider obligations to submit correct claims and PHP encounters;

(C) Onsite visits to verify compliance with standards;

(D) Implementation of HIPAA electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;

(E) Provider credentialing activities;

(F) Accessing federal Department of Health and Human Services (DHHS) database (exclusions);

(G) Quality improvement activities;

(H) Cost report settlement processes;

(I) Audits;

(J) Investigation of false claims, fraud or prohibited kickback relationships; and

(K) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities.

(b) The following people may review a request for services or items, or audit a claim or PHP encounter for care, services, or items, before or after payment, for assurance that the specific care, item, or service was provided in accordance with the program-specific and the generally accepted standards of a provider's field of practice or specialty:

(A) Department staff or designee;

(B) Medical utilization and professional review contractor;

(C) Dental utilization and professional review contractor; or

(D) Federal or state oversight authority.

(c) Payment may be denied or subject to recovery if the review or audit determines the care, service, or item was not provided in accordance with provider rules or does not meet the criteria for quality or medical appropriateness of the care, service, or item or payment. Related provider and hospital billings will also be denied or subject to recovery.

(d) If the Department determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.

(e) The Department may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0320
Provider Enrollment

(1) In some Department program areas, being an enrolled Department provider is a condition of eligibility for a Department contract for certain services or activities. If reimbursement for covered services will be made under a contract with the Department, the provider

must also meet the Department's contract requirements. Contract requirements are separate from the requirements of these provider enrollment rules. Enrollment as a provider with the Department is not a promise that the enrolled provider will receive any amount of work from the Department, a PHP, or a county.

(2) Relation to Program-Specific or Contract Requirements. Provider enrollment establishes essential Department provider participation requirements for becoming an enrolled Department provider. The details of provider qualification requirements, client eligibility, covered services, how to obtain prior authorization or review (if required), documentation requirements, claims submission, and available electronic access instructions, and other pertinent instructions and requirements are contained in the program-specific rules or contract.

(3) Criteria for Enrollment. Prior to enrollment, providers must:

(a) Meet all program-specific or contract requirements identified in program-specific rules or contracts in addition to those requirements identified in these rules;

(b) Meet Department contracting requirements, as specified by the Department's Office of Contracts and Procurement (OC&P);

(c) Meet Department and federal licensing requirements for the type of service for which the provider is enrolling;

(d) Meet Department and federal certification requirements for the type of service for which the provider is enrolling; and

(e) Obtain a provider number from the Department for the specific service for which the provider is enrolling.

(4) Participation as an Enrolled Provider. Participation with the Department as an enrolled provider is open to qualified providers that:

(a) Meet the qualification requirements established in these rules and program-specific rules or contracts;

(b) Enroll as a Department provider in accordance with these rules;

(c) Provide a covered service or item within their scope of practice and licensure to an eligible Department recipient in accordance with program-specific rules or contracts; and

(d) Accept the reimbursement amounts established in accordance with the Department's program-specific fee structures or contracts for the service or item.

(5) Enrollment Process. To be enrolled as a Department provider, an individual or organization must submit a complete and accurate provider enrollment form, available from the Department, including all required documentation, and a signed provider enrollment agreement.

(a) Provider Enrollment Form. The provider enrollment form requests basic demographic information about the provider that will be permanently associated with the individual or organization until changed on an update form.

(b) Provider and Program Addendum. Each Department program establishes provider-specific qualifications and program criteria that must be provided as part of the provider enrollment form.

(A) The provider must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules, and must comply with all Oregon statutes and regulations applicable to the provider's scope of service as well as the program-specific rules or contract applicable to the provision of covered services. The provider and program addendum will specify the required documentation of professional qualifications that must be provided with the provider enrollment form.

(B) All providers of services within Oregon must have a valid Oregon business license if such a license is a requirement of the state, federal, county, or city government to operate a business or to provide services. In addition providers must be registered to do business in Oregon by registering with the Oregon Secretary of State, Corporation Division, if registration is required.

(c) Provider Disclosure Form. All individuals and entities are required to disclose information used by the Department to determine whether an exclusion applies that would prevent the Department from enrolling the provider. Individual performing providers must submit a disclosure statement. All providers that are enrolling as an entity (corporation, non-profit, partnership, sole proprietorship, governmental) must submit a disclosure of ownership and control interest statemento. Payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs or that employs or is managed by excluded individuals or entities.

(A) Entities must disclose all the information required on the disclosure of ownership and control interest statement. Information that must be disclosed includes the name, address, and taxpayer identification number of each individual with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more; whether any of the named individuals are related as spouse, parent, child, or sibling; and the name

and taxpayer identification number of any other disclosing entity in which an individual with an ownership or control interest in the disclosing entity also has an ownership or control interest.

(B) A provider must submit, within 35 days of the date of a request by DHHS or the Department, full and complete information about the ownership of any subcontractor with whom the provider had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

(C) Before the Department enters into a provider enrollment agreement with a provider, or renews a provider agreement, or at any time upon written request of the Department, the provider must disclose to the Department the identity and taxpayer identification number of any individual who has an ownership or control interest in the provider; or is an agent or managing employee of the provider; or the individual performing provider that has been convicted of a criminal offense related to that individual's involvement in any program under Medicare, Medicaid, or Title XX services program, since the inception of those programs.

(D) The Department may refuse to enter into or may suspend or terminate a provider enrollment agreement if the individual performing provider or any individual who has an ownership or control interest in the entity, or who is an agent or managing employee of the provider, has been sanctioned or convicted of a criminal offense related to that individual's involvement in any program established under Medicare, Medicaid, Children's Health Insurance, Title XX services, or other public assistance program.

(E) The Department may refuse to enter into or may suspend or terminate a provider enrollment agreement, or contract for provider services, if it determines that the provider did not fully and accurately make any disclosure required under subsection (c) of this rule.

(F) Taxpayer identification numbers, including social security numbers (SSN) and employer identification numbers (EIN), must be provided where indicated on the Disclosure Statement or the Disclosure of Ownership and Control Interest Statement. The taxpayer identification number will be used to confirm whether the individual or entity is subject to exclusion from participation in the Oregon Medicaid program.

(6) Provider Enrollment Agreement. The provider must sign the provider enrollment agreement, and submit it for review to the Department at the time the provider submits

the provider enrollment form and related documentation. Signing the provider enrollment agreement constitutes agreement by a provider to comply with all applicable Department provider and program rules, and applicable federal and state laws and regulations in effect on the date of service.

(7) Request to Conduct Electronic Transactions. A provider may request to conduct electronic transactions with the Department by enrolling and completing the appropriate authorization forms in accordance with the electronic data transaction rules (OAR 407-120-0100 through 407-120-0200).

(8) Enrollment of Providers. A provider will be enrolled and assigned a provider number for use in specific payment or business operations and will be issued to the enrolled provider upon:

(a) Provider submission of a complete and signed (when applicable), provider enrollment form, provider enrollment agreement, provider certification and all required documents to the Department program responsible for enrolling the provider. Provider signature must be the provider or an individual with actual authority from the provider to legally bind the provider to attest and certify to the accuracy and completeness of the information submitted;

(b) The Department's verification of licensing or certification or other authority to perform the service or provide the item within the lawful scope of practice recognized under Oregon law. The Department may confirm any information on the provider enrollment form or documentation submitted with the provider enrollment form, and may request additional information; and

(c) The Department's acceptance of the provider enrollment form, provider enrollment agreement and provider certification by the Department unit responsible for approving the enrollment of the provider.

(9) Claim or Encounter Submission. Submission of a claim or encounter or other reimbursement document constitutes the enrolled provider's agreement that:

(a) The service or item was provided in compliance with all applicable rules and requirements in effect on the date of service;

(b) The provider has created and maintained all records necessary to disclose the extent of services or items provided and provider's compliance with applicable program and financial requirements, and that the provider agrees to make such information available upon request to the Department, the MFCU (for Medicaid-funded services or items), the Oregon Secretary of State, and (for federally-funded services or items) the federal funding authority and the Comptroller General of the United States, or their designees;

(c) The information on the claim or encounter, regardless of the format or other reimbursement document is true, accurate and complete; and

(d) The provider understands that payment of the claim or encounter or other reimbursement document will be from federal or state funds, or a combination of federal and state funds, and that any falsification, or concealment of a material fact, may result in prosecution under federal and state laws.

(10) Providers Required to Use a NPI. The Department has taken action to ensure compliance with the NPI requirements pursuant to 45 CFR Part 162 when those requirements became effective on May 23, 2007. In the event of a transition period approved by CMS beyond May 23, 2008, the following requirements for contractors, providers, and provider-applicants will apply:

(a) Providers and contractors that obtain a NPI are required to use their NPI where indicated. In situations where a taxonomy code may be used in conjunction with the NPI, providers must update their records as specified with the Department's provider enrollment unit. Providers applying for enrollment with the Department that have been issued a NPI must include that NPI and any associated taxonomy codes with the provider enrollment form;

(b) A provider enrolled with the Department must bill using the NPI pursuant to 45 CFR 162.410, in addition to the Department-assigned provider number, where applicable, and continue to bill using the Department assigned provider number until the Department informs the provider that the Department assigned provider number is no longer allowed, or the NPI transition period has ended, whichever occurs first. Failure to use the NPI and Department-assigned provider number as indicated during this transition period may result in delay or rejection of claims and other transactions;

(c) The NPI and applicable taxonomy code combinations will be cross-referenced to the Department assigned provider number for purposes of processing all applicable electronic transactions as specified in OAR 407-120-0100;

(d) The provider and PHP must cooperate with the Department with reasonable consultation and testing procedures, if any, related to implementation of the use of NPI's; and

(e) Certain provider types are not eligible for a NPI based on federal criteria for obtaining a NPI. Providers not eligible for a NPI must always use their Department provider number on claims, encounters or other reimbursement documents for that specific provider type.

(11) Retroactive Enrollment of Medical Assistance Providers. The effective date of provider enrollment is the date the provider's request is received by the Department if on that date the provider met all applicable requirements. The effective date may be retroactive for up

to one year to encompass dates on which the provider furnished covered services to a medical assistance recipient for which it has not been paid, if on the retroactive effective date the provider met all applicable requirements.

(12) Provider numbers are specific to the category of service or items authorized by the Department to be provided. Issuance of a Department-assigned provider number establishes enrollment of an individual or organization as a provider for the specific category of services covered by the provider and program addendum submitted with the provider enrollment form and provider enrollment agreement.

(13) Required Updates:

(a) An enrolled provider must notify the Department in writing of a material change in any status or condition on any element of their provider enrollment form. Providers must notify the Department of changes in any of this information in writing within 30 calendar days of any of the following changes:

(A) Business affiliation;

(B) Ownership;

(C) NPI;

(D) Associated taxonomy codes;

(E) Federal Tax Identification number;

(F) Ownership and control information; or

(G) Criminal convictions.

(b) These changes may require the submission of a provider enrollment form, provider enrollment agreement, provider certification or other related documentation.

(c) Claims submitted by, or payments made to, providers who have not timely furnished the notification of changes or have not submitted any of the items that are required due to a change may be denied or recovered.

(d) Notice of bankruptcy proceedings must be immediately provided to the Department in writing.

(14) Tax Reporting and Withholding.

(a) Providers must submit the provider's SSN unless the contractor provides a federal EIN, whichever is required for tax reporting purposes on IRS Form 1099.

Providing this number is mandatory to be eligible to enroll as a provider. The provider's SSN or EIN is required pursuant to 42 CFR 433.37 federal tax laws at 26 USC 6041. SSN's and EIN's provided pursuant to this authority are used for the administration of state, federal, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.

(b) The Department must comply with the tax information reporting requirements of section 6041 of the Internal Revenue Code (26 USC 6041). Section 6041 requires the filing of annual information returns showing amounts paid to providers, who are identified by name, address, and SSN or EIN. The Department files its information returns with the Internal Revenue Service (IRS) using Form 1099MISC.

(c) The IRS Code section 3406(a)(1)(B) requires the Department to begin backup withholding when notified by the IRS that a taxpayer identification number reported on an information return is incorrect. If a provider receives notice of backup withholding from the Department, the provider is responsible for timely complying with the notice and providing the Department with accurate information. The Department will comply with IRS requirements for backup withholding.

(d) Failure to notify the Department of a change in federal tax identification number (SSN or EIN) may result in the Department imposing a sanction as specified in OAR 407-120-0360.

(e) If the Department notifies a provider about an error in federal tax identification number, the provider must supply a valid federal tax identification number within 30 calendar days of the date of the Department's notice. Failure to comply with this requirement may result in the Department imposing a sanction as specified in OAR 407-120-0360, for each time the provider submits an inaccurate federal tax identification number, and may require back-up withholding. Federal tax identification number requirements described in this rule refer to any requirements established by the IRS.

(15) Enrollment of Out-of-State Providers. Providers of services to clients outside the State of Oregon will be enrolled as a provider under section (8) of this rule if they comply with the requirements of section (8) and under the following conditions:

(a) The provider is appropriately licensed or certified and is enrolled in the provider's home state for participation in that state's Medicaid program or, for non-Medicaid services, enrolled or contracted with the state agency in the provider's state to provide the same program-specific service in the provider's state. Disenrollment or sanction from the other state's Medicaid program, or exclusion from any other federal or state health care program or comparable program-specific service

delivery system is a basis for denial of enrollment, termination, or suspension from participation as a Department provider;

(b) The Oregon Board of Pharmacy issued a license to provide pharmacy services to a noncontiguous out-of-state pharmacy provider;

(c) The services must be authorized in the manner required for out-of-state services under the program-specific rules or contract for an eligible client;

(d) The services for which the provider bills are covered services under the OHP or other Department program for which covered services are authorized to be provided to the client;

(e) A facility, including but not limited to a hospital, rehabilitative facility, institution for care of individuals with mental retardation, psychiatric hospital, or residential care facility, is enrolled or contracted by the state agency in the state in which the facility is located or is licensed as a facility provider of services by Oregon; and

(f) If the provider is not domiciled in or registered to do business in Oregon, the provider must promptly provide to the Oregon Department of Revenue and the Oregon Secretary of State, Corporation Division all information required by those agencies relative to the provider enrollment form and provider enrollment agreement. The Department will withhold enrollment and payments until the out-of-state provider has provided documentation of compliance with this requirement to the Department unit responsible for enrollment.

(16) Provider Enrollment Agreement Termination.

(a) Mutual Consent. The provider may ask the Department to terminate the provider enrollment agreement at any time, subject to any specific provider termination requirements in program-specific rules or contracts.

(A) The request must be in writing, and signed by the provider, and mailed or delivered to the Department provider enrollment unit. The notice must specify the Department-assigned provider number, if known.

(B) When accepted, the Department will assign the provider number a termination status and the effective date of the termination status.

(C) Termination of the provider enrollment agreement does not relieve the provider of any obligations for covered services or items provided under these rules, program-specific rules or contracts in effect for dates of services during which the provider enrollment agreement was in effect.

(D) If the provider fails to submit any claims for reimbursement for an 18-month period, the Department will terminate the agreement in accordance with this rule. The provider may reapply for enrollment.

(b) Department Termination. The Department may terminate the provider enrollment agreement immediately upon notice to the provider, or a later date as the Department may establish in the notice, upon the occurrence of any of the following events:

(A) The Department fails to receive funding, appropriations, limitations or other expenditure authority at levels that the Department or the specific program determines to be sufficient to pay for the services or items covered under the agreement;

(B) Federal or state laws, regulations, or guidelines are modified or interpreted by the Department in a manner that either providing the services or items under the agreement is prohibited or the Department is prohibited from paying for such services or items from the planned funding source;

(C) The Department has issued a final order revoking the Department-assigned provider number based on a sanction under termination terms and conditions established in program-specific rules or contract; or

(D) The provider no longer holds a required license, certificate or other authority to qualify as a provider. The termination will be effective on the date the license, certificate, or other authority is no longer valid.

(c) In the event of any dispute arising out of the termination of the provider enrollment agreement, the provider's sole monetary remedy is limited to covered services or items the Department determines to be compensable under the provider agreement, a claim for unpaid invoices, hours worked within any limits set forth in the agreement but not yet billed, and Department-authorized expenses incurred prior to termination. Providers are not entitled to recover indirect or consequential damages. Providers are not entitled to attorney fees, costs, or expenses of any kind.

(17) Immediate Suspension. When a provider fails to meet one or more of the requirements governing participation as a Department enrolled provider, the provider's Department-assigned provider number may be immediately suspended, in accordance with OAR 407-120-0360. The provider shall not provide services or items to clients during a period of suspension. The Department shall deny claims for payment or other reimbursement requests for dates of service during a period of suspension.

(18) Provider Participation is Voluntary. The provision of program-specific or contract covered services or items to eligible clients is a voluntary action on the part of the provider. Providers are not required to serve all clients seeking service. If a provider

undertakes to provide a covered service or item to an eligible client, the provider must comply with these rules, program-specific rules or contract.

(19) For Medicaid services, a provider may not deny services to any eligible individual because of the client's inability to pay the cost sharing amount imposed by the applicable program-specific or provider-specific rule or contract. A client's inability to pay does not eliminate the client's liability for the cost sharing charge.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0330
Billing Procedures

(1) Billing Procedures. These rules only apply to covered services and items provided to clients that are paid for by the Department based on a Department fee schedule or other reimbursement method (often referred to as fee-for-service), or for services that are paid for by the Department at the request of a county for county-authorized services, in accordance with program-specific rules or contract.

(a) If a client's service or item is paid for by a PHP, the provider must comply with the billing and procedures related to claim submission established under contract with that PHP, or the rules applicable to non-participating providers if the provider is not under contract with that PHP.

(b) If the client is enrolled in a PHP, but the client is permitted by a contract or program-specific rules to obtain covered services reimbursed by the Department (such as family planning services that may be obtained from any provider), the provider must comply with the billing and claim procedures established under these rules.

(2) Use of Provider Number. All Department-assigned provider numbers are issued at enrollment and are directly associated with the provider as defined in OAR 407-120-0320(12) and have the following use:

(a) Log-on identification for the Department web portal;

(b) Claim submission in the approved paper formats; and

(c) For electronic claims submission including the web portal for atypical providers pursuant to 45 CFR 160 and 162 where a NPI is not mandated. Use of the Department-assigned provider number will be considered authorized by the provider and the Department will hold the provider accountable for its use.

(3) Limitations on Billing. Except as provided in section (4) below, an enrolled provider may not seek payment for any covered services from:

(a) A client for covered benefits; or

(b) A financially responsible relative or representative of that client.

(4) Exceptions on Billing Limitations. Providers may seek payment from an eligible client or client representative as follows:

(a) The provider may seek payment from any applicable coinsurance, co-payments, deductibles, or other client financial obligation to the extent and as expressly authorized by program-specific rules or contract;

(b) From a client who failed to inform the provider of Department program eligibility, of OHP or PHP enrollment, or of other third party insurance coverage at the time the service was provided or subsequent to the provision of the service or item. In this case, the provider could not bill the Department, the PHP, or third party payer for any reason, including, but not limited to; timeliness of claims and lack of prior authorization. The provider must document attempts to obtain information on eligibility or enrollment;

(c) The client became eligible for Department benefits retroactively but did not meet other established criteria described in the applicable program-specific rules or contracts.

(d) The provider can document that a TPR made payments directly to the client for services provided that are subject to recovery by the provider in accordance with program-specific rules or contract;

(e) The service or item is not covered under the client's benefit package. The provider must document that prior to the delivery of services or items, the provider informed the client the service or item would not be covered by the Department;

(f) The client requested continuation of benefits during the administrative hearing process and the final decision was not in favor of the client. The client will be responsible for any charges since the effective date of the initial notice of denial; or

(g) In exceptional circumstances, a client may request continuation of a covered service while asserting the right to privately pay for that service. Under this circumstance, a provider may bill the client for a covered service only if the client is informed in advance of receiving the specific service of all of the following:

(A) The requested service is a covered service and the provider would be paid in full for the covered service if the claim is submitted to the Department or the client's PHP, if the client is a member of a PHP;

(B) The estimated cost of the covered service, including all related charges, that the Department or PHP would pay, and for which the client is billed cannot be an amount greater than the maximum Department reimbursable rate or PHP rate, if the client is a member of a PHP;

(C) The provider cannot require the client to enter into a voluntary payment agreement for any amount for the covered service; and

(D) The provider must be able to document, in writing, signed by the client or the client's representative, that the client was provided the information described above; client was provided an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and the client agreed to be responsible for payment by signing an agreement incorporating all of the information described above. The provider must provide a copy of the signed agreement to the client. A provider must not submit a claim for payment for the service or item to the Department or to the client's PHP that is subject to such an agreement.

(5) Reimbursement for Non-Covered Services.

(a) Client Waiver for Non-Covered Services. A provider may bill a client for services that are not covered by the Department or a PHP, except as provided in these rules. The client must be informed in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the client or client's representative is financially responsible for payment for the specific service. Providers must provide written documentation, signed by the client, or the client's representative, dated prior to the delivery of services or item indicating that the client was provided this information and that the client knowingly and voluntarily agreed to be responsible for payment.

(b) Providers must not bill or accept payment from the Department or a managed care plan for a covered service when a non-covered service has been provided and additional payment is sought or accepted from the client. Examples include, but are not limited to, charging the client an additional payment to obtain a gold crown (not covered) instead of the stainless steel crown (covered) or charging an additional client payment to obtain eyeglass frames not on the covered list of frames. This practice is called buying-up, which is not permitted, and a provider may be sanctioned for this practice regardless of whether a client waiver is documented.

(c) Providers must not bill clients or the Department for a client's missed appointment.

(d) Providers must not bill clients or the Department for services or items provided free of charge. This limitation does not apply to established sliding fee schedules where the client is subject to the same standards as other members of the public or clients of the provider.

(e) Providers must not bill clients for services or items that have been denied due to provider error such as required documentation not submitted or prior authorization not obtained.

(6) Providers must verify that the individual receiving covered services is, in fact, an eligible client on the date of service for the service provided and that the services is covered in the client's benefit package.

(a) Providers are responsible for costs incurred for failing to confirm eligibility or that services are covered.

(b) Providers must confirm the Department's client eligibility and benefit package coverage using the web portal, or the Department telephone eligibility system, and by other methods specified in program-specific or contract instructions.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0340
Claim and PHP Encounter Submission

(1) Claim and PHP Encounter Submission. All claims must be submitted using one of the following methods:

(a) Paper forms, using the appropriate form as described in the program-specific rules or contract;

(b) Electronically using the web portal accessed by provider-specific PIN and password. Initial activation by provider of Department-assigned provider number and PIN for web portal access invokes provider's agreement to meet all of the standards for HIPAA privacy, security, and transactions and codes sets standards as defined in 45 CFR 162;

(c) Electronically in a manner authorized by the Department's EDT rules (OAR 407-120-0100 through 407-120-0200); or

(d) Electronically, for PHP encounters, in the manner required by the PHP contract with the Department and authorized by the Department's EDT rules.

(2) Claims must not be submitted prior to delivery of service unless otherwise authorized by program-specific rules or contracts. A claim for an item must not be submitted prior to

dispensing, shipping, or mailing the item unless otherwise specified in the Department's program-specific rules or contracts.

(3) Claims and PHP encounters must be submitted in compliance HIPAA transaction and code set rules. The HIPAA transaction and code set rules, 45 CFR 162, apply to all electronic transactions for which DHHS has adopted a standard.

(a) The Department may deny or reject electronic transactions that fail to comply with the federal standard.

(b) The Department is required to comply with the HIPAA code set requirements in 45 CFR 162.1000 through 162.1011, regardless of whether a request is made verbally, or a claim is submitted on paper or electronically, and with regard to the electronic claims and encounter remittance advice information, including the web portal. Compliance with the code set requirements includes the codes and the descriptors of the codes established by the official entity that maintains the code set. These federal code set requirements are mandatory and the Department has no authority to delay or alter their application or effective dates as established by DHHS.

(A) The issuance of a federal code does not mean that the Department covers the item or service described by the federal code. In the event of an alleged variation between a Department-listed code and a national code, the provider should seek clarification from the Department program. The Department will apply the national code in effect on the date of request or date of service and the Department-listed code may be used for the limited purpose of describing the Department's intent in identifying whether the applicable national code represents a Department covered service or item.

(B) For purposes of maintaining HIPAA code set compliance, the Department adopts, by reference, the required use of the version of all national code set revisions, deletions, and additions in accordance with the HIPAA transaction and code set rules in effect on the date of this rule. This code set adoption may not be construed as Department coverage or that the existence of a particular national code constitutes a determination by the Department that the particular code is a covered service or item. If the provider is unable to identify an appropriate procedure code to use on the claim or PHP encounter, the provider should contact the Department for assistance in identifying an appropriate procedure code:

(i) Current Procedural Terminology, Fourth Edition (CPT-4), (American Medical Association);

(ii) Current Dental Terminology (CDT), (American Dental Association);

(iii) Diagnosis Related Group (DRG), (DHHS);

(iv) Health Care Financing Administration Common Procedural Coding System (HCPCS), (DHHS);

(v) National Drug Codes (NDC), (DHHS); and

(vi) HIPAA related codes, DHHS, claims adjustment reason, claim status, taxonomy codes, and decision reason as available at the Washington Publishing Company web site: http://www.wpc.edi.com/content/view/180/223.

(C) For electronic claims and PHP encounters, the appropriate HIPAA claim adjustment reason code for third party payer, including Medicare, explanation of payment must be used.

(c) Diagnosis Code Requirement.

(A) For claims and PHP encounters that require the listing of a diagnosis code as the basis for the service provided, the code listed on the claim must be the code that most accurately describes the client's condition and the service or item provided.

(B) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis code set including the code and the descriptor of the code by the official entity that maintains the code set, unless the requirement for a primary diagnosis code is specifically excluded in the Department’s program-specific rules or contract. All diagnosis codes are required to the highest degree of specificity. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate program-specific rules or contract.

(C) Hospitals must follow national coding guidelines and must bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups.

(d) Procedure Code Requirement.

(A) The provider must identify the appropriate procedure code on claims and PHP encounters as instructed in the appropriate Department program-specific rules or contract and must use the appropriate HIPAA procedure code set, set forth in 45 CFR 162.1000 through 162.1011, which best describes the specific service or item provided.

(B) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards, describes an array of services, the provider must use that code rather than itemizing the services under multiple codes. Providers must not "unbundle" services in order to increase payment or to mischaracterize the service.

(4) Prohibition of False Claims. No provider or its contracted agent (including billing service or billing agent) shall submit or cause to be submitted to the Department:

(a) Any false claim for payment or false PHP encounter;

(b) Any claim or PHP encounter altered in such a way as to result in a duplicate payment for a service that has already been paid;

(c) Any claim or PHP encounter upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form or PHP encounter format; or

(d) Any claim or PHP encounter for providing services or items that have not been provided.

(5) Third Party Resources.

(a) A provider shall not refuse to furnish covered services or items to an eligible client on account of a third party's potential liability for the service or item.

(b) Providers must take all reasonable measures to ensure that the Department will be the payer of last resort, consistent with program-specific rules or contracts. If available, private insurance, Medicare, or worker's compensation must be billed before the provider submits a claim for payment to the Department, county, or PHP. For services provided to a Medicare and Medicaid dual eligible client, Medicare is the primary payer and the provider must first pursue Medicare payment (including appeals) prior to submitting a claim for payment to the Department, county or PHP. For services that are not covered by Medicare or other third party resource, the provider must follow the program-specific rules or contracts for appropriate billing procedures.

(c) When another party may be liable for paying the expenses of a client's injury or illness, the provider must follow program-specific rules or contract addressing billing procedures.

(6) Full Use of Alternate Community Resources.

(a) The Department will generally make payment only when other resources are not available for the client's needs. Full use must be made of reasonable alternate resources in the local community; and

(b) Providers must not accept reimbursement from more than one resource for the same service or item, except as allowed in program-specific or contract TPR requirements.

(7) Timely Submission of Claim or Encounter Data.

(a) Subsection (a) through (c) below only apply to the submission of claims data or other reimbursement document to the Department, including provider reimbursement by the Department pursuant to an agreement with a county. Unless requirements for timely filing provided for in program-specific rules or applicable contracts are more specific than the timely filing standard established in this rule, all claims for services or items must be submitted no later than 12 months from the date of service.

(b) A denied claim submitted within 12 months of the date of service may be resubmitted (with resubmission documentation, as indicated within the program-specific rules or contracts) within 18 months of the date of service. These claims must be submitted to the Department in writing. The provider must present documentation acceptable to the Department verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in program-specific rules or contracts. Acceptable documentation is:

(A) A remittance advice or other claim denial documentation from the Department to the provider showing the claim was submitted before the claim was one year old; or

(B) A copy of a billing record or ledger showing dates of submission to the Department.

(c) Exceptions to the 12-month requirement that may be submitted to the Department are as follows:

(A) When the Department confirms the Department or the client's branch office has made an error that caused the provider not to be able to bill within 12 months of the date of service;

(B) When a court or an administrative law judge in a final agency order has ordered the Department to make payment;

(C) When the Department determines a client is retroactively eligible for Department program coverage and more than 12 months have passed between the date of service and the determination of the client's eligibility, to the extent authorized in the program-specific rules or contracts.

(d) PHP encounter data must be submitted in accordance with 45 CFR 162.1001 and 162.1102 and the time periods established in the PHP contract with the Department.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0350
Payments and Overpayments

(1) Authorization of Payment.

(a) Some services or items covered by the Department require authorization before a service, item or level of care can be provided or before payment will be made. Providers are responsible for checking the appropriate program-specific rules or contracts for information on services or items requiring prior authorization and the process to follow to obtain authorization.

(b) Documentation submitted when requesting authorization must support the program-specific or contract justification for the service or item or level of care. A request is considered complete if it contains all necessary documentation and meets any other requirements as described in the appropriate program-specific rules or contract.

(c) The authorizing program will authorize the covered level of care or type of service or item that meets the client's program-eligible need. The authorizing program shall only authorize services which meet the program-specific or contract coverage criteria and for which the required documentation has been supplied. The authorizing program may request additional information from the provider to determine the appropriateness of authorizing the service or item or level of care within the scope of program coverage.

(d) Authorizing programs are not required to authorize services or to make payment for authorized services under the following circumstances:

(i) The client was not eligible at the time services were provided. The provider is responsible for checking the client's eligibility each time services are provided;

(ii) The provider cannot produce appropriate documentation to support the level of care, type of service, or item meets the program-specific or contract criteria, or the appropriate documentation was not submitted to the authorizing program;

(iii) The delivery of the service, item, or level of care has not been adequately documented per OAR 407-120-0370, Requirements for Financial, Clinical

and Other Records, and the documentation in the provider's files is not adequate to determine the type, medical appropriateness, or quantity of services or items provided or the required documentation is not in the provider's files;

(iv) The services or items identified in the claim are not consistent with the information submitted when authorization was requested or the services or items provided are retrospectively determined not to be authorized under the program-specific or contract criteria;

(v) The services or items identified in the claim are not consistent with those provided;

(vi) The services or items were not provided within the timeframe specified on the authorization of services document; or

(vii) The services or items were not authorized or provided in compliance with the program-specific rules or contracts.

(e) Payment made for services or items described in subsections (d)(i) through (vii) of this rule will be recovered.

(f) Retroactive Department Client Eligibility.

(A) When a client is determined to be retroactively eligible for a Department program, or is retroactively disenrolled from a PHP or services provided after the client was disenrolled from a PHP, authorization for payment may be given if the conditions set forth in (A) through (D) of this section are met;

(i) The client was eligible on the date of service and the program-specific rules or contract authorize the Department to reimburse the provider for services provided to clients made retroactively eligible;

(ii) The services or items provided to the client meet all other program-specific or contract criteria and Oregon Administrative Rules;

(iii) The request for authorization is received by the appropriate Department branch or Department program office within 90 days of the date of service; and

(iv) The provider is enrolled with the Department on the date of service, or becomes enrolled with the Department not later than the date of service as provided in OAR 407-120-0320(11).

(B) Requests for authorization received after 90 days from date of service require all the documentation required in (6)(a)(i), (ii) and (iv) and documentation from the provider that states that authorization could not have been obtained within 90 days of the date of service.

(g) Service authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the client's benefit package no longer covers the service, in which case the authorization terminates on the date coverage ended.

(h) Service authorization for clients with other insurance or for Medicare beneficiaries is governed by program-specific rules or contracts.

(2) Payments.

(a) This rule only applies to covered services and items provided to eligible clients within the program-specific or contract covered services or items in effect on the date of service that are paid for by the Department based on program-specific or contract fee schedules or other reimbursement methods, or for services that are paid for by the Department at the request of a county for county-authorized services in accordance with program-specific or provider-specific rules or contracts.

(b) If the client’s service or item is paid for by a PHP, the provider must comply with the payment requirements established under contract with that PHP, and in accordance with OAR 410-120 and 410-141, applicable to non-participating providers.

(c) The Department will pay for services or items based on the reimbursement rates and methods specified in the applicable program-specific rules or contract. Provider reimbursement on behalf of a county must include county service authorization information.

(d) Providers must accept, as payment in full, the amounts paid by the Department in accordance with the fee schedule or reimbursement method specified in the program-specific rules or contract, plus any deductible, co-payment, or coinsurance required to be paid by the client. Payment in full includes:

(A) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding the Department’s allowable payment; or

(B) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate

manner, or failure to follow other required procedures identified in the program-specific rules or contracts.

(e) The Department will not make payments for duplicate services or items. The Department will not make a separate payment or co-payment to a provider for services included in the provider's all-inclusive rate if the provider has been or will be reimbursed by other resources for the service or item.

(f) Prepayment and Post-Payment Review. Payment by the Department does not limit the Department or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical, clinical, program-specific or contract review, audit, or other post-payment review determines the service or item was not provided in accordance with applicable rules or contracts or does not meet the program-specific or contract criteria for quality of care, or appropriateness of the care, or authorized basis for payment.

(3) Recovery of Overpayments to Providers - Recoupments and Refunds

(a) The Department may deny payment or may deem payments subject to recovery as an overpayment if a review or audit determines the item or service was not provided in accordance with the Department's rules, agreement of contract, or does not meet the criteria for quality of care, or appropriateness of the care or payment. Related provider billings will also be denied or subject to recovery.

(b) If a provider determines that a submitted claim or encounter is incorrect, the provider must submit an individual adjustment request and refund the amount of the overpayment, if any, or adjust the claim or encounter, as is consistent with the requirements in program-specific rules or contracts.

(c) The Department may determine, as a result of review or other information, that a payment should be denied or that an overpayment has been made to a provider, which indicates that a provider may have submitted claims or encounters, or received payment to which the provider is not properly entitled. Such payment denial or overpayment determinations may be based on, but not limited to, the following grounds:

(A) The Department paid the provider an amount in excess of the amount authorized under a contract, state plan or Department rule;

(B) A third party paid the provider for services, or portion thereof, previously paid by the Department;

(C) The Department paid the provider for services, items, or drugs that the provider did not perform or provide;

(D) The Department paid for claims submitted by a data processing agent for whom a written provider or billing agent or billing service agreement was not on file at the time of submission;

(E) The Department paid for services and later determined they were not part of the client's program-specific or contract-covered services;

(F) Coding, data processing submission, or data entry errors;

(G) Medical, dental, or professional review determines the service or item was not provided in accordance with the Department's rules or contract or does not meet the program-specific or contract criteria for coverage, quality of care, or appropriateness of the care or payment;

(H) The Department paid the provider for services, items, or drugs when the provider did not comply with the Department's rules and requirements for reimbursement; or

(I) The provider submitted inaccurate, incomplete or untrue encounter data to the Department.

(d) Prior to identifying an overpayment, the Department may contact the provider for the purpose of providing preliminary information and requesting additional documentation. The provider must provide the requested documentation within the time frame requested.

(e) When an overpayment is identified, the Department will notify the provider in writing as to the nature of the discrepancy, the method of computing the overpayment, and any further action that the Department may take on the matter. The notice may require the provider to submit applicable documentation for review prior to requesting an appeal from the Department, and may impose reasonable time limits for when documentation must be provided for Department consideration. The notice will inform the provider of the process for appealing the overpayment determination.

(f) The Department may recover overpayments made to a provider by direct reimbursement, offset, civil action, or other legal action:

(A) The provider must make a direct reimbursement to the Department within 30 calendar days from the date of the notice of the overpayment, unless other regulations apply;

(B) The Department may grant the provider an additional period of time to reimburse the Department upon written request made within 30 calendar days from the date of the notice of overpayment if the provider includes a

statement of the facts and reasons sufficient to show that repayment of the overpayment amount should be delayed pending appeal because;

(i) The provider will suffer irreparable injury if the overpayment notice is not delayed;

(ii) There is a plausible reason to believe that the overpayment is not correct or is less than the amount in the notice, and the provider has timely filed an appeal of the overpayment, or that the provider accepts the amount of the overpayment but is requesting to make repayment over a period of time;

(iii) A proposed method for assuring that the amount of the overpayment can be repaid when due with interest, including but not limited to a bond, irrevocable letter of credit or other undertaking, or a repayment plan for making payments, including interest, over a period of time;

(iv) Granting the delay will not result in substantial public harm; and

(v) Affidavits containing evidence relied upon in support of the request for stay.

(C) The Department may consider all information in the record of the overpayment determination, including provider cooperation with timely provision of documentation, in addition to the information supplied in provider's request. If provider requests a repayment plan, the Department may require conditions acceptable to the Department before agreeing to a repayment plan. The Department must issue an order granting or denying a repayment delay request within 30 calendar days after receiving it;

(D) A request for hearing or administrative review does not change the date the repayment of the overpayment is due; and

(E) The Department may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when overpayments are not paid as a result of subsection (e)(i);

(f) In addition to any overpayment, the Department may impose a sanction on the provider in connection with the actions that resulted in the overpayment. The Department may, at its discretion, combine a notice of sanction with a notice of overpayment.

(g) Voluntary submission of an adjustment claim or encounter transaction or an individual adjustment request or overpayment amount after notice from the Department does not prevent the Department from issuing a notice of sanction

The Department may take such voluntary payment into account in determining the sanction.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0360
Consequences of Non-Compliance and Provider Sanctions

(1) There are two classes of provider sanctions, mandatory and discretionary, that may be imposed for non-compliance with the provider enrollment agreement.

(2) Except as otherwise provided, the Department will impose provider sanctions at the direction of the assistant director of the Department's division whose budget includes payment for the services involved.

(3) Mandatory Sanctions. The Department shall impose mandatory sanctions and suspend the provider from participation in the Department's programs:

(a) When a provider has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws, or other disqualifying criminal conviction pursuant to program-specific rules or contract;

(b) When a provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of DHHS or from the Medicare (Title XVIII) program of the Social Security Act as determined by the secretary of DHHS. The provider will be excluded and suspended from participation with the Department for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General; or

(c) If the provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the provider submits a provider enrollment form or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(4) Discretionary Sanctions. When the Department determines the provider fails to meet one or more of the Department's requirements governing participation in its programs the Department may impose discretionary sanctions. Conditions that may result in a discretionary sanction include, but are not limited to, when a provider has:

(a) Been convicted of fraud related to any federal, state, or locally financed health care program or committed fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes;

(b) Been convicted of interfering with the investigation of health care fraud;

(c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance or other potentially disqualifying crime, as determined under program-specific rules or contracts;

(d) By actions of any state licensing authority for reasons relating to the provider's professional competence, professional conduct, or financial integrity either:

(A) Had his or her professional license suspended or revoked, or otherwise lost such license; or

(B) Surrendered his or her license while a formal disciplinary proceeding is pending before the relevant licensing authority.

(e) Been suspended or excluded from participation in any federal or state program for reasons related to professional competence, professional performance, or other reason;

(f) Billed excessive charges including, but not limited to, charging in excess of the usual charge, furnished items or services in excess of the client's needs or in excess of those services ordered by a provider, or in excess of generally accepted standards or quality that fail to meet professionally recognized standards;

(g) Failed to furnish necessary covered services as required by law or contract with the Department if the failure has adversely affected or has a substantial likelihood of adversely affecting the client;

(h) Failed to disclose required ownership information;

(i) Failed to supply requested information on subcontractors and suppliers of goods or services;

(j) Failed to supply requested payment information;

(k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of the Department or the MFCU conducting their regulatory or statutory functions;

(l) In the case of a hospital, failed to take corrective action as required by the Department, based on information supplied by the QIO to prevent or correct inappropriate admissions or practice patterns, within the time specified by the Department;

(m) In the case of a licensed facility, failed to take corrective action under the license as required by the Department within the time specified by the Department;

(n) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the provider's health profession education;

(A) Providers must have made a reasonable effort to secure payment;

(B) The Department must take into account access of beneficiaries to services; and

(C) Will not exclude a community's sole physician or source of essential specialized services;

(o) Repeatedly submitted a claim with required data missing or incorrect:

(A) When the missing or incorrect data has allowed the provider to:

(i) Obtain greater payment than is appropriate;

(ii) Circumvent prior authorization requirements;

(iii) Charge more than the provider's usual charge to the general public;

(iv) Receive payments for services provided to individuals who were not eligible; or

(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount, or type of services or items provided.

(B) Does not comply with the requirements of OAR 410-120-1280.

(p) Failed to develop, maintain, and retain, in accordance with relevant rules and standards, adequate clinical or other records that document the client’s eligibility and coverage, authorization (if required by program-specific rules or contracts), appropriateness, nature, and extent of the services or items provided;

(q) Failed to develop, maintain, and retain in accordance with relevant rules and standards, adequate financial records that document charges incurred by a client and payments received from any source;

(r) Failed to develop, maintain, and retain adequate financial or other records that support information submitted on a cost report;

(s) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;

(t) Submitted claims or written orders contrary to generally accepted standards of professional practice;

(u) Submitted claims for services that exceed the requested or agreed upon amount by the OHP client, the client representative, or requested by another qualified provider;

(v) Breached the terms of the provider contract or agreement;

(x) Failed to comply with the terms of the provider certifications on the claim form;

(y) Rebated or accepted a fee or portion of a fee for a client referral; or collected a portion of a service fee from the client and billed the Department for the same service;

(z) Submitted false or fraudulent information when applying for a Department-assigned provider number, or failed to disclose information requested on the provider enrollment form;

(aa) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from the Department;

(bb) Submitted any claim for payment for which the Department has already made payment or any other source unless the amount of the payment from the other source is clearly identified;

(cc) Threatened, intimidated, or harassed clients, client representatives, or client relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the Department;

(dd) Failed to properly account for a client's personal incidental funds including, but not limited to, using a client's personal incidental funds for payment of services which are included in a medical facility's all-inclusive rates;

(ee) Provided or billed for services provided by ineligible or unsupervised staff;

(ff) Participated in collusion that resulted in an inappropriate money flow between the parties involved;

(gg) Refused or failed to repay, in accordance with an accepted schedule, an overpayment established by the Department;

(hh) Failed to report to Department payments received from any other source after the Department has made payment for the service; or

(ii) Collected or made repeated attempts to collect payment from clients for services covered by the Department, pursuant to OAR 410-120-1280.

(5) A provider who has been excluded, suspended, or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, must not submit claims for payment, either personally or through claims submitted by any billing agent or service, billing provider or other provider, for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension or termination.

(6) Providers must not submit claims for payment to the Department for any services or supplies provided by an individual or provider entity that has been excluded, suspended, or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension or termination.

(7) When the provisions of sections (5) or (6) are violated, the Department may suspend or terminate the billing provider or any provider who is responsible for the violation.

(8) Type and Conditions of Sanction.

(a) A mandatory sanction imposed by the Department pursuant to section (3) may result in any of the following:

(A) The provider will either be terminated or suspended from participation in Department's programs. No payments of Title XIX, Title XXI or other federal or state funds will be made for services provided after the date of termination. Termination is permanent unless:

(i) The exceptions cited in 42CFR 1001.221 are met; or

(ii) Otherwise stated by the Department at the time of termination.

(B) No payments of Title XIX, Title XXI, or other federal or state funds will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed if the conditions that caused the suspension have been resolved. The minimum duration of a suspension will be determined by the DHHS secretary, under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The state may suspend a provider from participation in the medical assistance programs longer than the minimum suspension determined by the DHHS secretary.

(b) The Department may impose the following discretionary sanctions on a provider pursuant to OAR 410-120-1400(4):

(A) The provider may be terminated from participation in the Department's programs. No payments of Title XIX, Title XXI or other federal or state funds will be made for services provided after the date of termination. Termination is permanent unless:

(i) The exceptions cited in 42 CFR 1001.221 are met; or

(ii) Otherwise stated by the Department at the time of termination.

(B) The provider may be suspended from participation in the Department's programs for a specified length of time, or until specified conditions for reinstatement are met and approved by the Department. No payments of Title XIX, Title XXI, or other federal or state funds will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed if the conditions that caused the suspension have been resolved.

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

(F) The Department may require repayment of amounts paid or provide for reduction of any amount otherwise due the provider; and

(G) Any other sanctions reasonably designed to remedy or compel future compliances with federal, state, or Department regulations.

(c) The Department will consider the following factors in determining the sanction to be imposed. Factors include but are not limited to:

(A) Seriousness of the offense;

(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 QIO;

(H) Adverse impact on the availability of program-specific or contract covered services or the health of clients living in the provider's service area; and

(I) Potential financial sanctions related to the non-compliance may be imposed in an amount that is reasonable in light of the anticipated or actual harm caused by the non-compliance, the difficulties of proof of loss, and the inconvenience or non-feasibility of otherwise obtaining an adequate remedy.

(d) When a provider fails to meet one or more of the requirements identified in OAR 407-120-0300 through 407-120-0380, the Department, in its sole discretion, may immediately suspend the provider's Department assigned billing number and any electronic system access code to prevent public harm or inappropriate expenditure of public funds.

(A) The provider subject to immediate suspension is entitled to a contested case hearing as outlined in ORS 183 to determine whether the provider's Department assigned number and electronic system access code will be revoked; and

(B) The notice requirements described in section (5) of this rule do not preclude immediate suspension in the Department’s sole discretion to prevent public harm or inappropriate expenditure of public funds. Suspension may be invoked immediately while the notice and contested case hearing rights are exercised.

(e) If the Department sanctions a provider, the Department will notify the provider by certified mail or personal delivery service of the intent to sanction. The notice of immediate or proposed sanction will identify:

(A) The factual basis used to determine the alleged deficiencies and a reference to the particular sections of the statutes and rules involved;

(B) Explanation of actions expected of the provider;

(C) Explanation of the Department’s intended action;

(D) The provider's right to dispute the Department’s allegations and submit evidence to support the provider's position;

(E) The provider's right to appeal the Department's proposed actions pursuant to ORS 183;

(F) A statement of the authority and jurisdiction under which the appeal is to be held, with a description of the procedure and time to request an appeal; and

(G) A statement indicating whether and under what circumstances an order by default may be entered.

(f) If the Department decides to sanction a provider, the Department will notify the provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(g) The provider may appeal the Department's immediate or proposed sanction or other actions the Department intends to take. The provider must appeal this action separately from any appeal of audit findings and overpayments. These include, but are not limited to, the following:

(A) Termination or suspension from participation in the Medicaid-funded medical assistance programs;

(B) Termination or suspension from participation in the Department's state-funded programs; and

(C) Revocation of the provider's Department assigned provider number.

(h) 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 Department may notify the applicable professional society, board of registration or licensure, federal or state agencies, OHP, PHP's and the National Practitioner Data Base of the findings and the sanctions imposed;

(C) At the discretion of the Department, providers who have previously been sanctioned or suspended may or may not be re-enrolled as Department providers;

(D) Nothing in this rule prevents the Department from simultaneously seeking monetary recovery and imposing sanctions against the provider;

(E) Following a contested case hearing in which a provider has been found to violate ORS 411.675, the provider shall be liable to the Department for treble the amount of payments received as a result of each violation.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 411.675, 411.690, 414.115, 414.125, 414.135

407-120-0370
Requirements for Financial, Clinical, and Other Records

(1) The Department shall analyze and monitor the operation of its programs and audit and verify the accuracy and appropriateness of payment, utilization of services, or items.

(2) The Department shall comply with client coverage criteria and requirements for the level of care or service or item authorized or reimbursed by the Department and the quality of covered services or items and service or item delivery, and access to covered services or items.

(3) The provider and the provider's designated billing service or other entity responsible for the maintenance of financial, service delivery, and other records must:

(a) Develop and maintain adequate financial and service delivery records and other documentation which supports the specific care, items, or services for which payment has been requested. Payment will be made only for services that are adequately documented. The following documentation must be completed before the service is billed to the Department:

(A) All records documenting the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service was provided, and identification of the individual who provided the service. Patient account and financial records must also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the provider must maintain adequate records to thoroughly and accurately explain how the amounts reported on the cost statement were determined.

(B) Service delivery, clinical records, and visit data, including records of all therapeutic services, must document the basis for service delivery and record visit data if required under program-specific rules or contracts. A client's clinical record must be annotated each time a service is provided and signed or initialed by the individual providing the service or must clearly identify the individual providing the service. Information contained in the record must be sufficient in quality and quantity to meet the

professional standards applicable to the provider or practitioner and any additional standards for documentation found in this rule, program-specific rules, and any pertinent contracts.

(C) All information about a client obtained by the provider or its officers, employees, or agents in the performance of covered services, including information obtained in the course of determining eligibility, seeking authorization, and providing services, is confidential. The client information must be used and disclosed only to the extent necessary to perform these functions.

(b) Implement policies and procedures to ensure confidentiality and security of the client's information. These procedures must ensure the provider may release such information in accordance with program-specific federal and state statutes or contract, which may include but is not limited to, ORS 179.505 through 179.507, 411.320, 433.045, 42 CFR Part 2, 42 CFR Part 431 subpart F, 45 CFR 205.50, and ORS 433.045(3) with respect to HIV test information.

(c) Ensure the use of electronic record-keeping systems does not alter the requirements of this rule.

(A) A provider's electronic record-keeping system includes electronic transactions governed by HIPAA transaction and code set requirements and records, documents, documentation, and information include all information, whether maintained or stored in electronic media, including electronic record-keeping systems, and information stored or backed up in an electronic medium.

(B) If a provider maintains financial or clinical records electronically, the provider must be able to provide the Department with hard-copy versions. The provider must also be able to provide an auditable means of demonstrating the date the record was created and the identity of the creator of a record, the date the record was modified, what was changed in the record and the identity of any individual who has modified the record. The provider must supply the information to individuals authorized to review the provider's records under section (e) of this rule.

(C) Providers may comply with the documentation review requirements in this rule by providing the electronic record in an electronic format acceptable to an authorized reviewer. The authorized reviewer must agree to receive the documentation electronically.

(d) Retain service delivery, visit, and clinical records for seven years and all other records described in this rule, program-specific rules and contract for at least five years from the date of service.

(e) Furnish requested documentation (including electronically recorded information or information stored or backed up in an electronic medium) immediately or within the time-frame specified in the written request received from the Department, the Oregon Secretary of State, DHHS or other federal funding agency, Office of Inspector General, the Comptroller General of the United States (for federally funded programs), MFCU (for Medicaid-funded services or items), or the client representative. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Department, Medicaid Fraud Unit, DHHS, or other authorized reviewers may review and copy the original documentation in the provider's place of business. Upon written request of the provider, the program or the unit, may, at their sole discretion, modify or extend the time for provision of such records if, in the opinion of the program or unit good cause for such extension is shown. Factors used in determining if good cause exists include:

(A) Whether the written request was made prior to the deadline for production;

(B) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;

(C) The efforts already made to comply with the request;

(D) The reasons the deadline cannot be met;

(E) The degree of control that the provider had over its ability to produce the records prior to the deadline; and

(F) Other extenuating factors.

(f) Access to records, inclusive of clinical charts and financial records does not require authorization or release from the client, unless otherwise required by more restrictive state and federal regulations if the purpose of such access is:

(A) To perform billing review activities;

(B) To perform utilization review activities;

(C) To review quality, quantity, medical appropriateness of care, items, and services provided;

(D) To facilitate service authorization and related services;

(E) To investigate a client's hearing request;

(F) To facilitate investigation by the MFCU or DHHS; or

(G) To review records necessary to the operation of the program.

(g) Failure to comply with requests for documents within the specified time-frame means that the records subject to the request may be deemed by the Department not to exist for purposes of verifying appropriateness of payment, clinical appropriateness, the quality of care, and the access to care in an audit or overpayment determination, and subjects the provider to possible denial or recovery of payments made by the Department or to sanctions.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135

407-120-0380
Fraud and Abuse

(1) Providers are required to promptly refer all suspected fraud and abuse, including fraud or abuse by its employees or in Department administration, to the MFCU, or to the Department's audit unit.

(2) Providers must permit the MFCU and the Department to inspect, copy, evaluate, or audit books, records, documents, files, accounts, and facilities, without charge, as required to investigate allegations or incidents of fraud or abuse.

(3) Providers aware of suspected fraud or abuse by a client must report the incident to the Department's fraud unit.

(4) The Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.

(5) The Department may take actions necessary to investigate and respond to substantiated allegations of fraud and abuse, including but not limited to suspending or terminating the provider from participation in the Department's programs, withholding payments or seeking recovery of payments made to the provider, or imposing other sanctions provided under state law or regulations. Such actions by the Department may be reported to CMS or other federal or state entities as appropriate.

Stat. Auth.: ORS 409.010, 409.050, 409.060, 409.070, 409.093 through 409.160, 411.060
Stats. Implemented: ORS 414.115, 414.125, 414.135