

410-120-0000 Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) or the Addictions and Mental health Division (AMH) administrative rules applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions, OAR 410-141-0300, and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 407 administrative rules, or contact the Division.

~~(1) AAA—Area Agency on Aging.~~

~~(21) “Abuse” means— P~~provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the ~~Division~~Authority, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Authority~~Division~~.

~~(32) “Acupuncturist” means a—A~~ person licensed to practice acupuncture by the relevant state licensing board.

~~(43) “Acupuncture sServices” means— S~~services provided by a licensed acupuncturist within the scope of practice as defined under state law.

~~(54) “Acute” means— A~~a condition, diagnosis or illness with a sudden onset and that is of short duration.

~~(65) “Acquisition eCost” means— U~~unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.

~~(76) “Addiction and Mental Health Division (AMH)” means a—A~~ division within the Authority that administers mental health and addiction programs and services.

~~(87) “Adequate rRecord kKeeping” means— D~~documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

~~(98) “Administrative mMedical eExaminations and rReports” mean— E~~examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department branch office or requested or approved by the Authority ~~Division~~ to establish client eligibility for a medical assistance program or for casework planning.

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

~~(10) “Adverse eEvent” means— A~~an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

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

(4412) All-inclusive Rate means — ~~T~~the nursing facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Division’s Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340, Payment.

(4213) Allied Agency means ~~L~~local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(14) Alternative Care Settings mean sites or groups of practitioners that provide care to members under contract with a PHP or CCO, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities and outpatient surgical centers.

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(4315) Ambulance means — Aa specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Authority Department or the licensing standards of the state in which the ambulance provider is located.

(4416) Ambulatory Surgical Center (ASC) means — Aa facility licensed as an ASC by the Authority Department.

(4517) American Indian/Alaska Native (AI/AN) means — Aa member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(4618) American Indian/Alaska Native (AI/AN) eClinic means — Aa clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(4719) Ancillary sServices mean — ~~S~~services supportive of or necessary ~~to the provision of for providing~~ a primary service, ~~{such ase.g., anesthesiology, which is an ancillary service necessary for a surgical procedure}; Typically, such medical services are not identified in the definition of a condition/treatment pair, but are medically appropriate to support a service covered under the OHP benefit package; ancillary services and limitations are specified in the OHP (Managed Care) administrative rules related to the Oregon Health Services Commission’s Prioritized List of Health Services (410-141-0480 through 410-141-0520), the General Rules Benefit Packages (410-120-1210), Exclusions (410-120-1200) and applicable individual program rules.~~

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(4820) Anesthesia sServices mean — Aaadministration of anesthetic agents to cause loss of sensation to the body or body part.

(21) Area Agency on Aging (AAA) means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.

(4922) Atypical pProvider means — ~~E~~entity able to enroll as a billing provider (BP) or performing provider for medical assistance programs related non-health care services but which does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(2023) "Audiologist" means Aa person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(2424) "Audiology" means— Tthe application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(2225) "Automated Voice Response (AVR)" means— Aa computer system that provides information on clients' current eligibility status from the Division by computerized phone or Web-based response.

(2326) "Benefit Package" means— Tthe package of covered health care services for which the client is eligible.

(2427) "Billing aAgent or bBilling sService" means— Tthird party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

(2528) "Billing pProvider (BP)" means— Aa person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from the Division on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider.

(2629) "Buying Up" means— Tthe practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up).

(2730) "By Report (BR):" means— Sservices designated, as BR require operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature, and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(31) "Case Management Services" mean services provided to ensure that CCO members obtain health services necessary to maintain physical, mental and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, chemical dependency and/or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency or dental services, referring members to community services and supports which may include referrals to Allied Agencies.

(2832) "Children, Adults and Families Division (CAF)" means— Aa division within the Department, responsible for administering self-sufficiency and child-protective programs.

(2933) "Children's Health Insurance Program (CHIP)" means— Aa federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the AuthorityDivision.

(3034) "Chiropractor" means— Aa person licensed to practice chiropractic by the relevant state licensing board.

(3435) "Chiropractic sServices" mean— Sservices provided by a licensed chiropractor within the scope of practice, as defined under state law and Federal regulation.

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~~(3236)~~ "Citizen/Alien-Waived Emergency Medical (CAWEM)" means— Aaliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210 (3)(f).

~~(3337)~~ "Claimant" means— a person who has requested a hearing.

~~(3438)~~ "Client" means— Aan individual found eligible to receive OHP health services. "Client" is inclusive of members enrolled in PHPs, PCMs and CCOs. ~~person who is currently receiving medical assistance (also known as a recipient).~~

~~(3539)~~ "Clinical Social Worker" means— Aa person licensed to practice clinical social work pursuant to State law.

~~(40)~~ "Clinical Record" means the medical, dental or mental health records of a client or member.

~~(41)~~ "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

~~(42)~~ "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act -when any of the following contests an action:

~~(a)~~ A client or member or their representative;

~~(b)~~ A CCO member's provider; or

~~(c)~~ A CCO.

~~(3643)~~ "Contiguous Area" means— Tthe area up to 75 miles outside the border of the State of Oregon.

~~(3744)~~ "Contiguous aArea ~~p~~Provider" means— Aa provider practicing in a contiguous area.

~~(45)~~ "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.

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~~(3846)~~ "Co-Payments" mean— Tthe portion of a claim or medical, dental or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment).

~~(3947)~~ "Cost effective" means— Tthe lowest cost health care service or item that, in the judgment of ~~Authority Division~~ staff or its contracted agencies, meets the medical needs of the client.

~~(4048)~~ "Current Dental Terminology (CDT)" means— Aa listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

~~(4149)~~ "Current Procedural Terminology (CPT)" means— The physicians' CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

~~(4250)~~ “Date of ~~r~~Receipt of a ~~e~~Claim” means— ~~T~~the date on which the ~~Authority Division~~ receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

~~(4351)~~ “Date of ~~s~~Service” means— ~~T~~the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

~~(4452)~~ “Dental ~~e~~Emergency ~~s~~Services” mean— ~~D~~dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

~~(4453)~~ “Dental Services” mean— ~~S~~services provided within the scope of practice as defined under state law by or under the supervision of a dentist.

~~(4654)~~ “Dentist” means— ~~A~~a person licensed to practice dentistry pursuant to state law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

~~(4755)~~ “Denturist” means— ~~A~~a person licensed to practice denture technology pursuant to State law.

~~(4856)~~ “Denturist ~~s~~Services” mean— ~~S~~services provided, within the scope of practice as defined under State law, by or under the personal supervision of a denturist.

~~(4957)~~ “Dental ~~h~~Hygienist” means ~~a~~— ~~A~~ person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

~~(5058)~~ “Dental ~~h~~Hygienist with an Expanded Practice Permit” means ~~a~~— ~~A~~ person licensed to practice dental hygiene services as authorized by the ~~b~~Board of ~~d~~Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to State law.

~~(59)~~ “Dentally Appropriate” means services that are required for prevention, diagnosis or treatment of a dental condition and that are:

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

~~(b)~~ Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

~~(c)~~ Not solely for the convenience of the client or a provider of the service;

~~(d)~~ The most cost effective of the alternative levels of dental services that can be safely provided to a client.

~~(51)~~ Department— the Department of Human Services.

~~(5260)~~ “Department of Human Services (Department) or DHS” means— ~~T~~the ~~agency~~Department or DHS means the Department of Human Services, established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. ~~Wherever the former Office of Medical Assistance Programs, OMAP or DMAP is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (Division). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMHD). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and Families or CAF is used in contract or rule, it shall mean the Children,~~

~~Adults and Families Division (CAF). Wherever the former Health Division is used in Contract or in rule, it shall mean the Public Health Division (PHD).~~

~~(5361)~~ “Department ~~r~~Representative” ~~means~~— ~~A~~a person who represents the Department and presents the position of the Department in a hearing.

~~(5462)~~ “Diagnosis ~~e~~Code” ~~means~~— ~~A~~a as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), the primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

~~(5563)~~ “Diagnosis Related Group (DRG)” ~~means~~— ~~A~~a system of classification of diagnoses and procedures based on the ICD-9-CM.

~~(5664)~~ “Division of Medical Assistance Programs (Division)” ~~means a~~—~~A~~ division within the Authority; the Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs.

~~(57) Division member~~— ~~An OHP client enrolled with a PHP.~~

~~(5865)~~ “Durable Medical Equipment, Prosthetics, Orthotics and ~~and~~ Medical Supplies (DMEPOS)” ~~mean~~— ~~E~~equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

~~(5966)~~ “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medichex)” ~~mean~~—~~T~~he Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help ~~Authority Division~~ clients and their parents or guardians effectively use them.

~~(6067)~~ “Electronic Data Interchange (EDI)” ~~means~~— ~~T~~he exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

~~(6468)~~ “EDI ~~s~~Submitter” ~~means~~— ~~A~~n individual or an entity authorized to establish an electronic media connection with the Authority to conduct an ~~ed~~ EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

~~(6269)~~ “Electronic Verification System (EVS)” ~~means~~ eligibility information that has met the legal and technical specifications of the ~~Authority Division~~ in order to offer eligibility information to enrolled providers of the Division.

~~(6370)~~ “Emergency ~~e~~Department” ~~means~~— ~~T~~he part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

~~(6471)~~ “Emergency ~~m~~Medical ~~e~~Condition” ~~means~~— a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman,

the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(3)(f)(B)).

~~(6572)~~ “Emergency Medical Transportation” means— ~~T~~ransportation necessary for a client with an emergency medical condition, as defined in this rule, and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

~~(73)~~ “Emergency Services” means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a client’s discharge from a facility or transfer to another facility.

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~~(6674)~~ “Evidence-Based Medicine”- means is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)).

~~(6775)~~ “False Claim” means— ~~Aa~~ claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading or omitted information and such inaccurate, misleading or omitted information would result, or has resulted, in an overpayment.

~~(76)~~ “Family Health Insurance Assistance Program (FHIAP)” means a program in which the State subsidizes premiums in the commercial insurance market for uninsured individuals and families who meet eligibility criteria.

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~~(6877)~~ “Family Planning Services” mean— ~~Ss~~services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

~~(6978)~~ “Federally Qualified Health Center (FQHC)” means— ~~Aa~~ federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the Public Health Service Act; or a facility designated as ~~an~~ FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

~~(7079)~~ “Fee-for-Service Provider” means— ~~Aa~~ medical provider who is not reimbursed under the terms of a ~~Authority Division~~ contract with a Prepaid Health Plan (PHP), also referred to as a

Managed Care Organization (MCO). A medical provider participating in a PHP may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP.

(80) “Flexible Service”- means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the mental condition, chemical dependency condition, or physical condition as documented in the Member’s Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Services, and other non-Traditional Services identified.

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(81) “Flexible Service Approach” means the delivery of any Coordinated Care Service in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering Coordinated Care Services at alternative sites such as schools, residential facilities, nursing facilities, Members' homes, emergency rooms, offices of DHS, OHA, other community settings; offering flexible clinic hours; offering Coordinated Care Services through outreach or a home-based approach; and using peers, paraprofessionals, Community Health Workers, Peer Wellness Specialists, or Personal Health Navigators who are Culturally Competent to engage difficult-to-reach Members.

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(7482) “Fraud” means— Aaan intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(7283) “Fully dDual eEligible” means— Ffor the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Department for full medical assistance coverage.

(7384) “General Assistance (GA)” means— Mmedical assistance administered and funded 100% with State of Oregon funds through OHP.

(7485) “Healthcare Common Procedure Coding System (HCPCS)” means— Aa method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I — American Medical Association’s Physician’s Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(86) “Health Care Professionals” mean individuals with current and appropriate licensure, certification or accreditation in a medical, mental health or dental profession who provide health services, assessments and screenings for clients within their scope of practice, licensure or certification.

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(87) “Health Evidence Review Commission” means a commission that, among other duties, develops and maintains a list of health services ranked by priority, from the most to the least important, representing the comparative benefits of each service to the population served.

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

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(7589) “Health Maintenance Organization (HMO)” means— Aa public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(90) "Health Plan New/noncategorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet all eligibility requirements to become an OHP client.

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(7691) "Hearing aAid eDealer" means— Aa person licensed by the Board of Hearing Aid Dealers to sell, lease or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(7792) "Home eEnteral nNutrition" means— Sservices provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract, as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

(7893) "Home hHealth aAgency" means— Aa public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by the Authority as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(7994) "Home hHealth sServices" mean— Ppart-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(8095) "Home iIntravenous sServices" mean— Sservices provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(8196) "Home pParenteral nNutrition" means— Sservices provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(8297) "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 certified by the federal Centers for Medicare and

Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(8398) "Hospital" means— Aa facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in the OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by the CMS as long-term care hospitals, long-term acute care hospitals or religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state, and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(8499) "Hospital-bBased pProfessional sServices" mean— Pprofessional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (Division 42) report for the Division.

(85100) "Hospital lLaboratory" means— Aa laboratory providing professional technical laboratory services as outlined under laboratory services, in a hospital setting, as either an inpatient or

outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.

(101) "Indian Health Care Provider" means an Indian health program or an urban Indian organization.

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(86102) "Indian Health Program" means— Any Indian Health Service (IHS) facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(103) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives.

(87104) "Individual Adjustment Request Form (DMAP 1036)" means— Form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(88105) "Inpatient Hospital Services" mean— Services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(89106) "Institutional Level of Income Standards (ILIS)" mean— Three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' (SPD) Home and Community Based Waiver.

(90107) "Institutionalized" means— A patient admitted to a nursing facility or hospital for the purpose of receiving nursing and/or hospital care for a period of 30 days or more.

(94108) "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)" mean— A book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(92109) "Laboratory" means— A facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory, under the Clinical Laboratory Improvement Act (CLIA).

(93110) "Laboratory Services" mean— Those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his/her scope of practice as defined under State law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

(94111) "Licensed Direct Entry Midwife" means— A practitioner who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery by the Public Health Division.

(95112) "Liability Insurance" means— Insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and

underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

~~(96113)~~ "Managed Care Organization (MCO)" means— ~~C~~contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

~~(97114)~~ "Maternity Case Management" means— ~~A~~ program available to pregnant clients. The purpose of Maternity Case Management is to extend prenatal services to include non-medical services, which address social, economic and nutritional factors. For more information refer to the Division's Medical-Surgical Services Program administrative rules.

~~(98115)~~ "Medicaid" means ~~a~~—~~A~~ federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Authority.

~~(99116)~~ "Medical ~~a~~Assistance ~~e~~Eligibility ~~e~~Confirmation" means— ~~V~~erification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

~~(117)~~ "Medical Assistance Program" means ~~a~~ program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project, and Medicaid and CHIP services under the State Plan.

~~(118)~~ "Medical Care Identification" means ~~the~~ card commonly called the "medical card" issued to clients.

~~(400119)~~ "Medical ~~s~~Services" mean— ~~C~~care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

~~(404120)~~ "Medical ~~t~~Transportation" means— ~~T~~ransportation to or from covered medical services.

~~(402121)~~ "Medically ~~a~~Appropriate" means— ~~S~~ervices and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

- (a) Consistent with the symptoms of a health condition or treatment of a health condition;
- (b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;
- (c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and
- (d) The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to a Division client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

~~(403122)~~ "Medicare" means ~~a~~—~~A~~ federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

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(a) Hospital Insurance (Part A) for Inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and

(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;

(c) Prescription drug coverage (Part D)— means Covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.

(123) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

~~(404124)~~ "Medicheck for Children and Teens" mean— Sservices also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. — The Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help AuthorityDivision clients and their parents or guardians effectively use them.

(125) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(126) "Mental Health Case Management" means services provided to CCO members who require assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the CCO member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring CCO members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services.

~~(405127)~~ NCCI— National Correct Coding Initiative (NCCI) means— The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

(128) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.

~~(406129)~~ "National Provider Identification (NPI)" means— Federally directed provider number mandated for use on HIPAA covered transactions; individuals, provider organizations and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

~~(407130)~~ "Naturopath" means— Aa person licensed to practice naturopathy pursuant to State law.

~~(408131)~~ "Naturopathic Sservices" means— Sservices provided within the scope of practice as defined under State law.

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~~(409132)~~ “Non-covered ~~s~~Services” ~~mean~~— ~~S~~services or items for which the ~~Authority Division~~ is not responsible for payment or reimbursement. Non-covered services are identified in:

- (a) OAR 410-120-1200, Excluded Services and Limitations; and,
- (b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;
- (c) 410-141-0480, OHP Benefit Package of Covered Services;
- (d) 410-141-0520, Prioritized List of Health Services; and
- (e) Any other applicable Division administrative rules.

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~~(440133)~~ “Nurse Anesthetist, C.R.N.A.” ~~means a~~— ~~A~~ registered nurse licensed in the State of Oregon who is currently certified by the American Association of Nurse Anesthetists Council on Certification.

~~(444134)~~ “Nurse Practitioner” ~~means~~ — ~~A~~a person licensed as a registered nurse and certified by the Board of Nursing to practice as a Nurse Practitioner pursuant to State law.

~~(442135)~~ “Nurse Practitioner ~~s~~Services” ~~mean~~— ~~S~~services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

~~(443136)~~ “Nursing ~~f~~Facility” ~~means a~~— ~~A~~ facility licensed and certified by the Department SPD and defined in OAR 411-070-0005.

~~(444137)~~ “Nursing ~~s~~Services” ~~mean~~— ~~H~~health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by State law.

~~(445138)~~ “Nutritional ~~e~~Counseling” ~~means~~— ~~C~~counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

~~(446139)~~ “Occupational Therapist” ~~means~~— ~~A~~a person licensed by the State Board of Examiners for Occupational Therapy.

~~(447140)~~ “Occupational Therapy” ~~means~~— ~~T~~the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, aging process, or psychological disability; the treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

~~(141)~~ “Ombudsman Services” mean advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of or limitations on the health services provided.

~~(142)~~ “Oregon Health Plan (OHP)” means the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project, which expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations, and Medicaid and CHIP services under the State Plan.

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~~(448143)~~ “Optometric ~~s~~Services” ~~mean~~— ~~S~~services provided, within the scope of practice of optometrists as defined under State law.

~~(449144)~~ “Optometrist” ~~means a~~— ~~A~~ person licensed to practice optometry pursuant to State law.

~~(420145)~~ "Oregon Health Authority (~~Authority or~~ OHA)" ~~means— Tthe agency~~ Authority or OHA means the Oregon Health Authority established in ORS Chapter 413, that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the OHA are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs. ~~These divisions are referred to as the Authority whereas the divisions under authority of the Department of Human Services are CAF and SPD and are referred to as the Department.~~

~~(424146)~~ "Oregon Youth Authority (OYA)" ~~means— Tthe~~ state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

~~(422147)~~ "Out-of-State ~~pP~~Providers" ~~mean— Aa~~ any provider located outside the borders of the State of Oregon:

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

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

~~(423148)~~ "Outpatient ~~hH~~ospital ~~sS~~ervices" ~~mean— Ss~~ services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules found in chapter 410, division 125.

~~(424149)~~ "Overdue ~~eC~~claim" ~~means— Aa~~ valid claim that is not paid within 45 days of the date it was received.

~~(425150)~~ "Overpayment" ~~means— Pp~~ payment(s) made by ~~Authority Division~~ to a provider in excess of the correct ~~Authority Division~~ payment amount for a service. Overpayments are subject to repayment to the ~~Authority Division~~.

~~(426151)~~ "Overuse" ~~means— Uu~~ use of medical goods or services at levels determined by ~~Authority Division~~ medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

~~(427152)~~ "Panel" ~~means— Tthe~~ Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

~~(428153)~~ "Payment Authorization" ~~means— Aa~~ authorization granted by the responsible agency, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

~~(429154)~~ "Peer Review Organization (PRO)" ~~means— Aa~~ an entity of health care practitioners of services contracted by the State to review services ordered or furnished by other practitioners in the same professional field.

~~(430155)~~ "Pharmaceutical Services" ~~mean— Ss~~ services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

~~(434156)~~ "Pharmacist" ~~means— Aa~~ person licensed to practice pharmacy pursuant to state law.

(432157) "Physical Capacity Evaluation" means— Aan objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(433158) "Physical Therapist" means a—A person licensed by the relevant State licensing authority to practice Physical Therapy.

(434159) "Physical Therapy" means— Ttreatment comprising exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis or treatment of a human being. Physical Therapy shall not include radiology or electrosurgery.

(435160) "Physician" means— Aa person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government.

(436161) "Physician Assistant" means— Aa person licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(437162) "Physician Services" mean— Sservices provided, within the scope of practice as defined under state law, by or under the personal supervision of a physician.

(438163) "Podiatric Services" mean— Sservices provided within the scope of practice of podiatrists as defined under state law.

(439164) "Podiatrist" means a—A person licensed to practice podiatric medicine pursuant to state law.

(440165) "Post-Payment Review" means— Rreview of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(441166) "Practitioner" means— Aa person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(442167) "Premium sSponsorship" means— Ppremium donations made for the benefit of one or more specified Division clients (See 410-120-1390).

(443168) "Prepaid Health Plan (PHP)" means— Aa managed health, dental, chemical dependency, or mental health organization that contracts with the Authority Division and/or AMH on a case managed, prepaid, capitated basis under OHP. PHP's may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(169) "Primary Care Dentist (PCD)" means a dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.

(444170) "Primary Care Physician" means —Aa physician who has responsibility for supervising, coordinating and providing initial and primary care to patients, initiating Rreferrals for consultations and specialist care, and maintaining the continuity of patient care.

(445171) "Primary Care Provider (PCP)" means— Aany enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their

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scope of practice for identified clients. PCPs initiate ~~R~~ referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically appropriate client care.

~~(446172) "Prior Authorization (PA)" means—P~~ payment authorization for specified medical services or items given by ~~Authority Division~~ staff, or its contracted agencies prior to provision of the service. A physician referral is not a PA.

~~(447173) "Prioritized List of Health Services" mean -the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP—Also referred to as the Prioritized List, the Oregon Health Services Commission's (HSC) listing of health services with "expanded definitions" of ancillary Services and preventive services and the HSC practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The Prioritized List governs medical assistance programs' health services and benefit packages pursuant to these General Rules (OAR 410-120-0000 et seq.) and OAR 410-141-0480 through 410-141-0520.~~

~~(448174) "Private Duty Nursing Services" mean—N~~ nursing services provided within the scope of license by a registered nurse or a licensed practical nurse, under the general direction of the patient's physician to an individual who is not in a health care facility.

~~(449175) "Provider" means—A~~ an individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.

~~(450176) "Provider Organization" means—aa~~ group practice, facility, or organization that is:

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

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility or organization; ~~r~~

(e) If such entity solely submits billings on behalf of providers and payments are made to each provider, then the entity is an agent.

(See Subparts of Provider Organization).

~~(451177) "Public Health Clinic" means—Aa~~ clinic operated by county government.

~~(452178) "Public Rates" mean—T~~ the charge for services and items that providers, including Hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to ~~Authority Division~~ clients.

~~(453179) "Qualified Medicare Beneficiary (QMB)" means—Aa~~ Medicare beneficiary, as defined by the Social Security Act and its amendments.

(454180) “Qualified Medicare and Medicaid Beneficiary (QMM)” means— Aa Medicare beneficiary who is also eligible for Division coverage.

(181) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.

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(455182) “Quality Improvement Organization (QIO)” means— Aa 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.

(456183) “Radiological Services” mean— T those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, Hospital, or independent radiological facility.

(457184) “Recipient” means— Aa person who is currently eligible for medical assistance (also known as a client).

(458185) “Recreational tTherapy” means— recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(459186) “Recoupment” means— Aa an accounts receivable system that collects money owed by the provider to the Authority Division by withholding all or a portion of a provider’s future payments.

(460187) “Referral” means— T the transfer of total or specified care of a client from one provider to another. As used by the Authority Division, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority Division.

(464188) “Remittance Advice (RA)” means— T the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

(462189) “Request for Hearing” means — Aa clear expression, in writing, by an individual or representative that the person wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

(190) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

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(463191) “Retroactive Medical Eligibility” means— E eligibility for medical assistance granted to a client retroactive to a date prior to the client’s application for medical assistance.

(192) “Rural” means a geographic area that is 10 or more map miles from a population center of 30,000 people or less.

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(464193) “Sanction” means— Aa an action against providers taken by the Authority Division in cases of fraud, misuse or abuse of dDivision requirements.

(465194) “School Based Health Service” means— Aa health service required by an Individualized Education Plan (IEP) during a child’s education program which addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

~~(166) Seniors and People with Disabilities Division (SPD) — An Office of the Department responsible for the administration of programs for seniors and people with disabilities.~~

(467195) “Service ~~a~~Agreement” means — ~~Aa~~ an agreement between the ~~Authority Division~~ and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

(468196) “Sliding Fee Schedule” means — ~~Aa~~ fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(469197) “Social Worker” means — ~~Aa~~ person licensed by the Board of Clinical Social Workers to practice clinical social work.

(470198) “Speech-Language Pathologist” means — ~~Aa~~ person licensed by the Oregon Board of Examiners for Speech Pathology.

(474199) “Speech-Language Pathology Services” mean — ~~T~~the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

~~(172) Spend-Down — The amount the client must pay for medical expenses each month before becoming eligible for medical assistance under the Medically Needy Program. The spend-down is equal to the difference between the client's total countable income and Medically Needy program income limits.~~

(473200) “State Facility” means — ~~Aa~~ Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(474201) “Subparts (of a ~~p~~Provider ~~e~~Organization)” mean — ~~F~~for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically, or has an entity do so on its behalf, could be components of an organization or separate physical locations of an organization.

(475202) “Subrogation” means — Right of the State to stand in place of the client in the collection of third party resources (TPR).

(476203) “Supplemental Security Income (SSI)” means — ~~Aa~~ program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(477204) “Surgical Assistant” means — ~~Aa~~ person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(478205) “Suspension” means — ~~Aa~~ sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's ~~Authority Division~~-assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(479206) "Targeted Case Management (TCM)" means— ~~Aa~~ activities that will assist the client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by Allied Agency providers.

(480207) "Termination" means— ~~Aa~~ sanction prohibiting a provider's participation in the Division's programs by canceling the provider's ~~Authority Division~~-assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of termination. Termination is permanent unless:

- (a) The exceptions cited in 42 CFR 1001.221 are met; or
- (b) Otherwise stated by the ~~Authority Division~~ at the time of termination.

(484208) "Third Party Resource (TPR)" means— ~~Aa~~ medical or financial resource which, under law, is available and applicable to pay for medical ~~Services~~ and items for a ~~Authority Division~~ client.

(482209) "Transportation" means— ~~See~~ Medical Transportation.

(483210) "Type A Hospital" means— ~~Aa~~ hospital identified by the Office of Rural Health as a Type A hospital.

(211) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services and regulatory programs for the elderly or the elderly and disabled.

(484212) "Type B AAA Unit" means— ~~Aa~~ Type B ~~Area Agency on Aging (AAA)~~ funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(485213) "Type B Hospital" means— ~~Aa~~ hospital identified by the Office of Rural Health as a Type B hospital.

(214) "Urban" means a geographic area that is less than 10 map miles from a population center of 30,000 people or more.

(215) "Urgent Care Services" mean health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.

(486216) "Usual Charge (UC)" means— ~~Tt~~ the lesser of the following unless prohibited from billing by federal statute or regulation:

- (a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;
- (b) The provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;
- (c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.

(487217) "Utilization Review (UR)" means— ~~Tt~~ the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and

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appropriateness of medical care to achieve the most effective and economic use of health care services.

~~(488218)~~ “Valid Claim” means— An invoice received by the Division or the appropriate Authority/Department office for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

~~(489219)~~ “Vision Services” mean— Provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

Stat. Auth.: ORS 413.042 414.065

Stats. Implemented: ORS 414.065