

Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs

410

Agency and Division
Number

Administrative Rules Chapter

In the Matter of: The adoption of OARs 410-141-3000 and 410-141-3010 and the amendment of OARs 410-141-0000 and 410-120-0000

Rule Caption: (Not more than 15 words that reasonably identify the subject matter of the agency's intended action.)
Implementation of Coordinated Care Organizations to Provide Care for Medical Assistance Recipients

Statutory Authority: ORS 410.032

Other Authority: None

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011 and 2012 SB 1580

Need for the Temporary Rule(s):

OAR 410-141-3000, together with the amendments to OARs 410-120-0000 and 410-141-0000, establish definitions for Oregon's Integrated and Coordinated Health Care Delivery System. OAR 410-141-3010 establishes the application, certification, and contract procedures for Coordinated Care Organizations (CCO). CCOs will improve health, increase the quality, reliability, availability and continuity of care, as well as to reduce costs. CCOs will provide medical assistance recipients with health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and reduce health disparities. The Authority needs to adopt these rules to establish transitional processes, the application process, application criteria, financial solvency requirements and the client grievance system.

Documents Relied Upon, and where they are available:

2011 HB 3650: <http://www.leg.state.or.us/11reg/measures/hb3600.dir/hb3650.en>

2012 SB 1580: <http://www.leg.state.or.us/12reg/measures/sb1500.dir/sb1580.en.html>

The Health Policy Board's *Coordinated Care Organizations Implementation Proposal*: www.health.oregon.gov

Justification of Temporary Rule(s):

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and low-income Oregonians eligible for medical assistance programs. The Authority needs to adopt these rules promptly to clarify requirements to apply to be a CCO and to clarify compliance criteria after becoming a CCO. Without these rules to guide their decisions, CCOs would be unable to apply.

Authorized Signer

Printed name

Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 945-2005

410-141-3000

Definitions

The Oregon Health Authority adopts and incorporates by reference the definitions in the following administrative rules and applies them to Health System Transformation and the use of Coordinated Care Organizations:

- (1) OAR 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;
- (2) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and
- (3) OAR 410-141-0000, definitions of the Oregon Health Plan's rules generally applicable to prepaid managed health care organizations and coordinated care organizations.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3010 CCO Application, Certification, and Contracting Procedures

(1) The following definitions apply to this rule:

(a) Applicant means the entity submitting an application to be certified as a CCO or to enter into or amend a contract for coordinated care services;

(b) Application means an entity's written response to a Request for Application (RFA);

(c) Award date means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts;

(d) Certification means the Authority's determination that an entity meets the standards, set forth in the RFA, for being a CCO, through initial certification or recertification;

(e) Coordinated care services means fully integrated physical health services, chemical dependency and mental health services, and shall include dental health services as provided in ORS 414.625(3), by July 1, 2014;

(f) CMS Medicare/Medicaid Alignment Demonstration means a demonstration proposal by the Authority to CMS that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent feasible for individuals who are eligible for both programs. The Authority and CMS shall jointly establish its timelines and requirements for participation in the Demonstration;

(g) Entity means a single legal entity capable of entering into a risk contract that covers coordinated care services with the State and conducting the business of a coordinated care organization;

(h) Request for applications (RFA) means the document used for soliciting applications for certification as a CCO, award of or amendment of a contract coordinated care services, or other objectives as the Authority may determine appropriate for procuring coordinated care services.

(2) The Authority shall establish an application process for entities seeking certification and contracts as CCOs.

(3) The Authority shall use the following RFA processes for CCO certification and contracting:

(a) The Authority shall provide public notice of every RFA on its Web site. The RFA shall indicate how prospective applicants shall be made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities, or upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;

(b) The RFA process begins with a public notice of the RFA, which shall be communicated using the Authority's website. A public notice of an RFA shall identify the certification requirements for the contract, the designated service areas where coordinated care services are requested and a sample contract;

(c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;

(d) The RFA may request applicants to appear at a public meeting to provide information about the application;

(e) The RFA will request information from Applicants in order to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;

(f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require submission of the application on its web portal in accordance with OAR 137-047-0330 (Electronic Procurements). If Electronic Procurement is used, applications will be accepted only from applicants who accept the terms and conditions for use of the Authority's web portal.

(4) At recertification the Authority may permit a current CCO contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the recertification and new contract or the new addenda or capacity, or other the Authority objective which is the subject of the RFA;

(5) The Authority shall evaluate applications for certification on the basis of information contained in the RFA, the application and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria;

(a) The Authority may enter into negotiation with Applicants concerning potential capacity and enrollment in relation to other available, or potentially available, capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;

(b) The Authority shall notify each Applicant that applies for certification of its certification status;

(c) Applicants that meet the RFA criteria shall be certified to contract as a CCO.

(6) Review for certification:

(a) The Authority shall issue certification to only applicants that meet the requirements and provide the assurances specified in the RFA. The Authority determines whether the applicant qualifies for certification based on the application and any additional information and investigation that the Authority may require;

(b) The Authority determines an Applicant is eligible for certification when the Applicant meets the requirements of the RFA, including written assurances, satisfactory to the Authority, that the Applicant:

(A) Provides or will provide the coordinated care services in the manner described in the RFA and the Authority's rules;

(B) Is responsible and meets or will meet standards established by the Authority and DCBS for financial reporting and solvency;

(C) Is organized and operated, and shall continue to be organized and operated, in the manner required by the contract and described in the application; and

(D) Shall comply with any assurances it has given the Authority.

(7) The Authority shall certify CCOs for a period of 6 years from the date the certification application is approved, unless the Authority certifies a CCO for a shorter period.

(8) The Authority may determine that an applicant is potentially eligible for certification if within a specified period of time the applicant is reasonably capable of being eligible for certification. The Authority is not obligated to determine whether an applicant is potentially eligible for certification if, in its discretion, the Authority determines that sufficient Applicants eligible for certification are available to attain the Authority's objectives under the RFA.

(9) The Authority may determine that an Applicant is potentially eligible for certification if:

(a) The Authority finds that the Applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period of time; and

(b) The Applicant enters into discussions with the Authority about areas of qualification that must be met before the Applicant is operationally and financially eligible for certification. The Authority shall determine the date and required documentation and written assurances required from the Applicant;

(c) If the Authority determines that an Applicant potentially eligible for certification cannot become certified within the time announced in the RFA for contract award, the Authority may:

(A) Offer certification at a future date when the applicant demonstrates, to the Authority's satisfaction, that the Applicant is eligible for certification within the scope of the RFA; or

(B) Inform the Applicant that it is not eligible for certification.

(10) The Authority may award contracts to certified CCOs for administering the Oregon Integrated and Coordinated Health Care Delivery System.

(11) The Authority shall enter into or renew a contract with a CCO only if the CCO has been certified and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System, which includes but is not limited to:

(a) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda;

(b) The number of CCOs in the region.

(12) The application is the Applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the Applicant to the contract:

(a) Except to the extent the Applicant is authorized to propose certain terms and conditions pursuant to the RFA, an Applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;

(b) Only an entity that the Authority has certified to contract as a CCO may enter into a contract as a CCO. Certification to contract as a CCO does not assure the CCO that it will be offered a CCO contract;

(c) The Authority may award multiple contracts or make a single award or limited number of awards to all certified or potentially certified Applicants, in order to meet Authority's needs including but not limited to adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA;

(d) Subject to any limitations in the RFA, the Authority may renew a contract for CCO services by amending an existing contract or issuing a replacement contract, without issuing a new RFA;

(e) The suspension or termination of a CCO contract issued under an RFA due to noncompliance with contract requirements or by a CCO's voluntary suspension or termination shall also be a suspension or termination of certification.

(13) Disclosure of application contents and release of information:

(a) Except for the letter of intent to apply, and the technical application (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA), application information may not be disclosed to any applicant or the public until the award date.

No information may be given to any applicant or the public relative to its standing with other applicants before the award date, except under the following circumstances:

(A) The information in the application may be shared with the Authority, the Department of Consumer and Business Services, CMS, and those individuals involved in the application review and evaluation process; and

(B) Information may be provided by the applicant to the public as part of a public review process.

(b) Application information may be disclosed on the award date, with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA, and if the Authority determines it meets the disclosure exemption requirements.

(14) CCOs may apply to participate in the CMS Medicare/Medicaid Alignment Demonstration, but participation is not required. This rule does not replace the CMS requirements related to the Medicare/Medicaid Alignment Demonstration, such as the CMS notice of intent to apply and required components for Part D coverage. The RFA provides information about the Demonstration requirements. Upon approval of the Demonstration by CMS, the Authority shall conduct, jointly with CMS, the evaluation for certification for the Medicare/Medicaid Alignment Demonstration and award of three-way contracts between CMS, the state, and Applicants who have been certified to contract as a CCO and participate in the Demonstration.

(15) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts.

(16) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following DOJ Model Public Contract Rules (as in effect on January 1, 2012) to govern RFAs and certification and contracting with CCOs:

(a) OAR 137-046 -- General Provisions Related to Public Contracting: 137-046-0100, 137-046-0110 and 137-046-0400 through 137-046-0480;

(b) OAR 137-047 -- Public Procurements for Goods or Services: OAR 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review) and OAR 137-047-0800;

(c) In applying the DOJ Model Rules to RFAs under this rule:

(A) An Application is a proposal under the DOJ Model Rules;

(B) An RFA is an RFP under the DOJ Model Rules;

(C) Certification as a CCO is pre-qualification under the DOJ Model Rules;

(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are considered to be incorporated therein;

(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.

(17) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority may be considered a final order for purposes of APA review.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

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 — ~~A~~a 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 — ~~A~~a facility licensed as an ASC by the Authority Department.

(4517) American Indian/Alaska Native (AI/AN) means — ~~A~~a 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 — ~~A~~a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(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 — ~~A~~administration 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— The area up to 75 miles outside the border of the State of Oregon.

~~(3744)~~ "Contiguous aArea pProvider" 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— The portion of a claim or medical, dental or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment).

~~(3947)~~ "Cost effective" means— The 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 Receipt of a Claim” means— ~~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 Service” means— ~~the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.~~

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

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

~~(4654)~~ “Dentist” means— ~~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 person licensed to practice denture technology pursuant to State law.~~

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

~~(4957)~~ “Dental 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 Hygienist with an Expanded Practice Permit” means a— ~~A person licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to State law.~~

~~(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—~~ ~~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~~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~~an 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 ~~t~~ransportation” 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-~~b~~Based ~~m~~edicine”- 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 ~~e~~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 ~~p~~lanning ~~s~~ervices” mean— ~~Ss~~ervices 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-~~s~~ervice ~~Pp~~rovider” 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.

(91108) "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 Assistance Eligibility 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 Services" mean— ~~C~~care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

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

~~(402121)~~ "Medically 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)~~ NCCL— 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~~roviders" ~~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~~laim" ~~means— Aa~~ valid claim that is not paid within 45 days of the date it was received.

~~(425150)~~ "Overpayment" ~~means— Pp~~ayment(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~~se 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

410-141-0000 Acronyms and Definitions

In addition to the definitions in 410-120-0000, the following definitions apply.

(1) “Action” means, in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

- (a) The denial or limited authorization of a requested service, including the type or level of service;
- (b) The reduction, suspension or termination of a previously authorized service;
- (c) The denial in whole or in part, of payment for a service;
- (d) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (Division);
- (e) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or
- (f) For a ~~Division~~ member in a single Fully Capitated Health Plan (FCHP) or Mental Health Organization (MHO) PHP or CCO service area, the denial of a request to obtain services outside of the FCHP or MHO’s participating provider panel pursuant to OAR 410-141-0160 and 410-141-0220 or OAR 410-141-3320, as applicable.

~~(2) Addictions and Mental Health Division (AMH) — The Oregon Health Authority (Authority) office responsible for the administration of the state’s policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.~~

~~(3) Administrative Hearing — An Authority hearing related to an action, including a denial, reduction or termination of benefits that is held when requested by the Oregon Health Plan (OHP) client or Division member. A hearing may also be held when requested by an OHP client or Division member that believes a claim for services was not acted upon with reasonable promptness or believes the payer took an action erroneously.~~

~~(4) Advance Directive — A form that allows a person to have another person make health care decisions when he/she cannot make decisions and tells a doctor if the person does not want any life sustaining help if he/she is near death.~~

~~(5) Aged — Individuals who meet eligibility criteria established by the Department Seniors and People with Disabilities Division (SPD) for receipt of medical assistance because of age.~~

~~(6) Americans with Disabilities Act (ADA) — Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service, delivery and facility accessibility.~~

~~(7) Alternative Care Settings — Sites or groups of practitioners that provide care to Division members under contract with the Division member’s PHP. Alternative care settings include but are not limited to urgent care centers, hospice, birthing centers, out-~~

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~~placed medical teams in community or mobile health care facilities, and outpatient surgicenters.~~

~~(8) Ancillary Services — Those medical services under the OHP not identified in the definition of a condition/treatment pair, but medically appropriate to support a service covered under the OHP benefit package. Ancillary services and limitations are referenced in the General Rules OAR s 410-120-1210, Benefit Packages and 410-120-1200, Exclusions and applicable individual program rules.~~

~~(92) "Appeal" — means a request for review of an action as defined in this rule.~~

~~(10) Automated Voice Response (AVR) — An Authority computer system that provides information on the current eligibility status of OHP clients and Division members by phone or by Web access.~~

~~(11) Blind — Individuals who meet eligibility criteria established by the Department' SPD for receipt of medical assistance because of a condition or disease that causes or has caused blindness.~~

~~(XX3) "Coordinated Care Services" means a CCO's fully integrated physical health, chemical dependency and mental health services pursuant to ORS 414.725 and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.~~

~~(124) "Capitated Services" — mean T those covered services that a PHP or Primary Care Manager (PCM) agrees to provide for a capitation payment under the Division OHP contract or agreement with the Authority.~~

~~(135) "Capitation Payment" means:~~

~~(a) Monthly prepayment to a PHP for the provision of all capitated health services needed by OHP the PHP provides to members clients enrolled with the PHP;~~

~~(b) Monthly prepayment to a PCM to provide primary care management services for an OHP a client enrolled with the PCM. Payment is made on a per OHP client, per month basis.~~

~~(XX6) "CCO Payment" means the monthly prepayment to a CCO for services the CCO provides to members in accordance with the global budget.~~

~~(167) "Chemical Dependency Organization (CDO)" — means a PHP that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as capitated services under the OHP.~~

~~All chemical dependency services covered under the OHP are covered as capitated services by the CDO.~~

~~(178) "Chemical Dependency Services" — means A assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others.~~

consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

~~(18) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Division established by Title XXI of the Social Security Act and administered in Oregon by the Authority.~~

~~(19) "Children Receiving Children, Adults and Families (CAF) Child Welfare or Oregon Youth Authority (OYA) Services" — mean individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (e), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of CAF, the Authority, or OYA who are in placement outside of their homes.~~

~~(20) Claim — (1) a bill for services; (2) a line item of a service; or (3) all services for one client within a bill.~~

~~(21) Client Enrollment Services (CES) — The Division unit responsible for adjustments to enrollments, retroactive disenrollment and enrollment of newborns.~~

~~(22) Clinical Record — The clinical record includes means the medical, dental or mental health records of an OHP client or Division member. These records include the PCP's record, the inpatient and outpatient hospital records and the Exceptional Needs Care Coordinator (ENCC), complaint and disenrollment for cause records that may reside in the PHP's administrative offices.~~

~~(239) "Cold Call Marketing" — means a PCP's or CCO's — Any unsolicited personal contact by a PHP with a potential member for marketing purposes as defined in this rule.~~

~~(24) Comfort Care — The provision of medical services or items that give comfort and/or pain relief to an individual who has a terminal illness. Comfort care includes 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. Comfort care includes but is not limited to care provided through a hospice program (see Hospice rules), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort care includes nutrition, hydration and medication for disabled infants with life-threatening conditions not covered under condition/treatment pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable comfort care is provided consistent with Section 4751 OBRA 1990 — Patient Self Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness with the intent to prolong life.~~

~~(x10) "Community Advisory Council" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members consumer's and the community, consistent with ORS 414.625's health~~

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~~services needs. The council's membership includes representatives of the community and of county government, with consumers making up a majority of the membership.~~

~~(11)~~ "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

~~(2512)~~ "Community Mental Health Program (CMHP)" —means Tthe organization of all services for ~~persons~~ individuals with mental or emotional disorders ~~and developmental disabilities~~ operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority's Addictions and Mental Health Division (AMH).

~~(2613)~~ "Co-morbid Condition" —means a medical condition or /diagnosis ~~(i.e., illness, disease and/or disability)~~ coexisting with one or more other current and existing conditions or /diagnoses in the same patient.

~~(2714)~~ "Community Standard" —means Ttypical expectations for access to the health care delivery system in the ~~Division client's member's or PCM member's~~ community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in PHPs and to PCM members take into consideration the community standard and be adequate to meet the needs of the Division and PCM members.

~~(2815)~~ "Condition/Treatment Pair" —means Ddiagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9-CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health ~~Services Evidence~~ Review Commission, constitute the line items in the Prioritized List of Health Services.

Condition/treatment pairs may contain many diagnoses and treatments. ~~The condition/treatment pairs are referred to in OAR 410-141-0520.~~

~~(20) Continuing Treatment Benefit—A benefit for OHP clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to an OHP benefit package that doesn't cover the treatment.~~

~~(30) Co-payment—The portion of a covered service that a Division member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.~~

~~(34) "Contract" —means The contract an agreement between the State of Oregon, acting by and through its the Authority, the Division and an FCHP, dental care organization (DCO), physician care organization (PCO), or a CDO, or between AMH and an PHP or CCO-MHO for the provision of to provide covered health services to eligible Division members, for a capitation payment. A contract may also be referred to as a service agreement.~~

~~(17) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.~~

~~(18) "Corrective Action or Corrective Action Plan" —means a A Division- initiated request for a contractor or a contractor- initiated request for a subcontractor to develop and implement a time specific plan, that is acceptable to the Division, for the correction of Division-identified areas of noncompliance, as described in Exhibit H, Encounter Data Minimum Data Set Requirements and Corrective Action, Schedule 4, Pharmacy Data Requirements and Corrective Action, and in Exhibit B, Part VI, Section 2, Sanctions.~~

~~(19) "Covered Services" —A means re medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that are funded by the the Legislature funds, based on the Prioritized List of Health Services, and described in ORS 414.705 to 414.750; OAR 410-120-1210; 410-141-0120; 410-141-0520; and 410-141-0480; except as excluded or limited under OAR 410-141-0500 and rules in chapter 410, division 120.~~

~~(20) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. -The individual makes the declaration when they are able to understand and make decisions related to treatment, which is and honored when the individual is unable to make such decisions.~~

~~(34) Dentally Appropriate— 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;~~

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~~(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 OHP member 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 Division member.~~

~~(3521) "Dental Care Organization (DCO)" — means aA PHP that provides and coordinates capitated dental services as capitated services under OHP. All dental services covered under the OHP are covered as capitated services by the DCO; no dental services are paid by the Division on a fee-for-service (FFS) basis for OHP clients enrolled with a DCO provider.~~

~~(3622) "Dental Case Management Services" — Smean services provided to ensure that eligible a Division a members obtain receives dental services, including a a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care of the Division member, plus and the development and implementation of a plan to ensure that eligible Division the members obtain capitated receives those services.~~

~~(37) Dental Emergency Services — Dental services may include, but are not limited to the treatment of severe tooth pain, unusual swelling of the face or gums, and avulsed tooth consistent with OAR 410-123-1060.~~

~~(38) Dental Practitioner — A practitioner who provides dental services to Division members under an agreement with a DCO, or is a FFS practitioner. Dental practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.~~

~~(39) Department — The Department of Human Services or any of its programs or offices established in ORS chapter 407, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs (OMAP) 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 (AMH). 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).~~

~~(4023) "Diagnostic Services" — Tmeans those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.~~

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~~(41) Disabled—Individuals who meet eligibility criteria established by DHS SPD for receipt of medical assistance because of a disability.~~

~~(4224) "Disenrollment" —means the act of removing or discharging an OHP client from enrollment with a PHP, or PCM, or CCO's responsibility. After the effective date of disenrollment an OHP client is no longer required to obtain capitated services from the PHP or PCM, nor be referred by the PHP for medical case managed services or by the PCM for PCM case managed services.~~

~~(43) Division—The Division of Medical Assistance Programs or Division of the Authority responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and CHIP. The Division writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays Division providers.~~

~~(44) DMAP Member—An OHP client enrolled with a PHP.~~

~~(45) Emergency Medical Condition—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))~~

~~(46) Emergency Services—covered services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition. Emergency services include all inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the Division member or transfer of the Division member to another facility.~~

~~(4725) "Enrollment" —means the assignment of a OHP client s, subject to OAR 410-141-0060, become Division members of a to a PHP, or PCM or CCO for management and receipt of health services. PCM members of a PCM that contracts with the Division to provide capitated services. An OHP client's enrollment with a PHP indicates that the Division member must obtain or be referred by the PHP for all capitated services and referred by the PHP for all medical case managed services subsequent to the effective date of enrollment. An OHP client's enrollment with a PCM indicates that the PCM member must obtain or be referred by the PCM for preventive and primary care and referred by the PCM for all PCM case managed services subsequent to the effective date of enrollment.~~

~~(48) Enrollment Area — Client enrollment is based on the client's residential address and zip code. The address is automatically assigned a county code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the Authority worker that PHPs are in the area.~~

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~~(49) Enrollment Year — A twelve-month period beginning the first day of the month of enrollment of the OHP client in a PHP and, for any subsequent year(s) of continuous enrollment, beginning that same day in each such year(s). The enrollment year of OHP clients who re-enroll within a calendar month of disenrollment shall be counted as if there were no break in enrollment.~~

~~(50) End Stage Renal Disease (ESRD) — End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.~~

~~(5426) "Exceptional Needs Care Coordination (ENCC)" — means aA specialized case management service provided by FCHPs fully capitated health plans to Division members identified as aged, blind or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes-, including:~~

~~(a) Early identification of those Division members who are aged, blind, disabled or who have complex medical needs eligible for ENCC services-;~~

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

~~(e) Aid with coordinating coordinating necessary and appropriate linkage of community support and social service systems linkage with medical care systems, as necessary and appropriate.~~

~~(52) Family Health Insurance Assistance Program (FHIAP) — A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the Federal Poverty Level (FPL). FHIAP is funded with federal and states funds through Title XIX, XXI or both.~~

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~~(53) Family Planning Services — Services for clients of childbearing age (including minors who can be considered sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.~~

~~(54) Fee-for-Service (FFS) Health Care Providers — Health care providers who bill for each service provided and are paid by the Division for services as described in the Division provider rules. Certain services are covered but are not provided by PHPs or by PCMs. The client may seek such services from an appropriate FFS provider. PCMs~~

~~provide primary care services on a FFS basis and may refer PGM members to specialists and other providers for FFS care. In some parts of the state, the State may not enter into contracts with any managed care providers. OHP clients in these areas will receive all services from FFS providers.~~

~~(55) FPL — Federal Poverty Level~~

~~(56)(27) "Free-Standing Mental Health Organization (MHO)" —means Tthe single MHO in each county that provides only mental health services and is not affiliated with an a fully capitated health plan for FCHP for that service area. In most cases this "carve-out" MHO is a county CMHP or a consortium of CMHPs, but may be a private behavioral health care company.~~

~~(57)(28) "Fully-Capitated Health Plan (FCHP)" —means PHPs that contract with the Division Authority to provide capitated health services, including inpatient hospitalization under the OHP. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.~~

~~(58) Fully Dual Eligible — For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Division for full medical assistance coverage. The covered categories include Qualified Medicare Beneficiary (QMB) plus OHP with limited drug benefit package (system identifier BMM) and OHP with limited drug benefit package (system identifier BMD). The covered categories do not include OHP Plus benefit package; OHP Standard benefit package; QMB only; Specified Limited Medicare Beneficiary (SLMB/SMB) and SLMB with a Federal match aka Qualified Individual (SMF)~~

~~(xx29) Global Budget means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members, including providing access to and ensuring the quality of those services.~~

~~(59)(30) "Grievance" —means aA Division member's or representative's expression of dissatisfactioncomplaint to contractor a PHP, CCO or to a participating provider about any matter other than an action.~~

~~(60)(31) "Grievance System" —means Tthe overall system that includes:~~

~~(a) complaints Grievances to a PHP or CCO on matters other than actions;~~

~~(b) Appeals to a PHP or CCO on actions; and~~

~~(c) Contested case hearings through the state on actions, and appeals handled at the PHP level and access to the State fair hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Division member's rights.~~

~~(61) Health Care Professionals — Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: medical doctors (including psychiatrists), osteopathic physicians, pharmacists, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physicians assistants (PA), qualified mental health professionals (QMHPs), and qualified mental health associates (QMHAS), dentists, dental hygienists, limited access permit (LAP), denturists, and certified dental assistants. These professionals may conduct health, mental health or dental assessments of Division members and provide screening services to OHP clients within their scope of practice, licensure or certification.~~

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~~(62) Health Insurance Portability and Accountability Act (HIPAA) of 1996 — HIPAA is 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.~~

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~~(63) Health Plan New/noncategorical client (HPN) — A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an OHP client.~~

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~~(64) Health Services Commission — An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.~~

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~~(xx32) “Health Services” means:~~

~~(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025, for the physical medical, mental health, chemical dependency and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;~~

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~~(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025, for the physical medical, mental health, chemical dependency and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.~~

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~~(xx33) “Health Systems Transformation (HST)” means the transformation of health care delivery in medical assistance programs as prescribed by 2011 House Bill 3650, Chapter 602, Oregon Laws 2011 and 2012 Enrolled Senate Bill 1580, Chapter 8, Oregon Laws 2012; and including the CCO Implementation Proposal from the Oregon Health Policy Board (January 24, 2012) approved by Section 2 of 2012 Enrolled Senate Bill 1580.~~

~~(65) Hospice Services — 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 and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.~~

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~~(66) Hospital Hold — A hospital hold is a process that allows a hospital to assist an individual admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the OHP due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP if clients become eligible through a hospital hold process and are placed in the adults/couples category.~~

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~~(67) Indian Health Care Provider — An Indian health program or an urban Indian organization.~~

~~(68) Indian Health Program — An Indian health service facility, any federally recognized tribe or tribal organization or any tribe 638 FQHC enrolled with the Authority as an American Indian/Alaska Native (AI/AN) provider.~~

~~(6934) "Line Items" — means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services, developed by the Health Services Commission for the OHP Medicaid Demonstration Project.~~

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~~(70) Local and Regional Allied Agencies include the following: local Mental Health Authority; CMHPs; local DHS offices; Commission on Children and Families; OYA; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.~~

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~~(7135) "Marketing" — A means any communication from a PHP or a CCO to an OHPa client who is not enrolled in that the PHP or CCO, and which the communication can reasonably be interpreted as to be an attempt to influence the OHP client;:~~

~~(a) To enroll in that particular PHP or CCO;~~

~~(b) To either disenroll or not to enroll with another PHP or CCO.~~

~~(72) Marketing Materials — Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for marketing as defined in this rule.~~

~~(73) Medicaid — 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 DHS.~~

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~~(74) Medical Assistance Program — 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 the Authority.~~

~~(75) Medical Care Identification — The preferred term for what is commonly called the "medical card" That is the size of a business card and issued to Medical Assistance Program clients.~~

~~(7636)~~ "Medical Case Management Services" — ~~means~~ Services provided to ensure ~~that Division~~ members obtain health ~~care~~ services necessary to maintain physical and emotional development and health. ~~Medical case management services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are capitated services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.~~

~~(77) Medically Appropriate~~ — ~~Services 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 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 that can be safely provided to a Division member or PCM member in the PHP's or PCM's judgment.~~

~~(78) Medicare~~ — ~~The federal health insurance program for the aged and disabled administered by CMS under Title XVIII of the Social Security Act.~~

~~(79) "Medicare Advantage"~~ — ~~An organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.~~

~~(8037)~~ "Mental Health Assessment" — ~~means~~ The a qualified mental health professional's determination of a ~~Division~~ member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a member's mental status, psychosocial history and current problems through interview, observation and testing.

~~(8438)~~ "Mental Health Case Management" — ~~S~~means services provided to ~~Division member's~~ members who ~~require~~ need 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 Division member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring Division member's to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services. ENCC Services are separate and distinct from Mental Health Case Management.~~

~~(8239)~~ "Mental Health Organization (MHO)" — ~~means~~ A a PHP under contract with AMH that provides capitated mental health services ~~as capitated services under~~ for the

OHP clients. MHOs can be FCHPs, CMHPs or private behavioral organizations or combinations thereof.

~~(83) "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 first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing~~

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~~(84) National Provider Identifier (NPI) — A federally directed provider number mandated for use on Health Insurance Portability and Accountability Act (HIPAA) transactions; individuals, provider organizations and subparts of provider organizations that meet the definition of health care providers (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. (85) Non-Capitated Services — Those OHP covered services paid for on a FFS basis and for which a capitation payment has not been made to a PHP.~~

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~~(86) Non-Covered Services — Services or items for which the Division is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the OHP. Non-covered services for the OHP are identified in:~~

~~(a) OAR 410-141-0500;~~

~~(b) Exclusions and limitations described in OAR 410-120-1200; and~~

~~(c) Individual provider administrative rules.~~

~~(8740) "Non-Participating Provider" — A means a provider that does not have a contractual relationship with the a PHP or CCO and, i.e. is not on their panel of providers.~~

~~(88) "Ombudsman Services" — Ombudsman Services — Services mean services provided by the Authority to OHP client's who are aged, blind or disabled who have complex medical needs. Ombudsman staff may serve as the OHP client's advocate whenever the OHP client (a representative, a physician or other medical personnel, or other personal advocate serving the OHP client) is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the OHP. Ombudsman services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about OHP systems.~~

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~~(89) "Oregon Health Plan (OHP)" — means, Tthe Medicaid and Children's Health Insurance (CHIP) Demonstration Project which expands Medicaid and CHIP eligibility to eligible OHP clients. The OHP relies substantially upon prioritization of health services~~

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and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

~~(90) Oregon Health Plan (OHP) Plus Benefit Package—A benefit package available to eligible OHP clients as described in OAR 410-120-1210.~~

~~(91) Oregon Health Plan (OHP) Standard Benefit Package—A benefit package available to eligible OHP clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210.~~

~~(92) Oregon Health Plan (OHP) client—An individual found eligible by the Authority to receive services under the OHP. The OHP categories eligible for enrollment are defined as follows:~~

~~(a) Temporary Assistance to Needy Families (TANF)—OHP clients categorically eligible with income under current eligibility rules;~~

~~(b) CHIP—Children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;~~

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

~~(d) PLM Adults over 100% of the FPL are OHP 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 OHP clients aged 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 OHP clients, aged 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 OHP clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;~~

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

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

~~(m) Old Age Assistance (OAA) with Medicare eligibles are OHP clients with concurrent Medicare Part A or Medicare Parts A & 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 OHP clients without Medicare with income under current eligibility rules;~~

~~(p) CAF Children are OHP clients who are children with medical eligibility determined by CAF or OYA receiving OHP under ORS 414.025(2)(f), (l), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of CAF or OYA who are in placement outside of their homes.~~

~~(93) Oregon Youth Authority (OYA) — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.~~

~~(9441) "Participating Provider" — means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers. An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to Division members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.~~

~~(95) "PCM Case Managed Services" include the following: Preventive services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, rural health clinics (RHC), migrant and community health clinics, federally qualified health centers (FQHC), county health departments, Indian health service clinics and Tribal health clinics, CMHPs, MHOs; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.~~

~~(9642) "PCM Member" — means An OHPa client enrolled with a PGM primary case manager.~~

~~(97) PHP Coordinator — the Division employee designated by the Division as the liaison between the Division and the PHP.~~

~~xx(43) "Peer Wellness Specialist" means an individual who assists mental health services consumers to reduce stigmas and discrimination and to provide direct services to assist individuals to create and maintain recovery, health and wellness by:~~

~~(a) -Assessing the individual's mental health service and support needs through community outreach;~~

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(b) Assisting individuals with access to available services and resources; and

(c) Addressing barriers to services and providing education and information about available resources and mental health issues.

(xx44) "Person Centered Care" means care that reflects the individual patient's strengths and preferences; reflects the clinical needs of the patient as identified through an individualized assessment; is based upon the patient's goals; and will assist the patient in achieving the goals.

(xx45) "Personal Health Navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(9846) "Physician Care Organization (PCO)" —means a PHP that contracts with the Division Authority to provide partially-capitated health services under the OHP, exclusive. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.

(99) Post Hospital Extended Care Benefit — A 20-day benefit for non-Medicare Division members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(100) Post Stabilization Services — covered services, related to an emergency medical condition that is provided after a Division member is stabilized in order to maintain the stabilized condition or to improve or resolve the Division member's condition.

(101) Potential Division member — An OHP client who is subject to mandatory enrollment in managed care, or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.

(102) Practitioner — A 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.

(103) Prepaid Health Plan (PHP) — A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with the Division and/or AMH on a case managed, prepaid, capitated basis under the OHP. PHPs may be DCOs, FCHPs, MHOs, PCOs or CDOs.

(104) Preventive Services — Those services as defined under expanded definition of preventive services for OHP clients in OAR 410-141-0480, and OAR 410-141-0520.

(10547) "Primary Care Management Services" —mean sPrimary care management services are services provided tothat ensure PCM members obtain health care services

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~~that are necessary to maintain physical and emotional development and health. Primary care management services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are preventive or primary care services or PCM case managed services and follow-up, as appropriate, to assess the impact of care.~~

~~(10648) "Primary Care Manager (PCM)" — means Aa physician (MD or DO), nurse practitioner, physician assistant, or naturopath with physician backups, primary care provider who agrees to provide primary care management services as defined in rule to PCM their members. PCMs may also be hospital primary care clinics, RHCs, migrant and community health clinics, FQHCs, county health departments, Indian health service clinics or Tribal health clinics. The PCM provides Primary Care Management Services to PCM members for a capitation payment. The PCM provides preventive and primary care services on a FFS basis.~~

~~(107) Primary Care Dentist (PCD) — A Dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for Division members. PCDs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.~~

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~~(108) Primary Care Provider (PCP) — A practitioner who has responsibility for supervising and coordinating initial and primary care within their scope of practice for Division members. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.~~

~~(10949) "Prioritized List of Health Services" — means Tthe listing of condition and treatment pairs developed by the Health Services Evidence Review Commission for the purpose of implementing the administering OHP Demonstration Project health services. See OAR 410-141-0520, for the listing of condition and treatment pairs.~~

~~(110) Professional Liability Insurance — Coverage under the Federal Tort Claims Act (the "FTCA") if contractor is deemed covered under the FTCA, and to the extent the FTCA covers contractor's professional liability under this contract~~

~~(111) Proof of Indian Heritage — Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service — services provided by Indian health service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.~~

~~(112) Provider — An individual, facility, institution, corporate entity or other organization which supplies medical, dental or mental health services or medical and dental items.~~

~~(113) Provider Taxonomy Codes: is a standard administrative code set, as defined under HIPAA in federal regulations at 45 CFR 162, for identifying the provider type and area of specialization for all providers.~~

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~~(114) Quality Improvement — Quality improvement is 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 (as used in these rules) 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."~~

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~~(115) Representative — A person who can make OHP related decisions for OHP clients who are not able to make such decisions themselves. A representative may be, in the following order of priority, a person who is designated as the OHP client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the OHP client, the Individual Service Plan Team (for developmentally disabled clients), a Department case manager or other Department designee.~~

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~~(116) Rural — A geographic area is 10 or more map miles from a population center of 30,000 people or less.~~

~~(117) Seniors and People with Disabilities Division (SPD) — The division within the Authority responsible for providing services such as:~~

~~(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;~~

~~(b) Cash assistance grants for persons with long-term disabilities through GA and the Oregon Supplemental Income Program (OSIP); and~~

~~(c) Administration of the Federal Older Americans Act.~~

~~(41850) "Service Area" — Tmeans the geographic area within which the PHP or CCO has identified in their agreed under Ccontract or Agreement with the Authority, to provide health services under the OHP.~~

~~(119) Stabilize — No material deterioration of the emergency medical condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.~~

~~(120) Terminal Illness — An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.~~

~~(121) Triage—Evaluations conducted to determine whether or not an emergency condition exists, and to direct the Division member to the most appropriate setting for medically appropriate care.~~

~~(122) "Urban"—A means a geographic area is less than 10 map miles from a population center of 30,000 people or more.~~

~~(123) "Urgent Care Services" mean c— Covered services that are medically appropriate and immediately required to prevent serious deterioration of a Division member's health that is a result of unforeseen illness or injury. Services that can be foreseen by the individual are not considered urgent services.~~

~~(124) Valid Claim:~~

~~(a) An invoice received by the PHP for payment of covered health care services rendered to an eligible client that:~~

~~(A) Can be processed without obtaining additional information from the provider of the service or from a third party; and~~

~~(B) Has been received within the time limitations prescribed in these rules.~~

~~(b) A valid claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical appropriateness. A valid claim is synonymous with the federal definition of a clean claim as defined in 42 CFR 447.45(b).~~

~~(42551) "Valid Pre-Authorization" means a document the Authority, a PHP or CCO receives requesting a health service for a client who would be eligible for the service at the time of the service, and the document contains:~~

~~(a) A beginning and ending date not exceeding twelve months; and~~

~~(b) All data fields required for processing of the request or payment of the service, including the appropriate billing codes.~~

~~— A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:~~

~~(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and~~

~~(b) Has been received within the time limitations prescribed in these rules.~~

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

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