DEPARTMENT OF HUMAN SERVICES
SENIORS AND PEOPLE WITH DISABILITIES DIVISION
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 370

COMMUNITY SERVICES PROGRAMS

Provider Enrollment, Service Billing, and Service Payment

411-370-0010 Definitions
(Adopted 7/1/2011)

(1) "Administrator" means the administrators of the Department of Human Services or that person's designee.

(2) "Appropriate Service" means services that are required by a recipient's approved individual service or support plan that are:

(a) Consistent with the recipient's identified needs, goals, and desired outcomes;

(b) Appropriate with regard to standards of generally recognized practice, evidence based practice, and professional standards of service as effective;

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

(d) The most cost effective of the alternative services that may be effectively provided to a recipient; and

(e) Coordinated with the recipient's local community developmental disability program.

(3) "Authorization" means either service or payment authorization for specified covered services given prior to services being rendered by Department staff, or the Department's designee including community developmental disability programs.

(4) "Benefit Package" means the array and type of services, as described by program-specific rules, for which the recipient is eligible.

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

(6) "Claim" means a bill for services, a line item of a service, or all services for one recipient within a specified billing period. Claims include a bill submission, an invoice, or an encounter associated with requesting payment whether submitted on paper or electronically. Claim also includes any other methodology for requesting payment or as verification of an expenditure of an advanced payment that may be established in contract, provider enrollment agreement, or program-specific rules.

(7) "Client Process Monitoring System (CPMS)" means the Department's information system that tracks and documents service delivery of claims funded by the Department.

(8) "Community Developmental Disability Program (CDDP)" as defined in OAR 411-320-0020.

(9) "Community Services Programs" are services provided for recipients under the following program names, service element numbers, or descriptions:

(a) Nursing facility specialized services (DD45) as described in OAR chapter 411, division 070.

(b) Residential facilities (DD50) as described in OAR chapter 411, division 325.

(c) Supported living services (DD51) as described in OAR chapter 411, division 328.

(d) Transportation services (DD 53) as described in the applicable service element standards and procedures.

(e) Employment and community inclusion services (DD54) as described in OAR chapter 411, division 345.

(f) Rent subsidies (DD 56) as described in the applicable service element standards and procedures.

(g) Developmental disabilities special projects (DD 57) as described in the applicable service element standards and procedures.

(h) Children’s residential facilities (DD142) as described in OAR chapter 411, division 325.

(i) Children’s proctor foster homes (DD143) as described in OAR chapter 411, division 335.

(j) Room and board (DD 156) as described in the applicable service element standards and procedures.

(10) "Covered Services" mean appropriate services that are funded by the legislature and applicable Department rules describing the benefit packages of community services programs provided to eligible recipients under service element standards and procedures, program-specific requirements, provider enrollment agreements, or contracts by providers required to enroll with the Department under these rules.

(11) "Date of Service" means the date the recipient receives community services program services, unless otherwise specified in the appropriate program-specific rules.

(12) "Department" means the Department of Human Services. For the purpose of these rules, Department also includes its role as a delegated designee of the Oregon Health Authority (OHA) in carrying out the OHA responsibilities as the designated single Medicaid state agency.

(13) "Express Payment and Reporting System (eXPRS)" means the Department's information system for managing the disbursement and tracking of Department funding for certain developmental disability programs.

(14) "False Claim" means a claim or encounter that a provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and that information would result, or has resulted, in an overpayment or other improper payment.

(15) "Fraud" means an intentional deception or misrepresentation made by a recipient or provider with the knowledge that the deception may result in some unauthorized benefit to himself or herself, or some other recipient or provider. Fraud includes any act that constitutes fraud or false claim under applicable federal or state law.

(16) "Medicaid" means a federal and state funded program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department.

(17) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to an enrolled provider once enrollment of that provider is completed as described in these rules.

(18) "Medicaid Performing Provider Number" means the numeric identifier assigned to an entity or person by the Department, following enrollment to deliver Medicaid funded services as described in these rules. The Medicaid Performing Provider Number is used by the rendering provider for identification and billing purposes associated with service authorizations and payments.

(19) "Medicaid Fraud Control Unit (MFCU)" means the unit of the Oregon Department of Justice that investigates and prosecutes billing fraud committed by Medicaid providers. MFCU also may investigate and prosecute physical, sexual, or financial abuse and neglect of residents who reside in Medicaid-funded facilities.

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

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

(22) "Provider" or "Performing Provider" means an individual, agency, corporate entity, or other organization that provides community services program services that is enrolled with the Department in accordance with these rules to seek payment from the Department.

(23) "Quality Improvement" means the effort to improve the level of performance of key processes, practices, or outcomes in service provision. A quality improvement program measures the level of current performance of the processes and practices, finds ways to improve the performance or outcomes, and implements new and better methods for the processes or practices. Quality improvement includes the goals of quality assurance, quality control, quality planning, and quality management.

(24) "Recipient" means an individual found eligible by the community developmental disability program and the Department to receive community services program services for individuals with developmental disabilities under OAR chapter 411, division 320.

(25) "Service Element Standards and Procedures" means the standard for a particular service element number that further describes the applicable service and details the purpose, performance requirements, special reporting requirements, and applicable rules to adhere to when providing that particular service element.

(26) "SFMA" means the Oregon Statewide Financial Management Services.

(27) "Suspension" means a sanction prohibiting a provider’s participation in the Department's community services programs by deactivation of the assigned provider number for a specified period of time or until the occurrence of a specified event.

(28) "These Rules" mean the rules in OAR chapter 411, division 370.

(29) "Third Party Resource (TPR)" means a service or financial resource that, by law, is available and applicable to pay for covered services for community services programs.

(30) "United States Department of Health & Human Services (USDHHS)" means the Cabinet department of the United States government with the goal of protecting the health of all Americans and providing essential human services.

Stat. Auth.: ORS 409.050, 410.070, 411.060, & 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610 to 430.695, & 443.400 to 443.455

411-370-0020 Provider Requirements
(Adopted 7/1/2011)

(1) These rules cover all programs and services of the Department's community services programs for recipients with developmental disabilities (hereinafter referred to as community services programs). All providers seeking payment from the Department for the provision of covered services to eligible service recipients of community services programs must comply with these rules and the applicable rules, standards, and procedures of the specific programs or services defined as community services programs in OAR 411-370-0010.

(2) COVERED PROVIDER AGREEMENTS. Agreements with providers for community services programs may include:

(a) Direct contracts with the Department;

(b) Contracts with Department designees, including CDDPs; or

(c) Provider enrollment agreements with the Department.

(3) Covered services paid for with state, Medicaid (Title XIX), or other funds by the Department for community services programs are also subject to federal and state Medicaid rules and requirements. In interpreting these rules and program-specific rules, the Department shall construe them as much as possible in a manner that shall comply with federal and state laws

and regulations, and the terms and conditions of federal waivers and the state plans.

(4) A provider paid with state or Medicaid funds for community services programs must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid services under the Medicaid Act, Title XIX, 42 United States Code (USC)1396 et seq.

(5) Payment for any service by a provider of community services programs may not be made by or through (directly or by power of attorney) any individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the person or organization for an added fee or a deduction of a portion of the accounts receivable.

(6) The Department shall make community services programs provider payments to only the following:

(a) The provider who actually performed the service;

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

(c) An organization operating as an organized health care delivery system, if the provider has a contract under which the organization submits the claim and the organization is enrolled with the Department as a billing provider; or

(d) To an enrolled billing provider, such as a billing service or an accounting firm that, in connection with the submission of claims, receives or directs payments in the name of the provider, if the billing provider's compensation for this service is:

(A) Related to the cost of processing the billing; and

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

(7) Providers must comply with TPR requirements in Department policies, program-specific rules, provider enrollment agreements, or contracts.

(8) PROGRAM INTEGRITY.

(a) The Department shall use several approaches to promote integrity of the community services programs. This section of the rule describes integrity actions related to:

(A) Provider billings and payments, including actions and expectations contained within service element standards and procedures, program-specific rules, or contracts with Department representatives including CDDPS. The program integrity goal is to pay the correct amount to a properly enrolled provider for covered services provided to an eligible recipient according to these rules and the program-specific services in effect on the date of the service; and

(B) Provider performance in the delivery of services to recipients as well as general program practices. The program integrity goal includes approaches to assure the provision of appropriate services for which payment is to be made as well as compliance with these rules, service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts.

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

(A) Review, including but not limited to the evaluation of services in accordance with appropriate service or process, error identification, and prior authorization processes including all actions taken to determine the provision of services in accordance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contract;

(B) Onsite visits to verify compliance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts;

(C) Quality improvement activities;

(D) Coordination with the Department of Justice MFCU and other oversight authorities including law enforcement; and

(E) For provider billings and payments:

(i) Implementation of transaction standards to improve accuracy and timeliness of claims processing;

(ii) Cost report settlement processes;

(iii) Audits; and

(iv) Investigation of false claims, fraud, or prohibited business relationships.

(F) For provider service delivery:

(i) Provider licensing or certification required responsibilities and activities; and

(ii) Specific service monitoring and evaluation activities provided in program-specific rules or Department policy.

(c) The following may engage in program integrity activities including but not limited to general monitoring of the provider's performance in service delivery, reviewing a request for services, or auditing a claim of services, before or after payment, for assurance that the specific care or service was provided in accordance with the program-specific rules and the generally accepted standards of performance:

(A) Department staff or designees, including staff of a CDDP; and

(B) Federal or state oversight authority.

(d) Payment may be denied or may be subject to recovery if the review or audit determines the service was not provided in

accordance with provider rules, program-specific rules, provider enrollment agreements or contracts, or does not meet the criteria for quality or appropriateness of the service or payment.

(e) If the Department or other federal or state oversight authorities determine that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.

(f) The provider may face other sanctions or penalties, including termination of provider enrollment agreements or contracts as allowed by program-specific or Department rules.

(g) The Department may communicate with and coordinate any program integrity actions with the MFCU, USDHHS, other federal or state oversight authorities including law enforcement, or Department designees including CDDPs.

Stat. Auth.: ORS 409.050, 410.070, 411.060, & 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610 to 430.695, & 443.400 to 443.455

411-370-0030 Provider Enrollment
(Adopted 7/1/2011)

(1) For the purpose of this rule, all providers of community services programs, authorized to utilize the eXPRS, SFMA, MMIS, or CPMS systems, and licensed or certified by Department rules, or otherwise qualified by program-specific rules, prior to July 1, 2011 shall be deemed to be an enrolled provider as of July 1, 2011, subject to all provisions of these rules.

(2) Being an enrolled provider is a condition of eligibility for a Department payment for claims in community services programs. The Department requires billing providers to be enrolled as providers consistent with the provider enrollment processes set forth in this rule. If payment for community services program services shall be made under a contract with the Department or the Department's designees, including CDDPs, the provider must also meet the contract requirements. Contract requirements are separate from the requirements of these provider enrollment rules.

(3) Enrollment as a provider with the Department is not a promise that the enrolled provider shall receive any minimum amount of work from the Department, or the Department's designees, including CDDPs.

(4) RELATION TO SERVICE ELEMENT STANDARDS AND PROCEDURES, PROGRAM-SPECIFIC RULES, PROVIDER ENROLLMENT AGREEMENT, OR CONTRACT REQUIREMENTS. Provider enrollment establishes essential provider participation requirements for becoming an enrolled provider for the Department. The details of provider qualification requirements, recipient eligibility, covered services, how to obtain service authorization, documentation requirements, claims submission, available electronic access instructions, and other pertinent instructions and requirements are contained in the service element standards and procedures, program-specific rules, or provider enrollment agreement or contract.

(5) CRITERIA FOR ENROLLMENT. To be enrolled after July 1, 2011 providers must:

(a) Meet the requirements, if applicable, of the statewide agency certification process as prescribed in OAR chapter 411, division 323.

(b) Meet all program-specific requirements identified in service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts in addition to the requirements identified in these rules;

(c) Meet Department licensing, certification, or service endorsement requirements for the type of community services programs the provider shall deliver as described in the program-specific rules, provider enrollment agreements, or contracts; and

(d) Obtain a Medicaid Agency Identification Number and applicable Medicaid Performing Provider Number from the Department for the specific services for which the provider is enrolling.

(6) PARTICIPATION AS AN ENROLLED PROVIDER. Participation with the Department as an enrolled provider is open to qualified providers that:

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

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

(c) Provide or shall provide a covered service within their scope of licensure, certification, or service endorsement, if applicable, to an eligible recipient in accordance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts; and

(d) Accept the payment amounts established in accordance with the Department's program-specific payment structures, service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts for services providers.

(7) ENROLLMENT PROCESS. To be enrolled as a provider with the Department, an individual or organization must submit a complete and accurate provider enrollment form, provider disclosure form, and provider enrollment agreement, available from the Department.

(a) PROVIDER ENROLLMENT REQUEST FORM. The provider enrollment form requests basic demographic information about the provider that shall be permanently associated with the provider or organization until changed on an updated form. For the purpose of provider enrollment, the Department may use, instead of the provider enrollment form required under these rules, the application for certification required under OAR chapter 411, division 323 if such an application is applicable to the provider.

(b) PROVIDER DISCLOSURE FORM. All individuals and entities are required to disclose information used by the Department to determine whether an exclusion applies that would prevent the Department from enrolling the provider. Individual performing providers must submit a disclosure statement. All providers that are enrolling as an entity (corporation, non-profit, partnership, sole proprietorship, governmental) must submit a disclosure of ownership and control interest statement. For the purpose of provider enrollment, the Department may use, instead of the provider disclosure form required

under these rules, the application for certification required under OAR chapter 411, division 323 if such an application is applicable to the provider.

(A) Entities must disclose all the information required on the disclosure of ownership and control interest statement.

(B) Payment may not be made to any individual or entity that has been excluded from participation in federal or state programs or that employs or is managed by excluded individuals or entities.

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

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

(8) PROVIDER ENROLLMENT AGREEMENT. The provider must sign the provider enrollment agreement and submit it to the Department for review at the time the provider submits the provider enrollment form and related documentation. Signing the provider enrollment agreement constitutes agreement by a provider to comply with all applicable Department service element standards and procedures, provider and program rules, and applicable federal and state laws and regulations in effect on the date of service. The provider enrollment agreement must be submitted even if alternatives to submitting the provider enrollment form and provider disclosure form are used, as provided in sections (7)(a) and (7)(b) of this rule.

(9) ENROLLMENT OF PROVIDERS. A provider shall be enrolled, assigned, and issued a Medicaid Agency Identification Number and Medicaid Performing Provider Number upon the following criteria:

(a) Provider submission, consistent with Department procedures, of a completed and signed provider enrollment form, provider disclosure form, provider enrollment agreement, any applicable provider licensure, certification, or service endorsement materials, and all other required documents to the Department.

(b) Provider signature on required forms must be the provider or an individual with actual authority for the provider to legally bind the provider to attest and certify to the accuracy and completeness of the information submitted.

(c) The provisions of this rule, OAR chapter 411, division 323 if applicable, program-specific rules, service element standards and procedures, provider enrollment agreements, or contracts relating to provider qualifications, certification, licensure, and service endorsement are completed.

(10) Provider enrollment is not complete until all required information has been submitted, verified, and the Medicaid Agency Identification Number and the Medicaid Performing Provider Number are issued.

(11) CLAIM OR ENCOUNTER SUBMISSION. Submission of a claim or encounter or other payment request document constitutes the enrolled provider's agreement that:

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

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

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

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

(12) Medicaid Agency Identification Numbers and Medicaid Performing Provider Numbers shall be specific to the provider, and the service sites, locations, or type of service authorized by the Department or the Department's designee including CDDPs. Issuance of a Department-assigned Medicaid Agency Identification Number and Medicaid Performing Provider Number establishes enrollment of an individual or organization as a provider for community services programs.

(13) Providers must provide the following updates:

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

(A) Business affiliation;

(B) Ownership;

(C) Federal tax identification number;

(D) Ownership and control information; or

(E) Criminal convictions.

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

(14) The provider enrollment agreement may be terminated as follows:

(a) PROVIDER TERMINATION REQUEST.

(A) The provider may ask the Department to terminate the provider enrollment agreement upon the following conditions and timelines unless otherwise required by service element standards and procedures, program-specific rules, or provider enrollment agreement or contract.

(i) Upon the provider's convenience with at least 90 days advance written notice; or

(ii) Upon a minimum of 30 days advance written notice if the Department does not meet the obligations under these rules and such dispute remains unresolved at the end of the 30 day period or such longer period, if any, as specified by the provider in the notice.

(B) The request must be in writing, signed by the provider, and mailed or delivered to the Department. The notice must specify the Department-assigned Medicaid Agency Identification Number and Medicaid Performing Provider Number, if known.

(C) When accepted, the Department shall assign the Medicaid Agency Identification Number and Medicaid Performing Provider Number a termination status and the effective date of the termination status.

(D) Termination of the provider enrollment agreement does not relieve the provider of any obligations for covered services provided under these rules in effect for dates of services during which the provider enrollment agreement was in effect.

(b) DEPARTMENT TERMINATION. Pursuant to the provisions of OAR chapter 407, division 120, the Department may terminate the provider enrollment agreement immediately upon notice to the provider, or a later date as the Department may establish in the notice, upon the occurrence of any of the following events:

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

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

(C) The Department has issued a final order revoking the Department-assigned Medicaid Agency Identification Number, service endorsement, or Medicaid Performing Provider Number based on a sanction;

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

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

(15) IMMEDIATE SUSPESION. When a provider fails to meet one or more of the requirements governing participation as a Department enrolled provider, the provider's Department-assigned Medicaid Agency Identification Number or Medicaid Performing Provider Number may be immediately suspended consistent with the provisions of OAR chapter 407, division 120. The provider may not provide services to recipients during a

period of suspension. The Department shall deny claims for payment or other payment requests for dates of service during a period of suspension.

(16) The provision of a program-specific provider enrollment agreement or contract covered services to eligible recipients is voluntary on the part of the provider. Providers are not required to serve all recipients seeking service.

(17) The provider performs all services as an independent contractor. The provider is not an officer, employee, or agent of the Department.

(18) The provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. The provider is solely responsible for its acts or omissions including the acts or omissions of its own officers, employees, or agents. The Department's responsibility shall be limited to the Department's authorization and payment obligations for covered services provided in accordance with these rules.

Stat. Auth.: ORS 409.050, 410.070, 411.060, & 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610 to 430.695, & 443.400 to 443.455

411-370-0040 Variances
(Adopted 7/1/2011)

(1) The Department may grant a variance to these rules based upon a demonstration by the provider that an alternative method or different approach provides equal or greater effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals.

(2) The provider requesting a variance must submit, in writing, an application on a Department approved form that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance; and

(c) The alternative practice, service, method, concept, or procedure proposed.

(3) The Department shall approve or deny the request for a variance. In reviewing the variance request, the Department may seek input or information from the Department's designees, including CDDPs.

(4) The Department's decision shall be sent to the provider and to all relevant Department programs or offices within 30 calendar days of the receipt of the variance request.

(5) The provider may appeal the denial of a variance request by sending a written request for review to the Administrator, whose decision is final.

(6) The Department shall determine the duration of the variance.

(7) The provider may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 411.060, 410.070, 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610-695, 443.400-.455