Oregon Medical Assistance Programs Worker Guide

Contains updates through December 2019

Oregon Health Authority

Health Systems Division

Oregon HEALTH PLAN

Revision Log

For a description of specific Worker Guide changes, please see the OHP Staff Transmittals at www.oregon.gov/OHA/HSD/Pages/transmittals.aspx (refer to the date in the table below for the transmittal issue date).

Date	Changes
10/1/2012	Combined for a single document format; all sections are up-to-date.
12/14/2012	Medical Transportation section only
1/1/2013	■ *Table 2: Professional (non-hospital) Services* referenced in the Worker Guide Administrative Examinations section. ■ Provider Services' telephone number correction in the Medical Transportation section changes effective 12/14/12 (above).
7/1/2013	■ OHP Medical Resources – Benefit chart updated ■ Medical Transportation update ■ Health Care Delivery Systems – Added CCOA plan type ■ Admin Exams - CPT/HCPCs Codes – Table 2 change only
10/1/2013	Medical Resources – All pregnant CAWEM (standard) members Statewide are eligible for CAWEM Plus, effective Oct. 1, 2013
11/1/2013	Health Care Delivery Systems – Updates to delivery service area and death sections
12/1/2013	■ Administrative Examinations and Reports – Updated CPT/HCPCS Table 2 – Professional (non-hospital) Services ■ Health Care Delivery Systems – Overview to add CCOG; PCO and Death information updated ■ Prior Authorizations – Added Select Lab and Radiological studies to the list of equipment and services requiring prior authorization. ■ Processing Claims: *Office of Forms and Document Management* is now called *Information Resource Management Services (IRMS);* data from providers who bill electronically is sent electronically.
2/27/2014	Entire guide: Removed references to OHP Standard benefit package. ■ OHP Medical Resources: Benefit chart replaced ■ Health Care Delivery Systems - Updated the number of days a member has to change to a different managed care plan (90 days); added CCO enrollment resolution guide ■ Medical Savings Chart (MSC) – New MAGI codes added to the chart ■ Copayments and Special Requirements: Renamed section and removed obsolete information about premiums. Members on hospice are no longer responsible to pay copayments for any OHP services.
3/27/2014	Removed additional references to OHP Standard benefit package. ■ Copayments and Special Requirements: Updated which members are no longer responsible to pay copayments.

Date	Changes
3/27/2014	■ DMAP/Medicaid Overview –Clarify branch office text. ■ MC Special Conditions - Exemption Codes Chart updated. ■ Member Rights and Responsibilities - Billing members
4/30/2014	■ OHP Medical Resources - Clarified OHP Plus visual services coverage; updated benefit package chart ■ Other Medical Resources – Removed obsolete programs
5/30/2014	■ OHP Medical Resources – Updated Prioritized List of Health Services text; updated OHP medical assistance program codes. ■ Health Care Delivery Systems – Updated enrollment exemption info, added section about enrollment reason codes; updated Educating members about health care and Who to contact for help. ■ Medical Transportation - Link to staff transmittals is updated ■ Co-payments and Special Requirements - Updated instructions for reporting changes to an assigned pharmacy
11/30/2014	Health Care Delivery Systems – Always use the most current charts available.
4/30/2015	Updated hyperlinks throughout document. ■ DMAP/Medicaid Overview: Edited branch office section for clarity ■ Medical Resources: Updated with January 1, 2014 Prioritized List ■ Reorganized for clarity; updated TPL reporting, general contact information; added service area exceptions. Updated FCHP references ■ Other Medical Resources: Updated BCCTP link ■ Health Insurance Premium Payment Program: Renamed section, removed PHI program information ■ Prior Authorization: Updated medical transportation information ■ Medical Transportation: Updated to remove NEMT ambulance authorization instructions, update contacts and OAR references ■ Processing Claims: Updated to include all current claim formats
10/1/2015	Updated Medical Transportation section to update when branch authorizations are permitted (Marion and Polk counties only).
11/1/2015	Updated Medical Transportation section to remove branch authorization instructions.
6/21/2019	Updated hyperlinks and agency references throughout. Removed copayment information (OHP copayments ended 1/1/2017). Updated Admin Exam Table 2 (Professional Services). New flowcharts for prior authorization and NEMT approvals. Reorganized Health Care Delivery Systems into four sections: ■ Health care delivery systems ■ Choice counseling ■ Medicaid managed care enrollment changes ■ Third party liability (includes Health Insurance Premium Program information)
12/31/2019	Updated Division 141 Oregon Administrative Rule references throughout; process for requesting county-specific plan information; and Prioritized List funding line information.

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Agency roles

Oregon Health Authority

The Oregon Health Authority (OHA) acts as Oregon's single state Medicaid agency. It oversees administration of medical assistance in Oregon.

Health Systems Division

OHA's Health Systems Division administers Oregon's medical assistance programs, including the Oregon Health Plan (OHP) and:

- Determines policy and Oregon Administrative Rules (OARs) for medical assistance programs including Title XIX (Medicaid) and Title XXI Children's Health Insurance Programs (CHIP).
- Executes contracts with managed care plans such as coordinated care organizations to deliver medical assistance in Oregon.
- Informs members and providers about policy and OAR changes that affect OHP services.
- Pays claims and contracted payments (*e.g.,* payments to coordinated care organizations) for covered health care services.
- Oversees production and distribution of notices sent to members and providers from the Medicaid Management Information System (MMIS), including the Oregon Health ID and coverage letter.

Community Partner Outreach Program

This program works with more than 400 community partner organizations statewide to help Oregonians get health coverage through the Oregon Health Plan or the Health Insurance Marketplace. OHP-certified community partners:

- Help people understand how to apply for, keep, and use their health coverage.
- Help in ways that respect each person's cultural background and language needs.
- Can be clinics, schools, community-based nonprofits, churches, small businesses, government offices, and other places where you may already go for help.

To find an OHP-certified community partner near you, use the search tool at OregonHealthCare.gov.

Staff resources

The Provider Contacts List contains current contact information, including member assistance, provider resources, billing, and prior authorization for services not covered by contracted plans.

The online State Agency Directory contains contact information for division units.

If you cannot find the number you need, call **800-527-5772** or **503-945-5772** (Salem).

Department of Human Services

The Department of Human Services (DHS) determines program eligibility for Oregon medical assistance clients. It also oversees the production and distribution of all eligibility notices issued by the Oregon Eligibility (ONE) system, including the *Notice of Eligibility* and annual renewal notices.

DHS branch offices

Branch offices throughout Oregon provide a direct link with members receiving medical assistance. Self Sufficiency Programs (SSP), Child Welfare (CW), Aging and People with Disabilities (APD), Area Agency on Aging (AAA), Developmental Disabilities (DD), and the Oregon Youth Authority (OYA) determine eligibility rules for their programs. Depending on the agency, branch staff will:

- Determine a client's program eligibility.
- Refer clients to OHP Customer Service (branch 5503) for Medicaid/CHIP eligibility.
- Provide choice counseling to clients when needed regarding the selection of managed care available in their area.

OHP member services

OHP Customer Service (800-699-9075) acts as the branch office for all medical-only clients, and does the following for all clients with Oregon Health Plan eligibility:

- Determine a client's medical eligibility.
- Enter medical eligibility data into the computer system.
- Order replacement Oregon Health ID cards and coverage letters or issue temporary Oregon Health IDs when needed

OHP Client Services (800-273-0557) is the customer service center for all OHP members who are not enrolled in a coordinated care organization (CCO).

OHP Client Services is also the home of **Client Enrollment Services** (CES), which manages all member enrollment requests.

Staff resources

OCCS Medical Policy is the contact for issues with eligibility notices and ONE.

Oregon Health ID and coverage letter

Oregon Health ID

For households newly eligible for OHP, QMB or CAWEM benefits, their first coverage letter will include a sheet of ID cards (one for each eligible client in the household). If members lose or misplace their cards, they can ask for a replacement card.

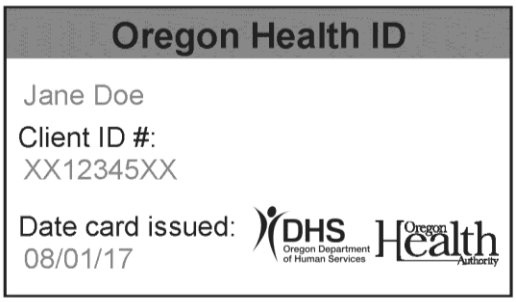
- The Oregon Health ID is the size of a business card and lists the member name, prime number and the date it was issued.
- Members should take the Oregon Health ID to all health care appointments to make it easier for providers to check member eligibility.

Member IDs are not proof of OHP eligibility.

See OAR 410-120-1140 in the General Rules for more information. Provider claim denials and billing errors are reduced when providers verify OHP eligibility and health plan enrollment prior to delivering services. Providers can use the Provider Web Portal, Automated Voice Response at 866-692-3864, or 270/271 electronic data interchange transaction to information.

Sample Oregon Health ID card

DHS Medical Care ID cards are still acceptable.



Front

Back

Coverage letter

The coverage letter is for the member's information only. It shows the worker's ID and phone number, which is helpful when the member has questions. It also shows benefit package, managed care enrollment, and other health coverage information for everyone in the household. OHA sends new coverage letters anytime this information changes for anyone in the household. A sample of the coverage letter follows.

OHA mails information about how to read the coverage letter (a.k.a. *yellow sheet*) with the letter. It includes a summary of OHP benefits and services.

Sample coverage letter – Page 1

5503 XX##### XX P2 EN AT

PO BOX #####
SALEM, OR 97309
DO NOT FORWARD: RETURN IN 3 DAYS

Branch name/Division: OHP/CAF

Worker ID/Telephone: XX/503-555-5555

JOHN DOE
123 MAIN ST

HOMETOWN OR 97000

Keep this letter!

This letter explains your Oregon Health Plan (OHP) benefits.

This letter is just for your information. You do not need to take it to your health care appointments.

We will only send you a new letter if you have a change in your coverage, or if you request one.

Welcome to the Oregon Health Plan (OHP). **This is your new coverage letter.**

This letter lists coverage information for your household. This letter does not guarantee you will stay eligible for services. This letter does not override decision notices your worker sends you.

We will send you a new letter and a Medical ID card any time you request one or if any of the information in this letter or on your Medical ID card changes. To request a new letter or Medical ID, call your worker.

The enclosed yellow sheet includes a chart that describes the services covered for each benefit package and a list of helpful phone numbers.

We have listed the reason you are being sent this letter below. The date the information in this letter is effective is listed next to your name.

Reason for letter:

Managed care plan enrollment changed for:
Doe, Timothy - 08/1/2017

Names were changed for:
Doe, Jane - 08/1/2017

Sample coverage letter – Page 2

Page 2 lists benefit package and enrollment information for each household member.

The following chart lists coverage information for everyone who is eligible in your household. See the enclosed Benefit Package chart for information about what each benefit package covers. Letters in the Managed Care/TPR enrollments section refer to the plans listed on the Managed Care/TPR Enrollment page.

Name	Date of birth	Client ID #	Copays?	Benefit Package	Managed Care/ TPR enrollment
John Doe	01/01/1968	XX1234XX	No	OHP Plus	A, B, C
Jane Doe	02/01/1968	XX1235XX	No	OHP with Limited Drug	A, B, C, G, H, I
Timothy Doe	03/01/2006	XX1236XX	No	OHP Plus	B, C, D, F
Kathy Doe	04/01/2007	XX1237XX	No	OHP Plus	B, C, E, G, H

Sample coverage letter – Page 3

Page 3 lists all managed care and third party liability information for the household.

Plan Information	Plan Information	Plan Information
A Coordinated Care Organization - CC CCO NAME 1-800-555-5555	**B** Dental Care Organizations - DC DENTAL PLAN NAME 1-866-555-5555	**C** Mental Health Organization - MH MENTAL HEALTH PLAN NAME 1-888-555-55555
D MAJOR MEDICAL MATERNITY PRIVATE INSURANCE NAME 1-800-555-1234 123456789012	**E** PRESCRIPTION DRUGS - COST AVOI PRIVATE INSURANCE NAME 1-800-555-1234 123456789012	**F** Medicare Part A MEDICARE NW - PART A
G Medicare Part B MEDICARE-B/BC N DAKOTA	**H** Medicare Part-D MEDICARE PART D	**I**

Oregon Health ID and coverage letter replacements

Members can contact OHP Customer Service if their ID cards get lost or destroyed. Workers may order replacement IDs through MMIS. For detailed instructions on how to order a replacement or issue a temporary ID or coverage letter, please see Self-Sufficiency's Staff Tools.

Replacement cards and coverage letters are mailed to the member's mailing address. To ensure cards and letters are mailed to the correct address:

- Enter member addresses using U.S. Postal Service (USPS) addressing standards (*e.g.*, "St" for street, "Ave" for avenue).
- Use the U.S. Postal Service ZIP code look-up tool to verify the address is correct and follows USPS standards.

Otherwise, items sent to non-standard or incorrect addresses may be thrown out by automatic mailing protocols and not reach members.

Medical assistance coverage and benefits

Prioritized List coverage *OAR 410-141-3820, 410-141-3825, 410-141-3830*

Oregon uses the Prioritized List of Health Services (Prioritized List) to help determine Oregon Health Plan coverage. The Benefit and HSC List Inquiry panel in the MMIS Reference Subsystem provides Prioritized List coverage information for specific dates of service.

How it works

The Prioritized List ranks paired health conditions and treatments. The primary diagnosis determines the condition, and the treatment is the service provided for the condition.

- Preventive services are at the top of the list.
- Treatment for conditions that get better on their own, are cosmetic in nature, or have no effective treatment available, are toward the bottom of the list.
- Diagnostic services are covered regardless of where they place on the list, as long as they are medically appropriate for the condition.

The "funded line" marks how much of the Prioritized List gets funded by the OHP budget. As of January 1, 2020, the funded line is 471.

- **Covered lines (1-471) -** OHP covers condition/treatment pairs on lines 1 through 469.
- **Not-covered lines (472-662) -** OHP does not cover these lines. However, OHA may cover a treatment pair listed on a not-covered line if it serves to improve the outcome of a higher-ranked treatment pair.

Technical changes

The Oregon Health Evidence Review Commission (HERC) manages the Prioritized List by:

- Updating the list in October and April each year, and every other January.
- Coordinating input on suggested list changes through a variety of workgroups.
- Adding or removing codes based on industry changes (e.g., ICD-10 implementation).
- Updating guideline notes that clarify Prioritized List coverage.

Coverage changes

The Oregon legislature decides whether to move the "funded line" higher or lower on the Prioritized List.

If the legislature decided to move the funded line "up the list," it would mean covering fewer treatment pairs (reducing coverage). Moving the funded line "down the list" would mean expanding coverage.

Non-covered conditions

Treatments for the following conditions are **not covered** unless there is another complicating diagnosis that is ranked above the funding line on the Prioritized List:

Description	Examples
Conditions that tend to get better on their own	■ Measles ■ Infectious mononucleosis ■ Mumps ■ Viral sore throat ■ Dizziness ■ Viral hepatitis ■ Benign cyst in the eye ■ Minor bump on the head ■ Non-vaginal warts
Conditions where a "home" treatment is effective	Home treatments include applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. ■ Canker sores ■ Corns/calluses ■ Sunburn ■ Diaper rash ■ Food poisoning ■ Sprains
Cosmetic conditions	Examples include: ■ Benign skin tumors ■ Cosmetic surgery ■ Removal of scars
Conditions where treatment is not generally effective	Examples include: ■ Some back surgery ■ Temporal-Mandibular Joint surgery ■ Some transplants

Non-covered services

Other non-covered services regardless of condition include, but are not limited to:

- Circumcision (routine)
- Weight loss programs
- Infertility services

Benefit packages

OARs: General Rules 410-120-1160 through 410-120-1230
OHP 410-141-3820

Members receive coverage for health care services based on their benefit package(s). Coverage is different for each package. Members are assigned benefit packages based on their program eligibility.

The "Benefit Plan" field on the MMIS Recipient Information panel displays the member's most current benefit package. The packages that indicate medical assistance eligibility are:

- **Oregon Health Plan (OHP) benefit packages** that provide full health coverage and managed care enrollment (with some exceptions)
- **Non-OHP benefit packages** that provide other medical assistance on a fee-for-service basis

Oregon Health Plan benefit packages — *BMH, BMD, BMM, BMP, CWX*

All members with an OHP benefit package get comprehensive medical, dental, mental health and chemical dependency services. Most members with OHP benefits can be enrolled in managed care.

- **OHP Plus (BMH)** covers OHP benefits for members age 0 through 64.
- **OHP with Limited Drug (BMD)** covers OHP benefits for members age 65 and older, except for drugs already covered by Medicare Part D.
- **QMB + OHP with Limited Drug (BMM)** covers the same OHP benefits as OHP with Limited Drug (BMM). It also covers the benefits described in the QMB benefit package section.

Type of service	Description/examples
Preventive services	■ Maternity and newborn care ■ Well-child exams and immunizations ■ Routine physical exams and immunizations ■ Maternity case management, including nutritional counseling
Diagnostic services	■ Medical examinations to tell what is wrong, even if the treatment for the condition is not covered ■ Laboratory, X-ray and other appropriate testing
Family planning services and supplies	Including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations

Type of service	Description/examples
Medical and surgical care	Medically appropriate treatments for conditions expected to get better with treatment. Includes, but is not limited to: ■ Appendicitis ■ Infections ■ Ear Infections ■ Broken bones ■ Pneumonia ■ Eye diseases ■ Cancer ■ Stomach ulcers ■ Diabetes ■ Asthma ■ Kidney stones ■ Epilepsy ■ Burns ■ Rheumatic fever ■ Head injuries ■ Heart disease
Medically appropriate ancillary services	When provided as part of treatment for covered medical conditions. ■ Hospital care, including emergency care ■ Home health services ■ Private duty nursing ■ Physical and occupational therapy evaluations and treatment ■ Speech and language therapy evaluations and treatment ■ Medical equipment and supplies ■ Prescription drugs and some over-the-counter drugs ■ Limited vision services ■ Hearing services including exams, evaluations, treatment, materials and fitting for hearing aids ■ Transportation, including ambulance, to health care for members who have no other transportation available to them
Other services	■ Dental services, including cleanings, fillings, and extractions ■ Outpatient chemical dependency services ■ Comfort care – Includes hospice care and other comfort care measures for the terminally ill, and death with dignity services ■ Mental health services

For children under age 21, OHP Plus **also covers** the following benefits:

Type of service	Description/examples
Services to improve vision	■ Exams to prescribe glasses or contacts ■ Fittings for glasses or contacts ■ Glasses or contacts

Type of service	Description/examples
Other dental services	■ Crowns ■ Root canals ■ Apexification/recalcification procedures ■ Gingival flap procedures ■ Apically positioned flap ■ Osseous surgery ■ Surgical revision procedure ■ Alveoplasty ■ Office visit for observation

OHP Plus – Supplemental **BMP**

This benefit package gives OHP women certain dental and vision benefits during pregnancy. The BMP benefits end 2 months after the pregnancy ends.

Type of service	Description/examples
Services to improve vision	■ Exams to prescribe glasses or contacts ■ Fittings for glasses or contacts ■ Glasses or contacts ■ ”Services to improve vision” included under “OHP Plus - Supplemental BMP” are **not covered** for **non-pregnant** adults, age 21 and over, unless they have a qualifying medical condition described in OAR chapter 410, division 140.
Other dental services	■ Crowns ■ Root canals ■ Apexification/recalcification procedures ■ Gingival flap procedures ■ Apically positioned flap ■ Osseous surgery ■ Surgical revision procedure ■ Alveoplasty ■ Office visit for observation

CAWEM Plus **CWX**

This benefit package gives CAWEM women both OHP Plus (BMH) and OHP Plus - Supplemental (BMP) benefits during pregnancy.

CWX benefits end 2 months after the pregnancy ends. After that, they return to the CAWEM (CWM) benefit. Benefits include:

- Pre-natal care, or services needed for the health of the baby
- Post-partum services
- Sterilization services
- Hospital claims related to the delivery of the child (admission through discharge)
- Emergency services

The CAWEM Plus benefit **does not cover** death with dignity.

Refer to OAR 410-120-0030 for coverage and exclusion details.

Women with the CWX benefit package cannot enroll in managed care.

Non-OHP benefit packages *MED, CWM*

Members with non-OHP benefit packages cannot enroll in managed care.

Qualified Medicare Beneficiary (QMB) **MED**

This benefit package pays for Medicare Part B premiums and deductibles and covers copayments for services covered by Medicare (except for Medicare Part D).

- If the provider accepts the Oregon Health ID card for reimbursement, they accept whatever our payment is and do not bill the member for the services covered by the QMB benefit package.
- By law, providers may only bill QMB-only members for services not covered by Medicare, and for Medicare Part D prescriptions.

CAWEM - Citizen/Alien-Waived Emergency Medical **CWM**

This benefit package covers treatment of emergency medical conditions only.

- Services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance are **not covered** by CAWEM.
- Refer to OAR 410-120-1210 for coverage and exclusion details.

Medical assistance program codes

The BMP benefit only applies to pregnant adults receiving BMH, BMM or BMD benefits.

Code	Program Title	Case Descriptor	Benefit Package						
			BMH	BMM	BMD	BMP	CWM	CWX	QMB
1, A1	Aid to the Aged	Various; see APD/AAA Staff Tools	X	X	X				
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	X				X		
V2	Refugee Assistance		X			*			
3, B3	Aid to the Blind	Various; see APD/AAA Staff Tools	X	X	X	*			
4, D4	Aid to the Disabled	Various; see APD/AAA Staff Tools	X	X	X	*			
19, 62	DHS Foster Care		X						
C5	Substitute/Adoptive Care	SAC, SCH, SCP, SFC, CR1, CR2, CR3	X				X		
GA (CSD)	Non-title XIX Foster Care		X						
5	OSIPM-PRS	Various; see APD/AAA Staff Tools	X		X	*	X		
P2	Qualified Medicare Beneficiary (QMB)	QMB							X
P2, M5, 2, 82	OHP Medical	AMO, CMO, PCR, PWO, OPC, OP6, OPP, CEC, CEM, CAK	X			*	X		
	Breast and Cervical Cancer Treatment Program	BCCTP	X			*	X		
	Children's Health Insurance Program (CHIP) and MAGI CHIP	CHP, C21, CAK	X						
	Extended Medical Program	EXT	X			*	X		
CW, CX	CAWEM	CWM					X		
	CAWEM Plus	CWX						X	
QMB	QMB + Any Program	QMM		X					

Health care delivery systems

Overview

OHA contracts with private companies, primary care providers and clinics to provide comprehensive coordination and management for medical, dental and mental health care. To deliver these services, there are two delivery systems:

- **Managed care** – OHA pays contracted managed care entities (MCEs) a monthly financial allotment for each enrolled member, whether or not the member gets services in that month.
- **Fee-for-service (FFS)** – OHA pays contracted providers a fee for each service they deliver to members who are not enrolled in an MCE.

Medicaid managed care

In the managed care delivery system, OHA pays MCEs a monthly financial allotment called a **capitation payment** for each enrolled member, regardless of services rendered.

- **Coordinated care** is what Oregon calls its Medicaid managed care model. This is the preferred delivery model for OHP members.
- The MCEs that deliver coordinated care are **coordinated care organizations (CCOs)**.

Members who live in a service area that has a CCO and do not have an approved exemption from managed care are required to enroll in a CCO for medical, dental and mental health services.

In the few rural parts of Oregon where no CCO provides mental health care, a **mental health organization** (MHO) is available for enrollment on a FFS basis.

Coordinated care

Over 90 percent of all OHP members get services through a CCO. There are four types of coordinated care:

- CCOA – Mental, medical and dental health coverage
- CCOB – Mental and medical health coverage
- CCOE – Mental health coverage
- CCOG – Mental and dental health

Coordinated care uses evidence-based approaches to:

- Improve quality of care and health outcomes
- Integrate behavioral or mental, physical and dental health care

- Focus on preventive care and management of chronic conditions
- Address community health factors that impact members' health
- Help members access appropriate care when they need it

Patient-Centered Primary Care Homes

OHA recognizes health care clinics that provide a patient-centered model of care as Patient-Centered Primary Care Homes (PCPCH). This type of care:

- Fosters strong relationships with providers, patients and their families.
- Improves care by focusing on prevention, catching problems earlier, wellness and management of chronic conditions.

CCOs are expected to include PCPCHs in their provider networks.

For more information, please visit www.primarycarehome.oregon.gov.

Intensive Care Coordination

CCOs provide **Intensive Care Coordination Services** or as formerly known, **Exceptional Needs Care Coordination**, for seniors, members with exceptional health care needs, and those having trouble getting the right services. Nurses called **Intensive Care Managers** help members get the right care and get it faster.

- If members tell you they are having problems getting services, tell them about this service.
- The OHP Handbook and the CCO's member handbook provide contact information for these services. Members can also call their CCO's customer service number.

Dental Care Organization (DCO)

A **Dental Care Organization** (DCO) provides comprehensive dental services to manage each enrolled member's dental care. Members are enrolled in DCOs when there is no local CCO with dental services (CCOA or CCOG) available.

Mental Health Organization (MHO)

In areas where no CCO provides mental health care, a Mental Health Organization (MHO) coordinates mental health services. Services provided by the MHO include:

- Evaluation
- Case management
- Consultation
- Mental health-related medication and medication management
- Individual, family, and group therapy
- Local acute inpatient care
- 24 hour urgent and emergency response

- For adults only:
  - ✓ Rehabilitation services
  - ✓ Skills training
  - ✓ Supported housing
  - ✓ Residential care

Former managed care models

These former models managed physical health care for OHP members. They were replaced by CCOs that cover physical health care (CCOA or CCOB). These plan types still display in a member's MMIS enrollment history if applicable:

- **Fully Capitated Health Plan (FCHP):** FCHP was the original managed care model for Oregon Medicaid. FCHPs covered all physical health care, including physical health prescriptions.
- **Physician Care Organization (PCO):** PCOs covered outpatient medical services but not hospitalization.

Fee-for-service

The fee-for-service (FFS) model serves non-OHP members, such as CAWEM and QMB members, who cannot enroll in managed care. For OHP members:

- Some services, such as most mental health prescriptions, are covered FFS for all members, including CCO members.
- In general, OHP members must have an important reason to get other services FFS.

Reasons for FFS OHP members *OAR 410-141-3810*

Also known as **enrollment exemptions,** reasons members may get services FFS include:

- American Indian or Alaska Native ("HNA") status. These members can choose to enroll in managed care at any time.
- Behavioral health residential treatment
- Continuity of care: To keep seeing a provider who is not part of the CCO's network. For example, to allow a member a small window of time to complete a needed medical service or treatment.
- Medicare enrollment: Medicare members are exempt from CCOA and CCOB enrollment only.
- Third party liability (TPL): The member has employer-sponsored or private health insurance that provides major medical coverage.
- Women in their third trimester of pregnancy, if they have not been enrolled in a CCO for at least three months or is newly eligible for OHP. In this case, FFS status lasts for 60 days post-partum.

Training on the exemption process is offered through the Learning Center.

How to request enrollment exemptions

Exemptions should include a specific start and end date. Submit all requests to Client Enrollment Services (CES) at ces.dmap@dhsoha.state.or.us, except for the following:

Continuity of Care exemptions

The HSD Provider Clinical Support Unit must approve all continuity of care requests. Once approved, HSD will submit the exemption request to CES.

- OHP members seeking to disenroll from their CCO for continuity of care reasons need to call OHP Client Services at 800-273-0557.
- Client Services will refer members to their CCO for further discussion, or have them complete the *Statement of Need for Temporary Fee-for-Service Health Care* (OHP 0416) form.
- The member will then need to give the completed, signed form to their primary care provider to complete the request.

Only the primary care provider can submit the request to HSD, using the prior authorization process and submitting documentation that supports the medical need for FFS enrollment.

The OHP 0416 form is for staff and provider use only.

Please remember that for the majority of OHP members, CCO disenrollment for continuity of care reasons is possible **only** if both the division and the CCO agree that the CCO cannot meet the member's health care needs.

Medicare Choice exemptions

Authorized APD workers can enter these exemptions.

TPL exemptions

Only the Health Insurance Group (HIG) can enter or update TPL exemptions. Members should submit their TPL information at ReportTPL.org.

Other health care coverage

Medicaid pays last. If a member has other coverage, then that coverage pays first. These other resources should also be the first resources members call if they have questions.

Medicare

Medicare is the federal health insurance program for people age 65 and older. Certain people younger than age 65 can qualify for Medicare, including those who have received Social Security Disability Income (SSDI) for 2 years, and those who have permanent kidney failure.

- Common questions and contact information related to Medicare can be found on Oregon's Senior Health Insurance Benefits Assistance (SHIBA) website.

Private health insurance

Private or employer-sponsored health insurance is called Third Party Liability (TPL). Anyone covered by Oregon medical assistance is **required to report** insurance that:

- Is through a job (employer-sponsored health insurance).
- Was purchased from an insurance company (commercial health insurance), including Medicare Supplements.
- Is student insurance.
- Is provided by someone who does not live in the same household as the medical assistance member.

The following types of insurance **do not need to be reported**:

- Medicare A, B, C, D or Medicare Advantage (Replacement) policy information
- Car insurance
- Homeowner's insurance

To report TPL, go to ReportTPL.org.

Choice counseling

Choosing a plan

Usually clients will make their own decisions about plans, knowing it is important to choose plans that best meet their needs. To help them decide, OHA includes comparison charts with all new application packets. Comparison charts are a choice counseling tool and are formatted so that all plans in a specific area can be compared to one another.

Clients may request a CCO on their OHP application. I

APD and other field staff should help clients select a CCO. Check to make sure the client's providers are in the CCO network using the CCO's online provider directory.

If the client is unable to choose a plan, one may be chosen for them by a legal health representative *(power of attorney, guardian, spouse, family member, a team of people, or an agency caseworker).*

For members who live in an area with more than one CCO:

Choosing a CCO during the application or renewal process does **not** guarantee enrollment with the CCO they choose. Members who have a CCO preference should call OHP Client Services or email Client Enrollment Services for help.

How long does it take to get enrolled in a CCO?

The enrollment process usually takes 1-1 ½ weeks.

What happens if clients do not choose a CCO?

Non-exempt clients who do not choose a CCO are automatically assigned to an open CCO in their area. A new coverage letter will let clients know which CCO they have.

- Members have a right to change to a different CCO within 90 days of enrollment *(OAR 410-141-3810(3)(a)(B))* if another plan is available in their area. To change, members should call OHP Customer Service.
- If they do not request a change within 90 days, they may change plans later using one of their disenrollment options.

What happens if clients get enrolled in the wrong CCO?

Clients get 30 days to change CCOs, if there is one in their area *(OAR 410-141-3810(3)(a)(A))*.

Plan availability

The MMIS Managed Care screen gives the following information (based on the FIPS/ZIP codes for the member's residence address):

- The medical, dental and mental health plans available
- Whether the plan is open or closed for new enrollment

Open means the CCO has enough providers to serve new members.

Closed may mean the CCO is still open to returning members for the first 0 to 120 days after the member ended his or her CCO enrollment. It is not open to new members.

Always use the most current plan availability information

The 2020 CCO Plans page shows the counties each plan serves, with links to provider directories and other useful information. You can also:

1. Sign up for text or email notifications to find out when updates are posted.
2. Order printed county-specific information using the OHA 6625 (OHP Application Order Form).
3. Subscribe with the OCE Print Shop to get updates when they occur. To do this, email ocemailroom@oce.oregon.gov with the following information:
    a. Branch number, or name of outreach agency
    b. Number of full application packets that include county-specific inserts, per language
    c. Number of county-specific inserts only (without application packets), per language
    d. Name, address and phone number of person at the agency to receive the order

Medicare members and Medicaid managed care enrollment *OAR: 410-141-3805*

Members eligible for both Medicaid and Medicare (benefit packages BMM or BMD) can choose to enroll with any CCO that is open in their area or choose to receive services on a fee-for-service basis. Most Medicare-Medicaid members already get at least part of their care through a CCO.

Federal law requires that these members get information about all their Medicaid managed care options, including:

- The opportunity to enroll in a CCOA for full coordination of physical, behavioral health and dental health benefits
- Information about Medicare and Part D plans
- Ways the CCOA can better coordinate with Medicare and Part D plans

Coordinating Medicare and Medicaid

CCO members with Medicare and Medicaid may choose to enroll in the CCO's Medicare Advantage (MA) Plan, enroll in another CCO's MA Plan, or keep Medicare fee-for-service (original Medicare).

Medicare rules require that Medicare members always have the option of FFS instead of managed care. However, we must ensure FFS members receive annual counseling that lets them know they can join a CCO.

CCO with corresponding Medicare Advantage Plan

During choice counseling, members who are enrolling in their CCO's corresponding Medicare Advantage Plan should complete the OHP 7208M within 30 days of receiving it. The following information is needed to complete the form:

- Information about the member – name, phone number, address, county, date of birth, gender, Social Security number, and Medicare claim number
- Name of the member's Primary Care Provider (PCP)
- Name of the member's OHP medical plan
- Name of the Medicare Advantage Plan the member chooses
- Effective date of Medicare:
  Part A – Hospital insurance coverage
  Part B – Medical insurance coverage

Members may also enroll with the CCO's Medicare Advantage Plan directly.

Important: Members who have End Stage Renal Disease (ESRD) or receive routine dialysis treatment or have received a kidney transplant within the last 36 months cannot enroll in a Medicare Advantage Plan. However, they can stay in the plan if they were already enrolled before being diagnosed with ESRD.

CCO without a corresponding Medicare Advantage Plan

Enroll these members in the CCO. These members will receive their health care as follows:

- Medicare services – from original Medicare
- Medicaid services – through their CCO

Choice counseling checklist

The following checklist shows major discussion areas to cover when helping a client choose a plan:

- Does the client's doctor (PCP) or dentist (PCD) participate with an available plan?
- Do the client's children have a PCP? Does the PCP participate with an available plan?

- Is the medical or dental office near the client's home or on a bus line? Can they get to their appointments easily?
- What transportation is available to the client to access medical services?
- Are the PCP's office hours convenient for the client?
- Where will they go for medicine? Is there a pharmacy near their home?
- Which hospital does the plan require the client to use for general hospital care? Is it near their home?
- Does the family have special medical, mental health, or chemical dependency needs to be considered?

Questions to ask Medicare-Medicaid members during choice counseling

Be sure to share the Medicare-Medicaid CCO promotional brochure (OHA 1424) with the client to help them understand the benefits of being in a CCOA or CCOB.

- **Are you satisfied with your current plan(s)?** If in a CCOG, CCOE, MHO or DCO, do they have the option of enrolling in a CCOA or CCOB?
- **Did you know that you can get all your physical, dental and mental health care through your CCO?** This means getting all your OHP benefits in one place.
- **Do you have questions about providers?** CCOs list their providers on their website. Ask your providers if they work with [CCO name]. The OHP Coordinated Care page lists all the CCOs and their websites.
- **Does your Medicare Advantage plan work with [CCO name]?** Review the affiliated plans listed for your client's county. Share how the CCO can work with Medicare Advantage.
  - ✓ Compare out-of-pocket costs, network providers and prescription coverage
  - ✓ Review Medicare options to see if client would like to change their Medicare plan enrollment. Changing MA plans is allowed at any time.

Educating members about health care

You can help educate members about accessing health care by sharing the following information:

- **When to go to the emergency room:** For services that need immediate medical attention due to serious injury or illness. Some examples are: broken bones, profuse bleeding, a tooth that has been knocked out, suspected heart attack and loss of consciousness. Refer to the OHP Handbook (OHP 9035) for more information.
- **Keep current on medical and dental checkups.** There could be a one- to three-month wait for a routine appointment, especially with a dentist, so do not wait for an emergency.

- If you cannot keep a routine appointment, you must cancel the appointment at least 24 hours in advance.
- **Primary care providers (PCPs) manage your health care needs.** The PCP works with you to keep you healthy. If you need a specialist, the PCP may need to make a referral.
- **Bring all your health coverage ID cards to all appointments:** Your Oregon Health ID, CCO member ID card, Medicare card and any other health insurance cards. In some cases identification may be requested.
- Some providers may not be taking new patients. To find providers in your area:
  - ✓ If you are in a CCO, call your CCO.
  - ✓ If you are not in a CCO, call OHP Care Coordination at 800-562-4620.
- If you are in a CCO:
  - ✓ You should receive a *Member Handbook* with a *Provider Directory* about 2 weeks after enrolling in a medical or dental plan for the first time.
  - ✓ Follow the rules of your plan and respect providers and their staff.
- Call the OHP Client Services to order a copy of the *OHP Handbook* (OHP 9035). It contains helpful information such as:
  - ✓ How to resolve billing problems
  - ✓ How to resolve provider care problems
  - ✓ How the appeal and grievance process works
  - ✓ Review your Oregon Health ID and coverage letter each time you receive one to make sure it is accurate.
  - ✓ Notify your worker of changes in your household such as new pregnancy, change of address, change to the number of people in your household, etc.

Remember: Many members have not had access to health care and may not automatically know doctor's office etiquette. See the *OHP Handbook*, *Rights and Responsibilities* for more information.

Medicaid managed care enrollment changes

If OHP members ask about changing their CCO or dental plan enrollment, please share this member fact sheet with them. It tells the members what to do and whom to contact, depending on:

- What kind of change they want
- Whether there is more than one CCO or dental plan where they live
- Other factors such as private health insurance, Medicare enrollment and American Indian or Alaska Native status

Effective date of enrollment changes

OAR: 410-141-3805

When any enrollment changes are entered into MMIS:

- **Before 5:00 p.m. on a Wednesday,** coverage begins the following Monday.
- **On Thursday or Friday,** coverage begins one week from the following Monday.

Use the right reason codes when changing or ending enrollment

Workers must use the most appropriate reason code when disenrolling or re-enrolling a member. For a list of the most commonly-used codes, go to the 834 Maintenance Reason Code Crosswalk and look at the far left column *(MMIS Reason Code).*

Changing CCO enrollment

OAR: 410-141-3810

Times members can choose to change their CCO

Members may change their plan at these times as long as another plan is available to them:

- When they renew their OHP benefits;
- If they move and their existing plan does not provide service at their new address;
- Within 90 days of first-time enrollment (for new OHP members);
- Within 30 days of an enrollment error;
- When approved by OHA for just cause, such as lack of access to appropriate care or services that the plan does not cover due to moral or religious objections

Changing Medicare Advantage Plans

Medicare members can only be in one Medicare Advantage Plan at a time. To disenroll from a Medicare Advantage Plan, the member must complete the *Request to End Medicare Advantage and Medicare Special Needs Plan Enrollment* (OHP 7209) and send it to the Medicare Advantage Plan they are leaving.

Enrolling newborns

If born to a CCO member, the newborn is enrolled in the mother's CCO effective on their date of birth. If born to an FFS member, the newborn is enrolled in a CCO during the next weekly enrollment cycle.

The newborn will always get CCOA enrollment for the highest level of care coordination, even if the mother has a different enrollment level (e.g., CCOB-CCOG enrollment).

Do not manually enroll newborns if the mother was enrolled in a plan on the newborn's DOB. Please allow the system to auto-enroll the newborn into the mother's plan, unless there are urgent access-to-care issues that require immediate enrollment.

To ensure timely enrollment, report OHP births to OHP Customer Service using the Newborn Notification form.

Re-enrolling members in their previous CCO or health plan

Members who changed plans or changed to FFS enrollment can re-enroll in their previous plan. Any new or returning family members can also enroll in the plan. This is true even if the plan is currently closed to new enrollment.

Change of residence

When a member moves out of their CCO's service area, staff will change their address as soon as possible and MMIS will disenroll the member during the weekend batch. Workers should only change the residential address for **permanent** home address moves.

- Do not manually disenroll the member for month-end; it can cause access to care issues in the new service area.
- If the member needs to be disenrolled sooner than the weekend batch or for assistance with enrollment errors that occur due to an address change, contact CES.

Reminder: Temporary placements such as substance use disorder residential treatment are **not** a change of residence. If the member requests, use the facility address as the member's temporary mailing address; **do not** change the member's residential address. Contact CES if a member in residential treatment is having access-to-care issues.

See OARs 410-141-3800 and 410-141-3815 to learn more about how OHA ensures temporary residential changes do not disrupt CCO enrollment.

Service area exceptions

As outlined in Oregon Administrative Rule (OAR) 410-141-3860, CCOs are responsible for coordinating care even when members are in a temporary placement to receive care outside the CCO's service area.

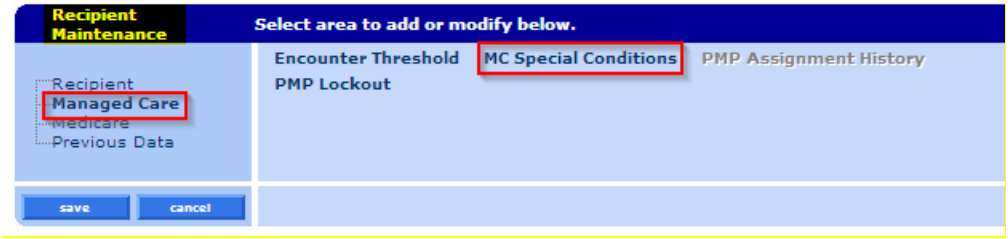
CES uses the **Service Area Exception (SAE)** process to ensure uninterrupted CCO enrollment for OHP members in such placements.

How to review for Service Area Exceptions (SAEs)

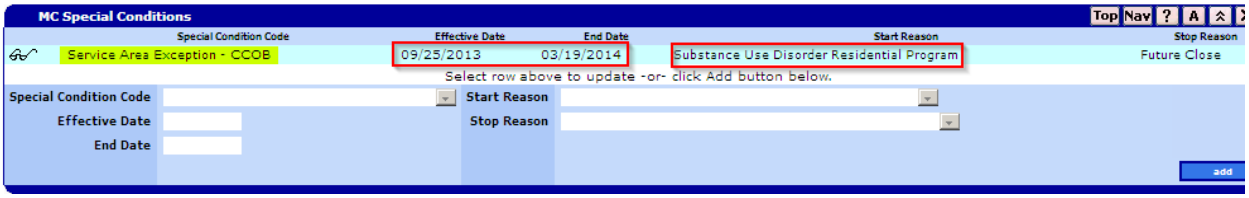
If present, SAEs will display in the MC Special Conditions panel of the member's MMIS Recipient Subsystem record.

1. In the MMIS Recipient Subsystem, click on **Search** and enter the member's Prime Number in the "Current ID" field.

2. Once in the Recipient Information Panel, go to **Recipient Maintenance**. Click on **Managed Care**, then click on **MC Special Conditions**.



3. In the **MC Special Conditions** Panel, review for current dates. SAEs will have Special Condition Codes that begin with "Service Area Exception." The **Start Reason** column will show why the member requires the SAE.



Who approves Service Area Exceptions

For the following exception reasons, specific groups are responsible for:

- Reviewing the member's case; and
- Adding the exception, or submitting the request to CES (if the request is approved).

Reason	Who reviews case?	Who adds the SAE?
Access to care	CES	CES
Behavior Rehabilitation Services Psychiatric residential treatment (for Child Welfare recipients)	Child Welfare Medical Assistance Resource Coordinators (MARCs)	Child Welfare MARCs and CES on their request
Choice Model (Adult Mental Health Residential Placement)	Choice Model Coordinators in local community mental health programs	CES

Reason	Who reviews case?	Who adds the SAE?
Continuity of care	HSD Provider Clinical Support Unit	HSD Provider Clinical Support or CES
Reasons related to domestic violence protection (good cause)	Eligibility workers	CES

How to submit SAE requests

Send an email to DMAP CES (ces.dmap@dhsoha.state.or.us) that includes the following information. Also include a period of time the exception shall apply (a true date, less than 2 years). Requestors are responsible to monitor the need for continuing exceptions.

- Member name
- Date of birth
- Prime number
- Placement start date
- State Hospital release date (if applicable)
- Temporary address (e.g., facility address)
- County of responsibility/jurisdiction (if applicable)
- Home CCO (if applicable)
- Member's CCO choice (if appropriate/available)

Moves between areas served by the same plan

When a member moves into an area served by his or her current CCO, the ZIP code change may cause MMIS to treat the move like an enrollment change. This will generate a new coverage letter that states the reason as a change in plan enrollment, even though from the member's perspective, enrollment did not change.

For other issues with service area changes, review the following chart.

If the issues and solutions listed below do not work or do not apply to your member's situation, please email Client Enrollment Services.

Potential issue	Solution
Child Welfare recipient is placed out of the CCO's service area for Behavioral Rehabilitation Services or to return to his/her community.	Please include CCO in care coordination prior to move and notify the CCO when placement occurs.

Potential issue	Solution
Member is disenrolled due to temporary address changes (*e.g.*, placement in an A&D facility).	Once permanent home address is corrected, send to CES to restore enrollment **Note: Only update member address when it is a *permanent* home address move.** Do not change the member's case address due to a placement in a facility or a temporary change in place of residence.
Member is experiencing challenges with out-of-area services	Contact the member's plan to ensure the CCO is aware that the member is obtaining temporary services out of the member's home area.

Ending CCO enrollment

Death

If a member dies, workers updating member information in the Client Maintenance (CM) system will **not** update the Living Arrangement or date of death through the system interface to MMIS panels.

- In order for the eligibility to process correctly, workers need to end the eligibility using a "D" (deceased) code instead of a regular end-of-eligibility code ("E"), and the appropriate reason code as needed.
- When the worker uses the "D" code and enters the date of death, CM will send the transaction to MMIS that will automatically apply the date of death and update the living arrangement. This in turn will also disenroll the member from any managed care plans as of the date of death.

Just entering the date of death does not end eligibility or enrollment.

New health coverage

Members are also disenrolled from their plan when the Health Insurance Group (HIG) determines that they have private or employer-sponsored major medical health insurance, called Third-Party Liability, or TPL. Only HIG can enter and remove TPL exemptions.

Disenrollment occurs the last day of the month that the TPL is identified. Any changes related to TPL, such as new coverage, ended coverage, or changes in coverage should be reported to HIG at ReportTPL.org.

MC Special Conditions - Exemption and Exception Reasons Chart

In MMIS, exemptions and service area exceptions are called **Managed Care (MC) Special Conditions** and are located in the MMIS Managed Care subsystem. This table lists reasons available and guidance about who can enter each code.

MC Special Conditions Reason	Reason can only be added by:		
	CES	HIG	Authorized APD worker
Assessment and evaluation (A&E)	X		
Behavioral Rehabilitation Services	X		
Member is hospitalized	X		
Member is in a temporary exception status waiting	X		
Member is in a medical management program	X		
Continuity of care	X		
Domestic Violence Protection	X		
End Stage Renal Disease	X		
Exceeded Contract Limits	X		
Hearing scheduled	X		
Language barrier	X		
Incarcerated	X		
Medical fragile child	X		
Medical Medicare choice	X		X
Medical necessity	X		
Other	X		
Providence Elder Place (PACE)	X		
Psychiatric Residential Treatment Services (PRTS)	X		
Psychiatric Security Review Board (PSRB)	X		
Rehabilitation/Inpatient/Facility	X		
Religious considerations	X		
Rosemont Treatment (CD/BRS)	X		
SCF-Parent no response	X		
Secure Adolescent Inpatient Program (SAIP)	X		
Secure Children Inpatient Program (SCIP)	X		
Secure Residential Treatment (SRTF)	X		
Special needs child	X		
Stabilization and Treatment Services (STS)	X		
Stop Loss	X		
Substance Use Disorder Residential Program	X		
Surgery scheduled for member	X		
Third Party Liability		X	
Third trimester pregnancy	X		

Who to contact for help

Issue	Contact	Phone/Fax/Email
CCO, DCO, MHO enrollment ■ No plan assigned or in wrong plan ■ AI/AN exemptions ■ Medical exemptions	Client Enrollment Services	800-273-0557 Email: CES DMAP or dmap.ces@dhsoha.state.or.us
CCO, DCO, MHO member issues: ■ Claim problems ■ Available services or providers ■ Dental plan changes for CCOA or CCOG members	Member's CCO, DCO or MHO If no resolution, contact Client Services Unit	Phone number listed on member's CCO/plan-issued member ID card 800-273-0557
Continuity of care exemptions	Provider Clinical Support Unit	503-947-5270 Fax 503-945-6548
Medical plan changes for Health Share of Oregon CCO members	Health Share of Oregon	888-519-3845
MMIS or CM case coding problems	OPAR - CMU Client Maintenance Unit	503-378-4369
TPL: ■ Adding or ending TPL ■ TPL exemptions ■ TPL changes ■ Plan disenrollment when there is TPL ■ Apply for HIPP	OPAR - HIG Health Insurance Group To report new TPL or changes: www.reportTPL.org To apply for HIPP: www.OregonHIPP.org	503 378-6233 Email: Referrals TPR or tpr.referrals@dhsoha.state.or.us

Third party liability (TPL)

Third party liability (TPL) is private or employer-sponsored health insurance. Oregon Administrative Rule 410-200-0220(1) and (2)(c) require that members make a good faith effort to retain their own health coverage.

Members should be advised that penalties such as loss of Medicaid coverage may happen if they end TPL because they qualify for Medicaid.

In many cases, the state can reimburse policyholders for the premiums that they pay for their private or employer-sponsored health insurance through the HIPP (Health Insurance Premium Payment) program. For more information about HIPP and to apply go to www.oregonhipp.org.

Only the Health Insurance Group (HIG) can add or end a TPL exemption. If you have questions or need help related to TPL exemptions, contact HIG, not CES.

Only major medical TPL is exempt from Medicaid managed care enrollment

Major medical TPL is major medical health insurance coverage that provides inpatient and outpatient hospital, lab, x-ray, physician and pharmacy benefits. This exempts members from CCOA and CCOB enrollment.

- This means that members with major medical TPL cannot be enrolled into a CCOA or CCOB.
- This is true even if HIG cannot pursue TPL due to good cause coding. They will receive their medical services on a fee-for-service basis.
- They could be enrolled in a CCOE or CCOG for mental health and/or dental coverage. However, MMIS will automatically disenroll members with TPL who have PERC codes other than 19, C5, GA or 62.

Dental coverage does not exempt members from MCO or CCO enrollment. Members who have private or employer-sponsored dental insurance are required to enroll in a DCO or CCO with dental coverage (CCOA, CCOB, CCOE).

Private coverage types and enrollment requirements

The table below lists the most common private health insurance policy types a member may have.

- Use this chart to determine whether the member's coverage requires CCO, DCO or MHO enrollment.
- If your member's policy type is not listed or you need more information, please contact HIG.

Enrollment codes for private health insurance		Can member enroll?		
Private Coverage Type	**Code**	**CCOA/CCOB**	**CCOG/ DCO**	**CCOE/ MHO**
Accident	20	Yes	Yes	Yes
Cancer	04	Yes	Yes	Yes
Champ VA	**05**	**No**	Yes	Yes
Dental	06-07	Yes	Yes	Yes
Hospital only	9	Yes	Yes	Yes
Long Term Care	10	Yes	Yes	Yes
Major Medical	**12 -16**	**No**	Yes	Yes
Medicare Supplement: A, B, C-J	**21-23**	**Member choice**	Yes	Yes
Prescription only	29-30	Yes	Yes	Yes
Skilled Nursing	25	Yes	Yes	Yes
Tricare/Triwest	**34**	**No**	Yes	Yes
Vision (Optical) only	26-27	Yes	Yes	Yes

Good Cause coding

If you think there is a good reason not to pursue TPL, you can ask for **Good Cause coding**. The main reasons to request Good Cause coding are:

- If a member with active TPL has domestic violence or safety concerns with the policyholder, including removal from parent due to abuse or neglect
- If the member has access to care issues (such as living in an area where their TPL is not available). For example, an absent parent provides Kaiser-Permanente coverage for a child, but the child lives in a county not served by Kaiser.

Only workers should request Good Cause coding. Please do not refer members to HIG to ask for this.

To request Good Cause coding, contact HIG:

- Email Referrals TPR (in Outlook) or tpr.referrals@dhsoha.state.or.us, or
- Call 503 378-6322.

To determine if HIG has already approved a member for TPL good cause:

- Look in the TPL subsystem in MMIS. This is where the most current information resides.
- When approved, “Good Cause” will show in the Suspect Code field in the Base Information area of the TPL panel.
- Any other value in the Suspect Code field means good cause is **not** currently approved.

Caution: For systematic reasons, the TPL information shown on the **TPL Good Cause** field in the MMIS Recipient panel may not be the most current. Please only consider the MMIS TPL Base Information panel when checking for Good Cause coding.

Health Insurance Premium Payment Program

The **Health Insurance Premium Payment Program (HIPP)** may be able to reimburse OHP members[1] for the amount they pay for TPL. This helps the state provide cost-effective health care.

MMIS issues the checks for reimbursement. In most cases, payments begin the month after the HIPP is approved. HIG re-determines eligibility at least annually and more frequently, if needed.

What does HIPP pay for?

HIPP reimburses eligible policyholders for the amount they pay for their employer-sponsored health insurance. Payments usually go directly to the policyholder. HIPP does **not** reimburse premiums for:

- Non-SSI institutionalized and waivered clients whose income deduction is used for payment of health insurance.
- Vision, dental, long-term care or other stand-alone policies.
- Clients covered by Medicare Part A, Part B, Part C or Part D.
- Insurance purchased through the Health Exchange when tax credits are being received.
- Insurance that has been court ordered.

TPL that qualifies for HIPP

To qualify for HIPP, the insurance must be:

- A comprehensive major medical policy[2] that includes inpatient and outpatient hospital, physician, lab, x-ray and full pharmacy benefits; and,
- Determined cost-effective based on the Medical Savings Chart (MSC); and,
- Meet HIPP requirements in OAR 410-120-1960.

To qualify for HIPP, the policyholder does not have to live in the same household as the Medicaid recipient. It is possible to reimburse eligible absent parents, grandparents or others who are paying for the health insurance premiums. However, the state does not reimburse for third party insurance premiums if the policyholder has been court-ordered to provide it.

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[1] Note: The state does not reimburse the employer's share of the premium cost.

[2] Note: Insurance policies that cover specific conditions or diseases, such as a cancer-only policy or only have a prescription discount card, are not eligible.

Process for determining HIPP eligibility

HIG's Premium Reimbursement Coordinators determine eligibility for this program. Determining eligibility includes collecting documents from clients, reviewing for cost effectiveness, data entry in MMIS to issue payments and all other administration related to the program.

After the HIG Premium Reimbursement Coordinator receives an application for HIPP:

- They do an initial screening to see if additional information is needed. If so, they send a request to the policyholder for more information.
- If the required documentation is received and the requirements in OAR 410-120-1960 are met, HIG authorizes and enters the HIPP reimbursement payment into MMIS.
- Notice of the determination is sent to the policyholder.

Examples of TPL scenarios reviewed for HIPP eligibility requirements

Head of household as policyholder

Mom/Policyholder applies April 1, 2018. Mom's employer provides insurance for herself, her husband and two children. Only the children are eligible for Medicaid.

- Mom has $435.00 deducted from her check each month for her portion of the insurance. The children have PERC codes of H2 and HB.
- The combined insurance allowance on the Medical Savings Chart is $687.00 ($448.00 for HB and $239.00 for H2).

The cost of their insurance is cost effective because the premium amount of $650 per month is below the allowable amount. They meet all other program requirements and are approved April 15, 2018. Their first payment is issued in May 2018.

Non-household member as policyholder

Dad/Policyholder applies April 25, 2018. He does not live in the household and is not covered by Medicaid, but he provides insurance through his employer for his disabled son who lives in a group home.

- The son's PERC is D4. The cost of the insurance is $537.00 per month.
- The allowance on the Medical Savings Chart is $1141.00. The cost of their insurance is cost-effective because the premium amount is below the allowable amount.

They meet all other program requirements and are approved May 10, 2018. Their first payment is issued in June 2018.

Medicare member as policyholder

Adult receiving Medicare applies for reimbursement of Medicare supplement. HIPP is denied for two reasons:

- Medicare recipients are not eligible for HIPP.
- Medicare supplements are not an eligible form of TPL for this program.

How to apply for HIPP

To apply, go to www.oregonhipp.org. Anyone can submit the application; however, only the policyholder will receive the payments.

Refer a client for HIPP when:

- Client indicates they have employer-sponsored insurance on their application for medical benefits.
- Client reports they have COBRA insurance.
- Paycheck stubs show that health insurance is deducted from a paycheck. This means the client is working and has a private, individual health insurance plan.
- The client indicates they purchase health insurance directly from an insurance carrier.

For instructions on how to complete the online web form refer to transmittal OPAR-IM-15-001.

Hearings

Insurance premium reimbursements are not a medical benefit and therefore are not subject to hearings. See OAR 410-120-1960.

Medical Savings Chart (effective January 1, 2014)

The Medical Savings Chart is used to determine HIPP eligibility.

Eligibility group	PERC Code	Cost-effective premium amount (employee cost)
CEM, OPC	HF, HG, H3, H4, MF, H2	$239
CEM-OP6	HE, HB, ME ,	$448
CEM, OHP,OHP	HD, HA, H1, MG, MD	$448
OHP-OPP	L2, L6, L8, HC, LA, LB, LC, LD	$705
MAA, MAF, EXT	2, 82, KA, XE	$386
SAC, Foster Children - SCF	C5, 19, MC	$1785
MAGI Adults/Couples	M3, M6	$592
MAGI Families	M1, M5	$353
OSIP-AB	3, B3	$495
OSIP-AD	4, D4	$1141
OSIPM-OAA	1, A1	$180
GA	5, GA	$163

Special Conditions Chart add-on list (effective January 1, 2012)

The Special Conditions Chart is used to determine eligibility for HIPP when premium amounts exceed the Medical Savings Chart and a recipient has one of the conditions listed below.

Description	Average paid per-client, per-month
Alcohol & chemical dependence disorders	$54
Blood disorder (sickle cell, hemophilia)	$213
Cancer	$231
Cardiovascular disorders	$137
Central nervous system (CNS) disorder • Cerebral Palsy • Epilepsy • Huntington's • Multiple sclerosis • Paralysis • Parkinson's • Plegia (Quad, Para, Mono)	$65
Childbirth (if neonatal delivery cost PMPM is $268)	$105
Chronic lung disease, COPD	$55
Diabetes	$40
Liver disease	$157
Mental Health disorders (autism, DD)	$61
Pancreatic disease – excluding diabetes	$396
Renal disorders (kidney disease)	$50
Spina bifida	$65
TB, HIV/AIDS, Hepatitis A, B or C	$173

Questions

- **About HIPP:** Refer clients to a Premium Reimbursement Coordinator at 503 378-6233 or reimbursements.hipp@dhsoha.state.or.us.
- **About TPL and Medicaid eligibility:** Refer clients to their local office or OHP Customer Service at 800-699-9075.

Where to report TPL and apply for HIPP

www.reportTPL.org or www.oregonhipp.org

Applicable OARs:

OHA	DHS-OHA			
410-120-1960	461-120-0330	461-120-0350	461-135-1100	461-170-0035
410-120-0345	461-120-0345	461-135-0990	461-155-0360	461-180-0097

Other medical resources

ContraceptiveCare

The Oregon ContraceptiveCare Program (CCare) is a Medicaid waiver program which serves Oregonians with incomes at or below 250% of the federal poverty level (FPL) who are not enrolled in the Oregon Health Plan (OHP).

CCare services include annual exams; follow-up visits to evaluate or manage problems associated with contraceptive methods; medical procedures, lab tests, and counseling services associated with contraceptive management; and contraceptive methods.

To learn more, visit the CCare website, or see Section C of the Program Manual.

Oregon's Health Insurance Marketplace

Oregonians who do not qualify for OHP can sign up for private health insurance ("Qualified Health Plans") at **HealthCare.gov**. Many people who qualify for private health insurance will also qualify for tax credits to help pay for coverage.

For people with questions about Qualified Health Plan benefits, the Oregon Health Insurance Marketplace offers free help from a network of certified health insurance agents and community partners. To learn more about the marketplace, go to www.OregonHealthCare.gov.

Oregon Prescription Drug Program (OPDP)

OPDP is a state-sponsored prescription discount card program. All underinsured Oregonians can join for free, and all FDA-approved drugs prescribed by a licensed clinician are eligible for discounts. To learn more, visit the OPDP website.

ScreenWise

ScreenWise (formerly known as the Breast and Cervical Cancer Treatment Program) helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers.

ScreenWise provides screening funds to promote early detection of breast and cervical cancer among Oregon's medically underserved individuals. It is funded by the Centers for Disease Control and Prevention, the Susan G. Komen for the Cure Oregon and SW Washington Affiliate, and the American Cancer Society.

- For information about free mammograms, call 877-255-7070.
- For information regarding eligibility, screening and diagnostic services, call 877-255-7070, visit your local county health department or visit the ScreenWise website.

Administrative examinations and reports

Overview

DHS|OHA staff can request examinations, evaluations, and reports, including copies of medical records to establish eligibility for a medical assistance program or for casework planning (see OAR 410-120-0000, Definitions).

To do this, they complete the OHP 729 form, also known as an *Administrative Medical Examination/Report Authorization (Medical Records Request)*.

Child Welfare (CW)

For detailed information about Admin Exams for Child Welfare staff, see Oregon Administrative Rules 413-050-0400 through 0450 Special Medical Services Provided by Child Welfare.

Presumptive Medicaid Disability Determination Team (PMDDT)

PMDDT will only request Admin Exams from "acceptable sources" (see 20 CFR §416.913). Once a diagnosis is established by the acceptable source, PMDDT can use other evidence to address severity. PMDDT uses the Social Security Act (SSA) definition of disability, so PMDDT is bound by the CFR and the Programs Operations Manual System.

Developmental Disabilities (DD)

See the DD Worker Guide for DD procedural codes and DHS-ODDS transmittals. For other DD requirements, refer to OAR 411-320.

Oregon Health Authority (OHA)

OHA processes Administrative Exam claims through the MMIS.

Ordering evaluations or professional services - OHP 729 forms

Workers use the OHP 729 series of forms to order evaluations or professional services. These forms are a series of seven forms (links appear at the end of this guide) workers use to order medical procedures. Not all DHS/OHA agencies use every form in the 729 series.

- Instructions to complete the OHP 729 are included with each form field of the current interactive PDF (point your cursor at the field you need help with to see the instructions).
- Send appropriate OHP 729s and a release of information to the provider.
- No prior authorization is needed. The OHP 729 forms act as the worker's authorization of the services.

OHP 729 series form links

- Administrative Medical Examination/Report Authorization OHP 729
- Comprehensive Psychiatric or Psychological Evaluation OHP 729A
- Report on Eye Examination OHP 729C
- Medical Records Checklist OHP 729D
- Physical Residual Function Capacity Report OHP 729E
- Mental Residual Function Capacity Report OHP 729F
- Rating of Impairment Severity Report OHP 729G

The 729 series of forms is also found on the DHS|OHA forms server.

Procedure codes

For accepted codes, descriptions, units and allowable fees, view the Administrative Exam and Report Codes (effective 1/1/2019).

Provider reimbursement

To be reimbursed for reports produced for DHS|OHA, the provider must bill OHA as follows:

- Using the professional claim format (electronically or using the current CMS-1500 paper claim form).
- Use V68.89 as the primary diagnosis code.

OHA will only reimburse providers that:

- Are enrolled Oregon Medicaid providers,
- Have Admin Exam provider contract,
- Have met the requesting program's criteria for a qualified provider, and
- Have a current contract to complete Admin Exams with the requesting agency.

Prior authorizations

Some services and equipment require prior authorization (PA) by OHA or the client's coordinated care organization (CCO) before they can be delivered to a member. PA is also known as prior approval. These services and equipment may include, but are not limited to:

- Some durable medical equipment and medical supplies
- Most physical therapy and occupational therapy
- Private duty nursing
- Most home health
- Most speech and hearing
- Some visual services
- Some home enteral/parenteral IV
- Some dental services
- Most transplants
- Out-of-state services
- Some surgeries
- Some behavioral health services
- Select lab and radiological studies

OHA also reviews continuity of care exemption requests using this process.

Where to get prior authorization

For authorization of services to covered by the CCO, the provider should contact the CCO.

For authorization of services covered by OHA (FFS), see page 5 of the Provider Contacts List.

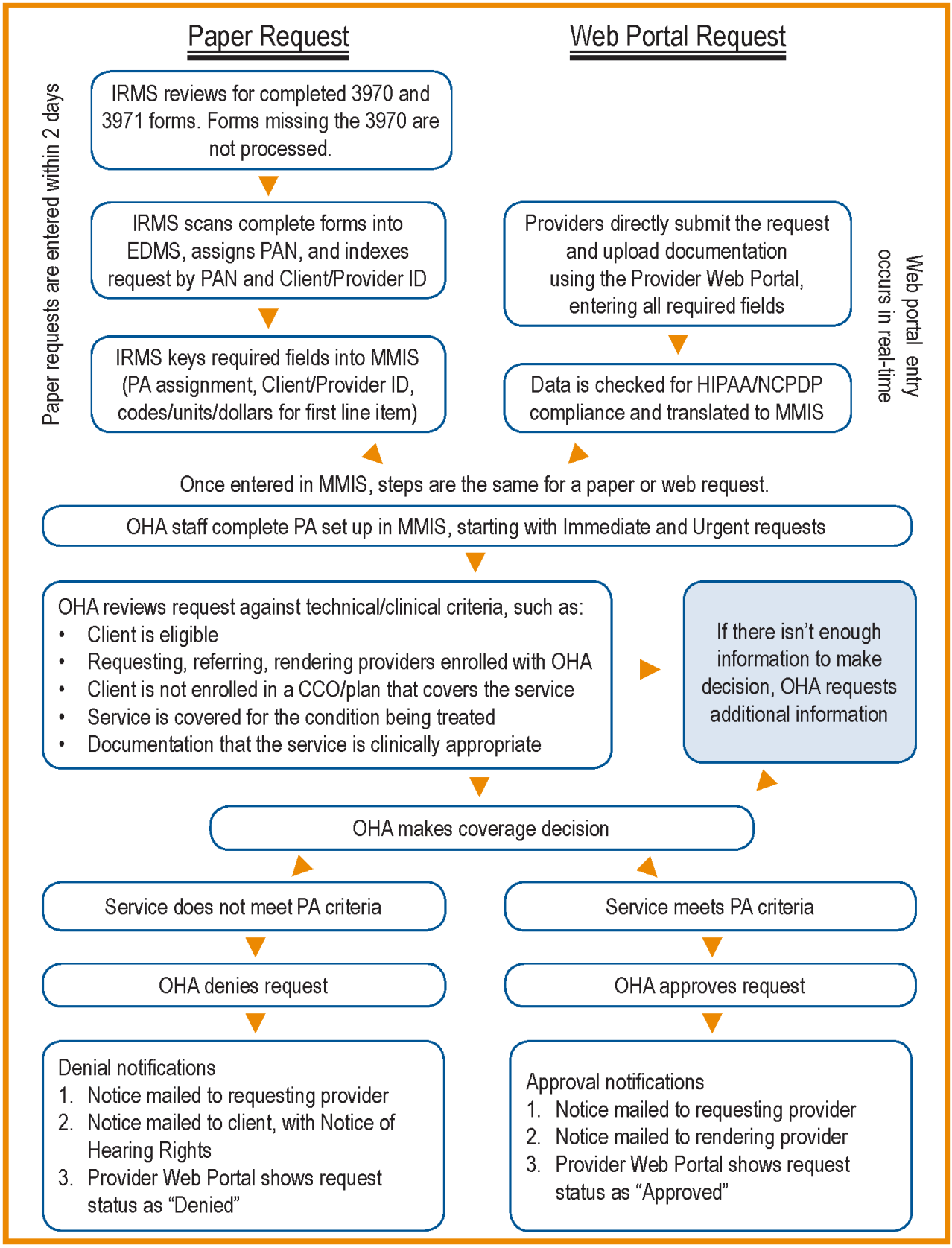
To learn about authorization of non-emergent medical transportation, see the Medical Transportation section of this guide.

Fee-for-service resources

The flow chart on page 41 shows how OHA processes FFS prior authorization requests. Like FFS claims, prior authorization requests are submitted two ways:

- Paper requests go through the DHS/OHA DHS/OHA Imaging and Resource Management Services (IRMS) for scanning, indexing and data entry.
- Web requests directly enter the Medicaid Management Information System (MMIS).

Prior authorization reviews are not automated. Staff cannot complete reviews until they receive all required information. Requirements are available on the OHP Prior Authorization page, as well as the program-specific rules and guidelines for the requested service.


Paper Request
Web Portal Request
Paper requests are entered within 2 days
IRMS reviews for completed 3970 and 3971 forms. Forms missing the 3970 are not processed.
IRMS scans complete forms into EDMS, assigns PAN, and indexes request by PAN and Client/Provider ID
IRMS keys required fields into MMIS (PA assignment, Client/Provider ID, codes/units/dollars for first line item)
Providers directly submit the request and upload documentation using the Provider Web Portal, entering all required fields
Data is checked for HIPAA/NCPDP compliance and translated to MMIS
Web portal entry occurs in real-time
Once entered in MMIS, steps are the same for a paper or web request.
OHA staff complete PA set up in MMIS, starting with Immediate and Urgent requests
OHA reviews request against technical/clinical criteria, such as:
• Client is eligible
• Requesting, referring, rendering providers enrolled with OHA
• Client is not enrolled in a CCO/plan that covers the service
• Service is covered for the condition being treated
• Documentation that the service is clinically appropriate
If there isn't enough information to make decision, OHA requests additional information
OHA makes coverage decision
Service does not meet PA criteria
Service meets PA criteria
OHA denies request
OHA approves request
Denial notifications
1. Notice mailed to requesting provider
2. Notice mailed to client, with Notice of Hearing Rights
3. Provider Web Portal shows request status as "Denied"
Approval notifications
1. Notice mailed to requesting provider
2. Notice mailed to rendering provider
3. Provider Web Portal shows request status as "Approved"

Member rights and responsibilities

Oregon Health Plan members have specific rights and responsibilities found in the OHP Handbook.

Billing members *OARs: General Rules 410-120-1280 and 410-141-3540*

Providers cannot bill members for services covered by Medicaid or Medicare. They may only bill for non-covered services, such as services not covered by the member's benefit package.

- Before providers can do this, members with OHP benefits must complete and sign an Agreement to Pay form (also known as a waiver).
- Members with CAWEM benefits **do not** need to complete this form before receiving or taking responsibility for non-covered services.

To learn more, see the OHP Handbook at https://apps.state.or.us/Forms/Served/he9035.pdf.

Notices of Action

When OHA or a CCO/plan decides to deny, reduce or stop a requested health care service, the member must receive a **Notice of Action** (also called Notice of Adverse Benefit Determination).

The Notice includes reason(s) for denial, important dates to attend to and instructions for initiating an administrative hearing if the member is not satisfied with a decision.

If OHA reduces or stops coverage of a health care service due to changing the scope of services covered by a benefit package, OHA will send a Notice to all members receiving benefits through the affected benefit package.

Complaints, appeals, and hearings *OARs: OHP 410-141-3875 through 3910 General Rules 410-120-1860*

Complaints

All members with complaints or concerns about how they are treated by providers, their CCO/plan, or OHA have options.

- **CCO/plan members** may contact the CCO/plan.
- **Fee-for-service (FFS) members** may contact OHP Client Services or complete the OHP 3001 form.

Appeals and hearings

There will be times when members are not satisfied with a health care decision made by OHA, their providers or their CCO/plan. When this happens:

- **For decisions made by OHA,** members can ask OHA for a hearing. Full instructions and timelines for hearings are on the OHP 3030 (Notice of Hearing Rights). This form is included with all Notices sent by OHA.
- **For decisions made by the CCO/plan,** members must first appeal the decision with the CCO/plan. The NOA from the CCO/plan will tell members how to ask for an appeal. If the decision does not change after the appeal, the member can then ask OHA for a hearing.

To learn more about appeals and hearings, read the OHP 3302 (Appeal and Hearing Request form).

Medical transportation

Emergency transportation

In an emergency, members should call 911 or go directly to the nearest hospital emergency room. **Prior authorization is never required for emergency medical transportation.**

If the member had a medical emergency and drove to a hospital emergency room, authorize reimbursement for mileage to the nearest hospital emergency room.

Emergency is defined in General Rules, OAR 410-120-0000, Acronyms and Definitions.

Non-emergency medical transportation *OARs: 410-136-3000 through 410-136-3360*

Non-emergent medical transportation (NEMT) is a benefit to help OHP members travel to and from scheduled medical services when:

- The service is covered by the Oregon Health Plan (OHP), and
- The member has no other way to access the service.

The federal law for NEMT is in 42 CFR §431.53. The Oregon Administrative Rules (OAR) for NEMT are in OAR chapter 410, division 136.

NEMT is only for members with an OHP benefit package **(BMD, BMH, BMM, or CWX).**

- NEMT resources are **not** available for members with CAWEM (CWM) or Medicare-only (MED), as these members are not mandatory populations under Medicaid.
- NEMT is only available for the actual member attending a medical service and if required, one guardian or attendant.

This guide outlines the relationship and responsibilities of transportation brokerages and DHS/OHA branch office staff in providing NEMT services to eligible members.

NEMT service delivery

For CCO members, the CCO manages all NEMT services. This is true for all levels of CCO enrollment (CCOA through CCOG).

For FFS members, OHA contracts regional transportation brokerages to manage NEMT.

Transportation brokerages

Both OHA and CCOs work with brokerages (also known as ride services). Brokerages perform the following services to support the NEMT needs of eligible members:

- Verify OHP member eligibility, assess the member's needs and resources, and arrange and provide NEMT as appropriate.
- Authorize transports that are the least expensive, medically appropriate mode in advance of the service being provided.
- Provide bus tickets and passes, taxi service, wheelchair vans, stretcher vans, secured transportation and common carrier.
- Arrange commercial travel (airline, train, etc.) and transportation locally to and from departure location if OHA has approved out-of-state travel for OHP-covered medical services.
- Arrange for reimbursement of any prior-authorized meals, lodging, and transportation that occurs in the other state.
- Authorize ambulance or air ambulance services.
- For fee-for-service members in counties that have volunteer programs, work with branch staff and volunteer coordinators to determine if a member can be served more cost-effectively using a volunteer. If so, the brokerage and volunteer coordinator will arrange transportation.

See page 46 for an overview of the NEMT review process.

Member reimbursement

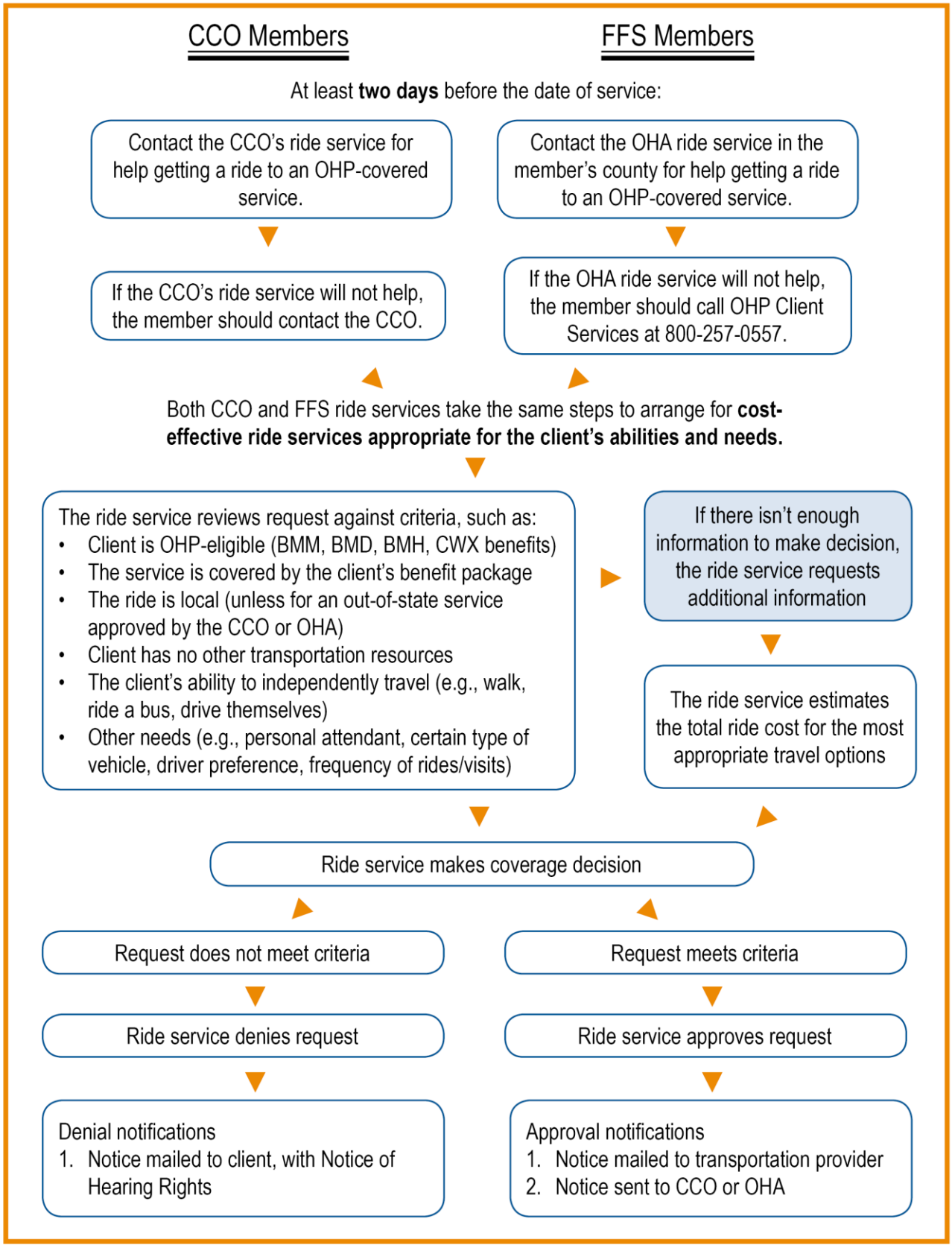
All member requests for reimbursement for NEMT services must be prior authorized by the brokerage or CCO. Branch office staff must **not** reimburse for these services.

Meal reimbursement is calculated using the following fee schedule:

- Breakfast: $3.00
- Lunch: $3.50
- Dinner: $5.50

Lodging is paid the lesser of the actual cost, or $40 per night.

The reimbursement rate for mileage is $0.25 per mile and is all-inclusive. It does not include reimbursement for gasoline, oil, or other expenses related to mileage.


CCO Members
FFS Members
At least **two days** before the date of service:
Contact the CCO's ride service for help getting a ride to an OHP-covered service.
Contact the OHA ride service in the member's county for help getting a ride to an OHP-covered service.
If the CCO's ride service will not help, the member should contact the CCO.
If the OHA ride service will not help, the member should call OHP Client Services at 800-257-0557.
Both CCO and FFS ride services take the same steps to arrange for **cost-effective ride services appropriate for the client's abilities and needs.**
The ride service reviews request against criteria, such as:
• Client is OHP-eligible (BMM, BMD, BMH, CWX benefits)
• The service is covered by the client's benefit package
• The ride is local (unless for an out-of-state service approved by the CCO or OHA)
• Client has no other transportation resources
• The client's ability to independently travel (e.g., walk, ride a bus, drive themselves)
• Other needs (e.g., personal attendant, certain type of vehicle, driver preference, frequency of rides/visits)
If there isn't enough information to make decision, the ride service requests additional information
The ride service estimates the total ride cost for the most appropriate travel options
Ride service makes coverage decision
Request does not meet criteria
Request meets criteria
Ride service denies request
Ride service approves request
Denial notifications
1. Notice mailed to client, with Notice of Hearing Rights
Approval notifications
1. Notice mailed to transportation provider
2. Notice sent to CCO or OHA

Urgent care after-hours

Occasionally, a member may require an urgent, but non-emergency, medical transport after hours when it is not possible to prior authorize.

- The member should follow the brokerage's instructions for urgent care on its after-hours telephone message.
- If the member normally uses reimbursement, the member can drive or be driven to urgent care, and then contact the brokerage for retroactive authorization the following business day.

NEMT does not include emergency ambulance transportation to a hospital. In an emergency, members should call 911 for immediate assistance.

Administrative exams

A client who does not have an eligible OHP benefit package may use NEMT **only** to attend an administrative examination for determining eligibility for medical assistance.

- The exam must be requested by the case manager.
- The case manager must open eligibility using the ADMIN benefit package code for the date of service and complete form OHP 729.
- If the member uses a brokerage, send a copy of the form to the brokerage.
- NEMT may only be used in this situation to attend the requested examination and may not be used to attend any other medical service.

NEMT policy exceptions for cost effectiveness

If in the best interest of both the member and OHP, OHA may approve NEMT that would ordinarily be unavailable according to program OARs or established exception procedures.

HSD evaluates policy exceptions on a case-by-case basis, and only approves those that show demonstrable saving to OHP, significant benefit for the member, and no burden placed on the member or providers.

- To request a policy exception, the DHS/AAA case manager should prepare a written proposal that clearly expresses all costs and benefits for submission.
- The NEMT Program Manager will review the proposal, ask for additional information if necessary, and submit to HSD Management for approval.
- If the exception is approved, the NEMT Program Manager will send the case manager confirmation by email and, if appropriate, send a copy to the brokerage.
- The case manager will make necessary arrangements and retain copies of the authorization and any supporting documents in the member case file.

Contacts and resources

NEMT policy questions and exception requests

Kian Messkoub, NEMT Program Manager
kian.z.messkoub@dhsoha.state.or.us or 971-283-6563

Local transportation brokerages

http://www.oregon.gov/oha/hsd/ohp/tools/Transportation%20Brokerage%20Map.pdf

Oregon Administrative Rules (OARs) for Medical Transportation

http://www.oregon.gov/oha/hsd/ohp/Pages/medical-transportation.aspx

Processing claims

Overview

The Oregon Medicaid claims processing system is highly automated. It handles approximately 1 million claims per month. This total number of claims includes capitation payments, electronic claims (point of sale, Provider Web Portal and Electronic Data Interchange 837 transactions), and paper claims. If all information is correct, providers who submit claims electronically by 2:00 p.m. on Thursday could receive payment the following week.

This system depends on workers to enter timely and accurate eligibility information on members. Two of the most common errors are that a member changes their name and it is not updated right away or a newborn is not added for medical coverage as soon as possible.

How a claim is processed

When a provider submits a claim to OHA, it is processed by the Medicaid Management Information System (MMIS). The MMIS is a completely automated claim processing system with payment logic built around all the data elements provided within a claim as it pertains to required, prior authorized and optional services.

Claims enter the MMIS in four ways:

1. Paper claims are mailed to DHS/OHA Imaging and Resource Management Services (IRMS) and submitted to a key/verify process.
2. Providers submit individual claims using the Provider Web Portal at https://www.or-medicaid.gov.
3. Providers or their submitter (e.g., billing service or clearinghouse) submit large batches of electronic claims through Electronic Data Interchange (EDI).
4. Pharmacies submit prescription claims through the Oregon Medicaid Point of Sale system.

Once claims enter the MMIS, they are checked against a series of validation rules to check for possible errors and missing or invalid data. A misplaced code or a blank field can cause the claim to suspend for further review or deny outright. If suspended, the claim will be reviewed by a staff person, potentially causing a delay in payment of several weeks.

Paper claim processing

The IRMS Imaging Unit scans incoming paper claims using Optical Character Recognition (OCR) and assigns each one an internal control number (ICN).

- The scanned documents are then manually keyed for OCR accuracy and verified. Depending on volume, this initial process may take one to five working days.

- The data is then sent to MMIS for processing. Images of the documents are stored in an Electronic Document Management System (EDMS) and indexed by identifiers such as member name, prime identification number, the date of service, and provider number.

Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms or take the time to read notes or written explanations attached to claims. If forms are not properly aligned, this could lead to claims not processing correctly.

Electronic claim processing

Claims billed electronically using the Provider Web Portal, EDI or POS directly enter MMIS.

- Web claims directly enter the MMIS if all information is entered correctly.
- EDI claims are reviewed for HIPAA compliance and translated to MMIS for processing.
- POS claims are reviewed for NCPDP compliance and translated to MMIS for processing.

MMIS claim adjudication

The MMIS makes determinations on both web and POS claims in real-time. All claims that enter MMIS by 2 p.m. Thursday are processed during the weekend claim cycle.

There are more than 900 potential questions MMIS may ask about a claim before it can make a payment decision. The fewer questions the computer asks, the more quickly the claim can be processed. Once in MMIS, the claim is not seen by any OHA staff unless it suspends for specific medical or administrative review.

For all claims reviewed by MMIS, providers receive a remittance advice (RA) explaining payments, suspended claims, and denied claims. Providers can also review the status of all claims they have submitted to OHA using the Provider Web Portal.

Suspended claims

When a claim **suspends**, MMIS is saying that it cannot make a decision — a claims analyst will have to review the data.

Claims also suspend when the claim's dates of service do not match the member's dates of OHP eligibility. When this happens, OHA allows two weeks to pass. If MMIS still shows "no eligibility for patient," the system will automatically deny the claim.

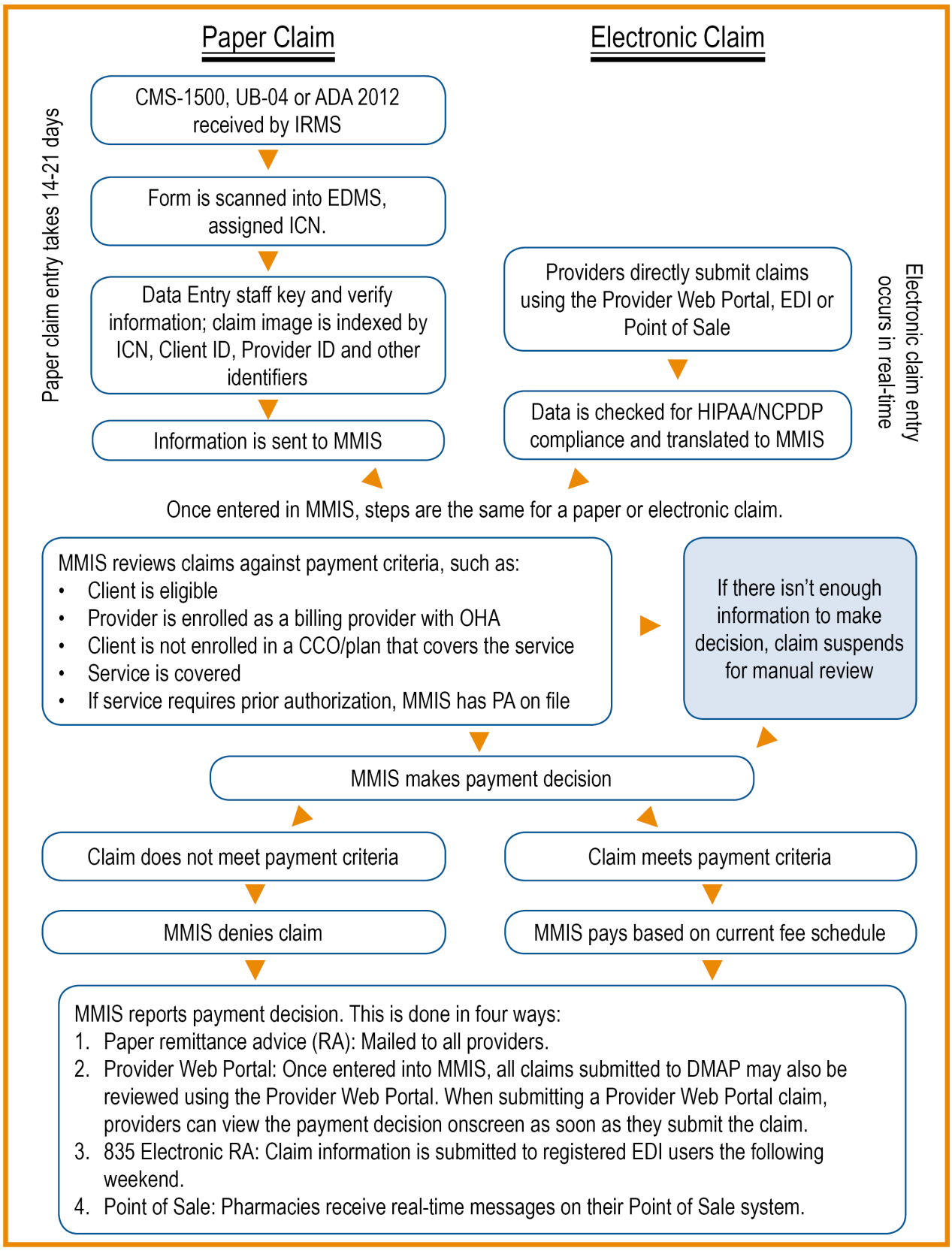
Only procedures that require "cost documentation" or "by report" will **suspend for medical review**. The Provider Clinical Support Unit analyzes those claims.

Denied claims

Most claims are **denied** because of incomplete or incorrect patient or provider data. Another common reason for denials is when providers incorrectly bill OHA, instead of the member's

CCO/plan. Members need to present both their Oregon Health and plan ID cards for correct billing.

To help avoid denied claims, please be sure case information is complete and accurate, and that members are aware of their CCO/plan enrollment.


Paper Claim
Electronic Claim
Paper claim entry takes 14-21 days
CMS-1500, UB-04 or ADA 2012 received by IRMS
Form is scanned into EDMS, assigned ICN.
Data Entry staff key and verify information; claim image is indexed by ICN, Client ID, Provider ID and other identifiers
Information is sent to MMIS
Providers directly submit claims using the Provider Web Portal, EDI or Point of Sale
Data is checked for HIPAA/NCPDP compliance and translated to MMIS
Electronic claim entry occurs in real-time
Once entered in MMIS, steps are the same for a paper or electronic claim.
MMIS reviews claims against payment criteria, such as:
• Client is eligible
• Provider is enrolled as a billing provider with OHA
• Client is not enrolled in a CCO/plan that covers the service
• Service is covered
• If service requires prior authorization, MMIS has PA on file
If there isn't enough information to make decision, claim suspends for manual review
MMIS makes payment decision
Claim does not meet payment criteria
Claim meets payment criteria
MMIS denies claim
MMIS pays based on current fee schedule
MMIS reports payment decision. This is done in four ways:
1. Paper remittance advice (RA): Mailed to all providers.
2. Provider Web Portal: Once entered into MMIS, all claims submitted to DMAP may also be reviewed using the Provider Web Portal. When submitting a Provider Web Portal claim, providers can view the payment decision onscreen as soon as they submit the claim.
3. 835 Electronic RA: Claim information is submitted to registered EDI users the following weekend.
4. Point of Sale: Pharmacies receive real-time messages on their Point of Sale system.

OHP pharmacy services

Home-Delivery Pharmacy Program (mail order)

Fee-for-service members who have ongoing prescription needs and a stable medication regimen may receive their prescriptions through the OHP Home-Delivery Pharmacy Program.

- Members can use this program even if they are restricted to one walk-in pharmacy through the Pharmacy Management Program (i.e., they can use both).
- Members may use the home-delivery service only for drugs that their CCO does **not** cover.

To learn more about this service, visit the pharmacy's website.

Pharmacy Management Program (Lock-in)

The purpose of this program is to maximize patient safety and minimize risk of medication misuse. Members in this program are limited to filling their prescriptions at one walk-in pharmacy of their choice. They can also use the Home-Delivery Pharmacy Program and a specialty pharmacy, in addition to the walk-in store.

Program criteria

Candidates for the Pharmacy Management Program are fee-for-service members who:

- Use three or more pharmacies,
- Use multiple prescribers to obtain the same or comparable prescriptions,
- Have patterns of prescription misuse, or
- Have altered a prescription

Exemptions

Members are exempt from enrollment in this program if they:

- Enroll in a CCO;
- Have a major medical insurance policy;
- Enroll in a Medicare drug coverage plan and have no other third party pharmacy benefits;
- Are in DHS care and custody; or
- Are inpatients in a hospital, long-term residential care facility, or another medical institution.

Member notification and hearing rights

If selected for this program, members will get a notice about the program in the mail. The notice will list the name and address of their assigned walk-in pharmacy (based on the

pharmacy the member used most often and most recently) and include a notice of hearing rights.

The member has 60 days to appeal this decision or change their assigned pharmacy.

Program enrollment

Members remain in the program beginning the first day of the month, following their notice date, for a period of 18 months.

In MMIS, workers can find the name of the member's assigned pharmacy in the MMIS Recipient Maintenance panel (choose Lock-in Details). The Lock-in Details panel will show the selected pharmacy's name, effective dates, and National Provider Identifier.

Changing an assigned pharmacy

Initially, the member has 60 days to change their pharmacy. After that, the member may change their pharmacy once every three months for reasons such as moving; reapplying for OHP benefits; their assigned pharmacy denies service to member or goes out of business.

Requests from members

If a member wants to change their assigned pharmacy, email Client Enrollment Services (CES) as soon as possible at ces.dmap@dhsoha.state.or.us.

- Include the member's full name and prime ID number.
- Include a secondary identifier like a case number or date of birth.
- If the change is urgent (i.e., the member needs their prescription filled right away), flag the email as "High Importance" or enter "URGENT" as the first word in the subject line.
- **Do not** send multiple requests for the same member. If you sent a routine request and the member's situation becomes urgent, recall that email (if possible) and re-send the request as URGENT. Please note in the new email that a previous request was sent.

Staff and members can also call OHP Customer Service at 800-699-9075 or Client Services Unit (CSU) at 800-273-0557. CSU will inform CES if a member requests to change their pharmacy.

Requests from unassigned pharmacies (one-time exception)

If a member needs to fill their prescription at a different pharmacy, the pharmacy may ask the Oregon Pharmacy Call Center for permission to fill the prescription. The Oregon Pharmacy Call Center may approve the one-time exception if, at the time the member needs the prescription filled:

- The member's pharmacy is closed;
- The member's pharmacy does not have the prescribed medication in stock; or
- The member is 50 miles or more away from their assigned pharmacy.