DHS Oregon Department of Human Services

Division of Medical Assistance Programs

Policy Transmittal

Jon Pelkey, Manager
Quality Improvement & Medical Section
Authorized Signature

No: DMAP PT 07-005
Issue Date:12/1/07

Topic: Medical Benefits

Transmitting (check the box that best applies):

☐ New Policy ☐ Policy Change ☒ Policy Clarification ☐ Executive Letter
☐ Administrative Rule ☐ Manual Update ☐ Other: ____________

Applies to (check all that apply):

☐ All DHS employees
☐ Area Agencies on Aging
☐ Children, Adults and Families
☐ County DD Program Managers
☐ County Mental Health Directors
☐ Health Services
☐ Seniors and People with Disabilities
☒ Other (please specify): DHS staff and others identified on the SPD, CAF, AMHD and DMAP transmittal lists

Policy/Rule Title:	Revision 27 of the DMAP Worker Guides		
Policy/Rule Number(s):	Medical Benefits	Release No:	DMAP-WG-27
Effective Date:	12/1/07	Expiration:	
References:			
Web Address:	www.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml		

Discussion/Interpretation:

WG V Wordsmithing to clarify managed care enrollment issues; update unit name changes; grammatical improvements.

Training/Communication Plan:

Local/Branch Action Required:

Read and become familiar with policy and procedure changes.

Central Office Action Required:

Field/Stakeholder review: ☐ Yes ☒ No

If yes, reviewed by:

Filing Instructions:

Replace TOC and DMAP Guides V with the revised versions.

All the current DMAP Worker Guides are posted online at
<www.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml>.

If you have any questions about this policy, contact:

Contact(s):	DMAP Delivery Systems Unit		
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Division of Medical Assistance Programs

Worker Guides

Contains updates through 12/1/2007

DMAP Worker Guides

Revision Record

Use this sheet to record any revisions to the DMAP Worker Guides. As replacement pages are inserted into the guide, enter the insertion date across from the corresponding revision number.

Rev No.	Rev Date	Rev No.	Rev Date
1	04/01/00	21	02/01/06
2	07/01/00	22	10/01/06
3	10/01/00	23	02/01/07
4	10/01/00	24	04/01/07
5	01/01/01	25	04/04/07
6	04/01/01	26	10/31/07
7	07/01/01	27	12/01/07
8	10/01/01	28	
9	01/01/02	29	
10	04/01/02	30	
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DMAP Worker Guide I
DMAP/Medicaid Overview

- Where to send claims
- DMAP field resources

A. DMAP/Medicaid Overview

The Division of Medical Assistance Programs (DMAP) is a part of the Department of Human Services (DHS), which:

- Determines policy and rules for medical assistance programs including the Oregon Health Plan (OHP).
- Is responsible for Title XIX and Title XXI State Plans.
- Informs clients and providers about policy and rule changes that affect OHP services.
- Pays claims for covered health care services.
- Contracts with managed care organizations (MCOs) for OHP.

Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD), and the Oregon Youth Authority (OYA) are the direct links with clients who receive medical assistance. The various agencies determine eligibility rules for their programs. Branch staff:

- Determine a client's eligibility.
- Ensure clients select medical and dental plans in mandatory enrollment areas.
- Provide choice counseling to clients when needed regarding the selection of MCOs available in their area.
- Enter eligibility data into the computer system.
- Order replacement Medical Care Identifications (IDs) on ELGH, or issue temporary Medical IDs on MID1, when needed.
- In areas without contracted medical transportation brokerages, arrange for and prior authorize clients' transportation, when needed, to access health care services.

When health services are delivered to clients not enrolled in an MCO, the provider submits either a paper or electronic claim to DMAP. Then DMAP sends claims through the Medicaid Management Information System (MMIS), a computerized claims processing system. We issue provider checks weekly, accompanied by a remittance advice (RA), which includes an explanation of benefits.

DMAP pays for health care and other client service needs. When a Medicaid client dies, the **Estate Administration Unit** is required by law to recover Medicaid funds spent for a client's care from the "estate" of the client. Money recovered is generally for Medicaid assistance provided after the client reached age 55. However, if the client received General Assistance or was permanently institutionalized at the time of their death, assistance that was provided prior to age 55 may be recovered. The money recovered is "recycled" to help other, living, low-income assistance recipients.

This section contains a list of addresses showing where to send specific forms, as well as a DMAP Field Resources chart.

B. Where to send provider claims – DMAP Mailing Addresses

CMS-1500	All medical provider claims	DMAP, PO Box 14955 Salem, OR 97309
	Speech/language pathology, audiology & hearing services; private duty nursing claims	DMAP, PO Box 14018 Salem, OR 97309
	Contract RN claims	DMAP, PO Box 14957 Salem, OR 97309
DMAP 505	Medicare/Medicaid claims	DMAP, PO Box 14015 Salem, OR 97309
UCF 5.1(Universal Claim Form)	Drug claims	DMAP, PO Box 14951 Salem, OR 97309
Any form used in conjunction with Death with Dignity	Death with Dignity claims	DMAP, PO Box 992 Salem, OR 97308-0992
ADA 2006	Dental claims	DMAP, PO Box 14953 Salem, OR 97309
UB-04	Hospital, Home Health, Hospice claims	DMAP, PO Box 14956 Salem, OR 97309
TADS	Long-term nursing home care claims	DMAP, PO Box 14954 Salem, OR 97309
OMAP 741 DMAP 742	Consent to hysterectomy Consent to sterilization	DMAP, PO Box 14958 Salem, OR 97309
Out-of-state claims (all claim types)	For providers more than 75 miles beyond the Oregon border. If within 75 miles, use previous instructions for each form type.	DMAP Claims Management PO Box 14016 Salem, OR 97309
Administrative exams	Exams requested by DHS offices. Send reports to requesting DHS office; mail claims to DMAP.	DMAP, PO Box 14165 Salem, OR 97309
DMAP/DHS forms	To order DMAP or DHS forms	DHS Distribution Center 550 Airport Rd Salem, OR 97310
DMAP 1036 – Individual adjustment request	To use if you have received an overpayment or underpayment for a claim	DMAP, PO Box 14952 Salem, OR 97309
Problem claims including administrative errors and claims over one year old	1. Send copy of claim with letter explaining the problem. 2. Attach paper RAs related to claim. 3. Include complete documentation.	DMAP Provider Services 500 Summer St NE, E44 Salem, OR 97301-1079
Appeals (reconsideration of non-covered services, CAWEM denials, and other appeals)	1. Send a letter stating reasons for the appeal. 2. Attach the claim for denied services. 3. Include complete medical record documentation.	DMAP Provider Services 500 Summer St NE, E44 Salem, OR 97301-1079

Sending claims to the wrong address delays payment.

C. DMAP Field Resources

AIS – Automated Information System (client eligibility info) 1-800-522-2508
First Health Technical Help Desk 1-800-884-3250

Billing Questions (for medical providers only, not clients)
In-state: Provider Services – DMAP 1-800-336-6016
dmap.providerservices@state.os.us

Buy-In (Medicare premium buy-in)
Buy-In Unit –OPAR 503-378-2220

Client Complaints
CAF clients – Local Branch Offices .... Operations Managers
SPD clients – SPD Administration .... 503-945-5811 or 1-800-282-8096
Medicaid Fraud Hotline .... 1-888-372-8301 (1-888 fraud 01)
Other DHS clients – Governor's Advocacy .... 1-800-442-5238 or 503-945-6904

Client Services Unit (CSU) clients can call for help with problems regarding billing or access, quality and limitations on care
DMAP – CSU .... 1-800-273-0557 or
.... TTY: 1-800-621-5260

DMAP HP/DHS Forms
Order through CICS .... Order on FBOS

Eligibility History (to correct information on eligibility files)
CMU – OPAR 503-378-4369

Estates Administration (to report the death of a client)
Forms SDS 454D and SDS 647 .... 1-800-826-5675 or Fax 503-378-3137

Health Insurance Group (addition or temination of private health insurance)
HIG – OPAR 503-378-2220
Form DHS 415H .... Fax 503-373-0358

Hearings and Expedited Hearings (medical service issues)
DMAP Hearings 503-945-5785

In-Home Services
Payments – Local Branch Offices
Policy – SPD In-Home Services Unit .... 503-945-5799 or 503-945-5990

Insurance Premiums
HIP – CAF .... 503-945-6106 or
.... 503-947-5129 or
.... 503-945-6072

Cont'd

Cont'd
Private Health Insurance (premium referral) – DMAP 503-945-6562
SSP-Policy, Medical in GroupWise

Interpreter for the Deaf (medical appointment/care)
ODC/DHHAP 1-800-521-9615

Managed Care Enrollment (questions/problems on plan enrollment)
DMAP – Client Enrollment Services (CES) .... 503-945-5772 or 1-800-527-5772
ces.dmap@state.or.us, or DMAP, CES in GroupWise

Medical Payment Recovery
MPR – OPAR 503-947-4250

OHP Application Requests
OHP Telecommunication Center .... 1-800-359-9517 or
.... TTY 1-800-621-5260

OHP Benefits RNs
Medical Unit – DMAP .... 1-800-393-9855 or
.... 503-945-5772

Out-of-State Medical
Prior authorization – DMAP Clinical Unit 503-945-5802
Emergency Claims – DMAP Claims Mgmt Unit 503-945-6522

Personal Injury Liens
PIL – Admin Services .... 503-378-4514 or
.... 1-800-377-3841 or Fax 503-378-2577

Premium Billing Questions
OHP Premium Billing Office 1-888-647-2729 (888-OHP-2PAY)
.... TTY 866-203-8931 or Fax 541-523-2145

Pharmacy Management Program
DMAP – Client Enrollment Services (CES) .... 503-945-5772 or 1-800-527-5772
ces.dmap@state.or.us, or DMAP, CES in GroupWise

Transportation
Policy – DMAP Policy and Planning Section .... 503- 945-6736 or 503-945-5752
Authorization – Contracted medical transportation brokerages or local branch offices in areas without a brokerage (see a list of brokerages by county in DMAP Worker Guide 12)

Transplant Services
DMAP Clinical Unit 503-945-6488

If you cannot find the number you need, call
DMAP Reception at 1-800-527-5772 or 503-945-5772.

DMAP Worker Guide II
The Oregon Health Plan History

A. The Oregon Health Plan

An historical overview of the Oregon Health Plan is available online at <http://egov.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdfT>.

DMAP Worker Guide III
Medical Care Identification

A. Medical Care Identification

The Medical Care Identification (ID) is a letter-sized sheet of paper that is mailed to each qualifying household once a month. When certain changes are made to a case, such as a change in the household or a change in managed care enrollment, the system automatically issues a new Medical ID. The system does not automatically send out a new Medical ID for every action taken on a case. ELGH will show the last three dates a Medical ID was sent.

For clients enrolled in a DMAP contracted managed care organization (MCO), the first Medical ID they receive may not show their MCO. Until their MCO choice is listed on the Medical ID, clients may go to any medical provider who will accept their Medical ID on a fee-for-service or open card basis. After the MCO is listed on the Medical ID, clients must get their care through their selected MCO.

The Medical ID also shows the benefit package for every eligible member in the household (fields 9a and 9b) and copayment requirements (fields 7a and 7b). Clients have been instructed to contact their worker if information on the Medical ID is incorrect or if information changes (examples include: address change, someone becomes pregnant, or someone leaves the household). Workers are then responsible for entering changes into the computer system.

Issuing a Replacement Medical Care ID

Sometimes workers may need to issue a replacement Medical ID. Replacements may be necessary if a client moves or if their card has been lost or destroyed. Workers may order replacement Medical IDs using the ELGH screen. Replacement cards are mailed the next working day to the client's mailing address and are intended to replace their original Medical ID. Replacements are only issued for the current month and cannot be requested for prior or future months.

Issuing a Temporary Medical Care ID

In some situations the client may not have time to wait for a replacement Medical ID to be mailed because they have a medical appointment or need a prescription filled. When this occurs the worker can create a temporary Medical ID through the MID1 screen, or if the DHS system is unavailable, the worker can complete a handwritten temporary Medical ID (DMAP 1086). Temporary IDs can be handed to the client or faxed directly to a client's medical provider or pharmacy. If the client does not have an immediate need, it is preferred that a replacement card is ordered on ELGH.

A sample of the Medical Care ID (front and back) is shown on pages 2 and 3. A sample of the temporary IDs (DMAP 1086 and MID1) are shown on pages 4, 5 and 6.

(1) (2) (3)

(7a) **Copy Requirements**

A $3 for outpatient services not paid for by your Plan (listed in 8a)

B $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)

(8a) **Managed Care/TPR**

A

B

C

D

E

F

G

H

I

OMAP Medical Care Identification (ID)

(4) Branch Name Division (5) Worker (6) Phone

(9a) **Benefit Package**

A – OHP Plus	D – OHP with limited drug
B – OHP Standard	E – CAWEM Emergency Medical
C – QMB	

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See OMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

(10) Name of Eligible Person(s)	(11) Recipient ID	(12) Date of Birth	(13) Dates of Coverage	(7b) Copay Req	(8b) ManagedCare/TPR	(9b) Benefit Package

IMPORTANT:

- **This is your new OMAP Medical Care ID. Issued on:**
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

(14)

State of Oregon Department of Human Services Office of Medical Assistance Programs OMAP 1417 (Rev 09/05)

Clients

If the information on the front is wrong, call your branch office right away (field 6).

Unless it is a true emergency, call your provider before you use the emergency room.

You may have to pay for the service if you use a provider who is not an Oregon Medicaid provider or with your Managed Care Plan.

If you need help making health care appointments or getting a ride, call your branch office (field 6).

For questions about:

- Eligibility – call your worker (field 6).
- Medical benefits – call your Managed Care Plan (field 8a) or provider.

Call the Client Advisory Services Unit (CASU) at 1-800-273-0557 if:

- You have concerns about access, quality, or limitations on your health care, or
- You receive a medical bill.

Your OMAP Medical Care ID shows:

Your worker's code.

Your worker's phone number.

(7a) Shows possible copay requirements. For a more detailed description of these copayments, see your OHP Client Handbook or call your worker to get a copy.

(7b) Letters in this space refer to the copay requirements (listed in field 7a) for each family member. If this space shows "NO COPAYS," a copay is not required for the time period listed in field 13.

(8a) Name and phone number of your Managed Care Plans, private insurance, or OMAP pharmacy.

(8b) Letters in this space refer to information listed in field 8a and show where each family member must receive health care services. If this space is blank, the family member can get health care services during the time period listed in field 13 on a fee-for-service basis. This means you can see any provider who will take your OMAP Medical Care ID.

(9b) Letters in this space refer to benefit packages (listed in field 9a) and show which package applies to each family member.

Health care providers use the recipient ID number to bill OMAP.

Dates show when family members are:

- Required to make a copayment (see field 7b).
- Covered on a fee-for-service basis or by Managed Care Plans, private insurance, or OMAP pharmacy (see field 8b).

Message Box. A monthly message from the Department of Human Services.

OMAP Client materials can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

Providers

OMAP will only pay for services according to OMAP's administrative rules and guidelines.

OMAP will only make payment to enrolled providers.

All OMAP administrative rules, guidelines and applications to become an enrolled OMAP provider can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

Remember:

- Clients must be eligible on the date of service.
- Bill all third party resources first.
- Prior authorization is required for all non-emergency care if provider is beyond 75 miles from Oregon. For out-of-state billing information, call the client's Managed Care/TPR (field 8a). If the client doesn't have Managed Care/TPR, call 503-945-6522.

Providers only: If you have questions about eligibility, call AIS at 1-800-522-2508. For billing questions, call OMAP Provider Services toll-free at 1-800-336-6016, or in Salem at (503) 378-3697.

OMAP 1417 (Rev 09/05)

OMAP Temporary Medical Care Identification (ID)

- Show this ID to all providers at the time of service, even if you have a Managed Care Plan card.
- Not valid outside the United States or US Territories.

1 This identification is valid for services provided

From ____________________ Thru ____________________ .

Provider: The persons named below are eligible to receive medical assistance through the Department of Human Services. All insurance and other medical resources must be billed prior to billing the Office of Medical Assistance Programs (OMAP). Some services must be prior authorized. If in doubt about services covered, prior authorization or other policy, please refer to the OMAP General Rules and provider guidelines or call the branch office listed below.

Important Note: To insure prompt payment processing, please delay submission of claims on these clients for two weeks following date of services so that eligibility can be recorded on the computer.

2a Managed Care/TPR

A

B

C

D

E

F

G

3a Copay Requirements

A	B
$3 for outpatient services not paid for by your Plan (listed in 2b)	$2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 2b)

4a Benefit Package

A – OHP Plus	D – OHP with limited drug
B – OHP Standard	E – CAWEM Emergency Medical
C – QMB	

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 2a. See OMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.oregon.gov/DHS/healthplan/

5 Name of Eligible Person(s)	6 Recipient ID	7 Date of Birth	3b Copay Req	2b ManagedCare/TPR	4b Benefit Package

8. Branch Office Name and Address	9. Phone Number
	10. Authorized Signature
	11. Date

Distribution: White - Client Copy; Canary - Branch Copy

OMAP 1086 (Rev 01/06)

Instructions for Completing the Temporary Medical Care ID (OMAP 1086)

1. Valid Dates – Enter the days this identification is valid.
2. Managed Care/TPR
   a) Enter all available medical resources for the case. Enter only one resource per letter. This includes OMAP contracted plans, private insurance, primary case managers, and pharmacies.
   b) Enter the appropriate Managed Care/TPR code letter from the choices listed in field 2a.
3. Copay Requirements
   a) Shows possible copay requirements.
   b) For clients who are required to pay copayments, enter "AB." For all other clients, enter "NO COPAYS."
4. Benefit Packages
   a) Shows the available benefit packages.
   b) Enter the appropriate benefit package code letter from the codes listed.
5. Name of Eligible Person(s) – Enter the names of the eligible clients.
6. Recipient ID – Enter the client's prime number; not case number.
7. Date of Birth – Enter the date of birth for each client listed.
8. Branch Office Name and Address – Enter the name and address of the client's branch.
9. Phone Number – Enter the branch's phone number.
10. Authorized Signature – Signature of an authorized branch worker.
11. Date – Enter the date this ID was signed.

Branches

Use this form for clients with immediate medical needs, only when the MID1 screen cannot be used. Issue a replacement Medical Care ID using the ELGH screen as soon as possible after completing this form.

OMAP 1086 (Rev 01/06)

```
                TEMPORARY MEDICAL CARE IDENTIFICATION
                          Valid for services
             Provided from 01/25/2006 through 01/31/2006

Case SCD    : XX####                     Prog Elig :  4
----------------------------------------------------------------------
Benefit    A-OHP PLUS  B-OHP STANDARD   C-QUALIFIED MEDICARE BENEFICIARY (QMB)
Package:  D-OHP with LIMITED DRUG       E-CAWEM EMERGENCY MEDICAL

Copay: A-OUTPATIENT   B-PHARMACY
----------------------------------------------------------------------
                      ---Managed Care/Private Insurance/Restrictions---
Recip                      Ref  Package      Ins Comp              Grp Pol
  Prime ID                   Copay             Ins Cov      Pol Nmbr
DOE, JANE                  ABC  A        A  SAFEWAY PHARMACY          PHARMACY
  XX####                     AB              OMAP PHARMACY          RESTRICTED
                                         B  ODS COMMUNITY HEALTH INC   OD01
                                             OMAP Dental Plan
                                         C  GREATER OR BEHAV HLTH INC
                                             OMAP Mental Health Plan


Branch/DHR Div : BAKER MSO     SSD         Wkr ID : XX
     Str       : 1768 AUBURN AVE            Tele BR : 541-523-5846
  City/St/Zip  : BAKER CITY, OR   97814

Authorized Signature ______________________      Date ___________
                       ATTENTION PROVIDERS
```

OMAP will only pay for services according to OMAP's administrative rules and guidelines. OMAP will only make payment to enrolled providers.

All OMAP administrative rules, guidelines and applications to become an enrolled OMAP provider can be found on the OMAP website at: www.dhs.state.or.us./healthplan/

REMEMBER:
Clients must be eligible on the date of service. Bill all third party resources first. All non-emergency care must be approved by applicable Managed Care/TPR. See OMAP General Rules OAR 410-120-1200 for specific benefit package limitations.

Prior authorization is required for all non-emergency care if provider is beyond 75 miles from Oregon. For out-of-state billing information, call the client's Managed Care/TPR. If the client doesn't have Managed Care/TPR, call 503-945-6522.

If you have questions about eligibility, call AIS at 1-800-522-2508. For billing questions, call OMAP Provider Services toll-free at 1-800-336-6016, in Salem at (503) 378-3697. (WMMMID1C-A)

DMAP Worker Guide IV
Benefit Packages

- What's covered and what's not
- Eligibility, copay, premium requirements
- Other DHS medical assistance programs

A. Benefit Packages General Rules 410-120-1160 through 410-120-1230

OHP Rule 410-141-0480

Clients receive health care services based on their benefit package. Each benefit package's coverage is different. Clients are assigned to benefit packages based on their program eligibility.

The codes in the "BEN" field on the ELGR screen and corresponding benefit package names are:

- BMH – OHP Plus
- KIT – OHP Standard*
- MED – Qualified Medicare Beneficiary (QMB)
- BMM – QMB + OHP with Limited Drug
- BMD – OHP with Limited Drug
- CWM – Citizen/Alien-Waived Emergency Medical (CAWEM)

** The OHP Standard benefit package closed to **new** enrollment July 1, 2004.*

B. What's Covered

1. The OHP Plus Benefit Package BEN Code – BMH

The Oregon Health Services Commission (HSC) developed a list of 730 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-530 on the Prioritized List of Health Services.

OHP Plus Benefit Package – Covered Services

- Preventive Services:
  - Maternity and newborn care
  - Well-child exams and immunizations
  - Routine physical exams and immunizations for children and adults
  - 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
- Medical and Surgical Care
- Family Planning Services and Supplies – including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations
- 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
  - ♦ Vision and hearing services including exams, evaluations, treatment, materials and fitting for glasses and hearing aids
  - ♦ Prescription drugs and some over-the-counter drugs
  - ♦ Transportation to health care for clients who have no other transportation available to them, including ambulance and other methods of transport
- Dental Services
- Outpatient Chemical Dependency Services
- Comfort Care – this includes hospice care and other comfort care measures for the terminally ill, and death with dignity services
- Mental health services

2. The OHP Standard Benefit Package*
BEN Code – KIT

This benefit package is similar to private insurance with premiums and benefit limitations. The Prioritized List also applies to the OHP Standard benefit package.

** The OHP Standard benefit package closed to* ***new*** *enrollment July 1, 2004.*

OHP Standard Benefit Package – Covered Services

- Physician services
- Ambulance

- Prescription drugs
- Laboratory and x-ray services
- Durable medical equipment and supplies, limited to:
  - Diabetic supplies (including blood glucose monitors)
  - Respiratory equipment (e.g., CPAP, BiPAP)
  - Oxygen equipment (e.g., concentrators and humidifiers)
  - Ventilators
  - Suction pumps
  - Tracheostomy supplies
  - Urology and ostomy supplies
- Outpatient mental health
- Outpatient chemical dependency services
- Limited emergency dental services – teeth cleaning, orthodontia, fillings, and other routine services are **not** covered (see OAR 410-123-1670)
- Hospice services, and
- Limited hospital benefit –includes:
  - Evaluation, lab, x-ray and other diagnostics to determine diagnosis (line zero on the Prioritized List)
  - Hospital treatment for urgent/emergent services
  - Inpatient and outpatient hospital treatment for diagnoses listed in the Limited Hospital Benefit Code list. Prior Authorization (PA) is required for certain services, as indicated.

OHP Standard Benefit Package – Excluded Services

- Acupuncture, except for treatment of chemical dependency
- Chiropractic and osteopathic manipulation
- Nutritional supplements taken by mouth
- Home health care
- Hospital services that are not for urgent or emergency care
- Occupational therapy
- Physical therapy
- Private duty nursing
- Speech therapy

3. QMB Benefit Package BEN Code – MED

The QMB benefit package pays for Medicare premiums, co-payments and deductibles for services covered by Medicare. This does not include any cost sharing for Medicare Part D coverage or prescriptions.

Providers are not allowed to bill clients with QMB benefit package coverage for deductible and co-insurance amounts for services covered by Medicare (except for Medicare Part D prescriptions). However, providers may bill these clients for services that are not covered by Medicare and for Medicare Part D prescriptions.

Clients with the QMB benefit package cannot be enrolled in managed care plans.

4. QMB + OHP with Limited Drug Benefit Package BEN Code – BMM

This is a combination of the OHP with Limited Drug and QMB benefit packages. To be eligible for this benefit package, clients must meet the eligibility requirements for both benefit packages. See the QMB and OHP with Limited Drug benefit package descriptions for coverage information.

5. OHP with Limited Drug Benefit Package BEN Code – BMD

The OHP with Limited Drug benefit package covers the same medical, dental and mental health services as the OHP Plus benefit package. However, the OHP with Limited Drug benefit package does not cover drugs covered by Medicare Part D.

6. CAWEM - Citizen/Alien-Waived Emergency Medical BEN Code – CWM

These clients are only eligible for treatment of emergency medical conditions. Labor and delivery services for pregnant women are considered an emergency.

Clients on the CAWEM benefit package do not pay premiums or copays and cannot be enrolled in managed care plans.

The following list is not all-inclusive but can be used as an illustration to identify services that are **NOT covered for clients on the CAWEM benefit package:**

- Pre-natal or post-partum care
- Private duty nursing
- Administrative medical examinations and reports
- Sterilization
- Family planning
- Preventative care
- Transplants or transplant related services
- Chemotherapy
- Hospice
- Dialysis
- Dental services provided outside an emergency room/hospital setting
- Outpatient drugs or over the counter products
- Non-emergency medical transportation
- Therapy services
- Rehabilitation services
- Medical equipment and supplies
- Home health services

CAUTION: Services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance are not covered for clients on the CAWEM benefit package.

C. What's Not Covered *OHP Rule 410-141-0500*

Services for conditions that the HSC ranks of lower priority are generally not covered. The HSC's report contains a complete listing of conditions/treatments that are not covered. There may be other limitations depending on the client's benefit package. Treatments for the following conditions that have no other complicating diagnosis are not covered:

- Conditions which tend to get better on their own, such as:
  - Measles
  - Mumps
  - Dizziness
  - Infectious mononucleosis
  - Viral sore throat
  - Viral hepatitis
  - Benign cyst in the eye
  - Non-vaginal warts
  - Minor bump on the head
- Conditions where a "home" treatment is effective, such as applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. Such conditions include:
  - Canker sores
  - Diaper rash
  - Food poisoning
  - Corns/calluses
  - Sunburn
  - Sprains
- Cosmetic conditions, such as:
  - Benign skin tumors
  - Removal of scars
  - Cosmetic surgery
- Conditions where treatment is not generally effective, such as:
  - Some back surgery
  - TMJ surgery
  - Some transplants
- Other not covered services include, but are not limited to, the following:
  - Circumcision (routine)
  - Surgical treatment of obesity
  - Weight loss programs
  - Infertility services

D. Benefit Package Overview

The following table lists some of the services that are covered for each benefit package as well as how the package is coded in the "BEN" field on the ELGR screen.

OHP Plus – BMH	
Physician, lab and X-ray services	Hospice services
Pharmacy services	Home health services
Physical therapy/occupational therapy	Dental services
Reasonable diagnostic services	Medical transportation
Durable medical equipment and supplies	Some over-the-counter drugs
Vision, glasses	Chemical dependency services
Hearing, speech services	Mental health services
Hospital services (inpatient and outpatient)	Preventive services (for example: tobacco cessation services)
OHP Standard – KIT	
Physician, lab and X-ray services	Some over-the-counter drugs
Pharmacy services	Outpatient mental health services
Hospice services	Outpatient chemical dependency services
Reasonable diagnostic services	Emergency medical transportation
Limited durable medical equipment (see OAR 410-122-0055)	Limited emergency dental (see OAR 410-123-1670)
Limited hospital services (see OAR 410-125-0047)	Preventive services (for example: tobacco cessation services)
Qualified Medicare Beneficiary (QMB) – MED	
Medicare premiums, deductibles and copays for Medicare covered services	
QMB + OHP with Limited Drug – BMM	
See QMB and OHP with Limited Drug benefit packages	
OHP with Limited Drug – BMD	
The OHP with Limited Drug benefit package covers the same medical, dental and mental health services as the OHP Plus benefit package. However, the OHP with Limited Drug benefit package does not cover drugs covered by Medicare Part D.	
Citizen/Alien-Waived Emergency Medical (CAWEM) – CWM	
Emergency medical services	Labor and delivery
Senior Prescription Drug Assistance Program (SPDAP) – PDA	
Prescription drug assistance for elderly – this is not a Medicaid program (see DMAP Worker Guide 6 for detailed information)	

E. OHP Plus Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

Eligible clients are:
Pregnant women – up to 185% of the Federal Poverty Level (FPL)
Children under age 19 – up to 185% of the FPL
Receiving SSI
Age 65 or older, blind, or disabled and receiving income at or below the SSI standard
Age 65 or older, blind, or disabled and receiving Department paid long term care services
Receiving Temporary Assistance to Needy Families (TANF)
Presumptively eligible prior to disability determination
Children in foster care or in adoptive assistance

Copays are (see OAR 410-120-1230 for more information):
$2 for generic prescription drugs
$3 for brand name prescription drugs
$3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copay is only for the visit to the provider. There is no copay for treatments performed by the provider (i.e., immunizations, labs or X-ray)

Copays are not required for the following clients and services:
Clients in prepaid health plans (PHP) – for services covered by the PHP
Pregnant women
Children under age 19
American Indians/Alaska Natives
Clients who are eligible for benefits through Indian Health Services
Clients who are receiving services under the Home and Community Based waiver and Developmental Disability waiver
Clients who are in a hospital as an inpatient, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR)
Family planning services and supplies
Emergency services, as defined in OAR 410-120-0000
Prescription drugs ordered through DMAP’s home delivery (mail order) vendor

F. OHP Standard Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

This benefit package closed to **new** enrollment July 1, 2004.

Eligible clients:
Are adults who do not meet eligibility requirements for the OHP Plus benefit package – up to 100% of the FPL
Do not currently have and have not had commercial insurance coverage during the previous six months

Copays
None

Premiums
Premiums are charged per member/per month
American Indians/Alaska Natives are not required to pay premiums
Clients who are eligible for benefits through Indian Health Services are not required to pay premiums
Clients with income of 10 percent or less of the Federal Poverty Level are not required to pay premiums
Clients must pay all required premiums before their coverage can be renewed for another enrollment period

The following services are not part of the OHP Standard benefit package:
Hospital services **not** on the Limited Hospital Benefit Code List (OAR 410-125-0047)
Therapy services (physical, occupational, and speech)
Acupuncture (except for treatment of chemical dependency)
Chiropractic services
Home health services/private duty nursing
Vision exams and materials
Hearing aids and exams for hearing aids
Non-ambulance medical transportation

G. DHS Medical Assistance Programs

Program Code	Program Title	Case Descriptor	Benefit Package
1, A 1	Aid to the Aged	See Computer Guide section 3 G & 3-L	OHP Plus, OHP with Limited Drug, QMB with OHP Plus
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	OHP Plus
V2	Refugee Assistance		OHP Plus
3, B3	Aid to the Blind	See Computer Guide section 3 G & 3-L	OHP Plus, OHP with Limited Drug, QMB with OHP Plus
4, D4	Aid to the Disabled	See Computer Guide section 3 G & 3-L	OHP Plus, OHP with Limited Drug, QMB with OHP Plus
19, 62	DHS Foster Care		OHP Plus
C5	Substitute/Adoptive Care	SAC, SCP, SFC	OHP Plus
GA (CSD)	Non-title XIX Foster Care		OHP Plus
P2, M5, 2, 82	Children's Health Insurance Program (CHIP)	CHP	OHP Plus
P2, M5, 2, 82	Extended Medical Program	EXT	OHP Plus
5	OSIPM-PRS	See Computer Guide section 3 G & 3-L	OHP Plus, OHP with Limited Drug
P2	Qualified Medicare Beneficiary (QMB)	QMB	QMB
Any Program	QMB + Any Program	QMM	QMB + OHP with Limited Drug
P2, M5, 2, 82	OHP Medical	OPC, OP6, OPP	OHP Plus
P2, M5, 2, 82	OHP Medical	OPU	OHP Standard
P2, M5, 2, 82	Breast and Cervical Cancer Program	BCP	OHP Plus
P2, M5, 2, 82	Senior Prescription Drug Assistance	PDA	N/A
Any Program	CAWEM	CWM	Emergency Medical

DMAP Worker Guide V
Managed Care Information

- Types of MCOs
- Enrollment process, disenrollment,
- Effective dates, exemptions
- Dual-eligibles, choice counseling
- Educating clients

A. Managed health care systems

The Division of Medical Assistance Programs (DMAP) contracts with managed care organizations (MCOs) to provide services to Medicaid clients. In exchange, MCOs receive a monthly capitation payment for each enrolled client. The following types of managed care plans are considered MCOs:

- Fully Capitated Health Plans (FCHP)
- Physician Care Organizations (PCO)
- Primary Care Manager (PCM)
- Dental Care Organizations (DCO)
- Mental Health Organization (MHO)
- Chemical Dependency Organization (CDO)

When the client has been enrolled into an MCO, the MCO provides the client with a handbook outlining the services it provides and how to access them.

Indian health services and tribal health clinics either have managed care programs or consider their clinics to be in managed care. When discussing managed care enrollment options for American Indian and Alaska Native clients, specify OHP managed care.

In managed care, services are coordinated through one primary care provider or clinic that manages the client's health care. When necessary, the primary care provider makes referrals to specialty providers, who are paid by the MCO. A comparison chart is included in the OHP application packet (not included in reapplication packets). The comparison chart describes the MCOs that are available in the area where the client lives and unique information about each plan.

Important: Medical Case Management (MCM) and Disease Case Management (DCM) are not managed care plans. A client's Medical Care ID may show an MCM or DCM in Field 8a, which indicates DMAP has assigned them extra services because they have high risk or high cost health conditions such as asthma, diabetes, COPD or heart failure. MCM and DCM clients receive services on a fee-for-service (open card) basis. MCM and DCM are not payers or third party resources and do not affect claim submissions or payments. Questions regarding either of these programs should be directed to DMAP. For more information about MCM and DCM services, see DMAP Worker Guide VI - *Other Medical Resources.*

1. Fully Capitated Health Plan (FCHP)

The most common delivery system is the Fully Capitated Health Plan (FCHP). DMAP pays the FCHP a monthly capitation payment to provide comprehensive services and to manage each enrolled client's health care. FCHPs provide medical services ranging from physician and hospital inpatient care to physical therapy and many medications. FCHPs provide an Exceptional Needs Care Coordinator (ENCC) for clients with special needs. Clients may be exempt from enrollment in an FCHP either temporarily or permanently for various reasons. See Section E – *Exemptions from Managed Care* in this worker guide for more information.

2. Physician Care Organization (PCO)

DMAP pays the Physician Care Organization (PCO) a monthly capitation payment to provide comprehensive services and to manage each enrolled client's health care.

Clients enrolled in a PCO receive inpatient hospital services and post-hospital extended care services on a fee-for-service basis.

Clients may be exempt from enrollment in a PCO either temporarily or permanently for various reasons. See section E – *Exemptions from Managed Care* in this worker guide for more information.

3. Primary Care Manager (PCM)

DMAP also contracts with independent providers to be Primary Care Managers (PCMs). PCMs manage a client's health care for a nominal monthly case management payment and bill DMAP on a fee-for-service basis for services provided to the client. Clients with major medical private health insurance can be enrolled with a PCM. PCMs may be physicians, physician assistants, nurse practitioners with a physician back-up, or naturopathic physicians with a physician back-up. PCMs may also be rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian health service clinics, or tribal health clinics. PCMs can refer clients to specialty services. PCMs are usually utilized when an FCHP is either not available or is closed to new enrollment.

4. Dental Care Organization (DCO)

A Dental Care Organization (DCO) is a prepaid dental plan that provides dental services to qualified medical assistance clients. DMAP pays the DCO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's dental care.

5. Chemical Dependency Organization (CDO)

A Chemical Dependency Organization (CDO) provides chemical dependency services in Deschutes County only to qualified medical assistance clients. DMAP pays the CDO a monthly capitation payment to provide comprehensive services and to manage each enrolled client's chemical dependency care.

6. Mental Health Organization (MHO)

A Mental Health Organization (MHO) provides mental health services to qualified medical assistance clients. A client's MHO enrollment is determined by the medical plan the client chooses. DMAP pays the MHO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's mental health care.

Clients who are eligible for mental health benefits will receive services through MHOs, which may be an FCHP, community mental health program, or private mental health organization. Services provided by MHOs 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

B. Enrollment process

Clients are required to be enrolled in the following types of managed care:

- A DMAP contracted medical plan (FCHP or PCO) or PCM (only if a medical plan is not available), and
- A DMAP contracted Dental Plan (DCO), and
- A DMAP contracted Chemical Dependency Plan (CDO), if the client resides in Deschutes County.
- An Addictions and Mental Health Division contracted Mental Health Plan (MHO)

A client's residential address, ZIP code and FIPS code determines which managed care plans are available to them. In certain approved situations, clients may be either temporarily or permanently exempt from managed care enrollment. See Section E *–Exemptions from Managed Care in this worker guide for detailed information*.

MCOs and PCMs serve clients in different service areas throughout the state. Each service area is made up of one or more counties. Service areas are considered "mandatory" or "voluntary" based on the number of MCOs available and whether or not they have enough provider access to continue accepting new enrollees. Clients who live in a mandatory service area are required to enroll in an MCO or PCM if an MCO is not available. Enrollment in voluntary service areas is not required, however, it is preferred. The enrollment screen (ENRC) shows if the client lives in a mandatory or voluntary enrollment area. If a client is enrolled and moves to a voluntary ZIP code served by their existing managed care plan, they would not be eligible to disenroll until their next recertification period.

The KSEL screen gives the following information (based on the FIPS/ZIP codes for the client's residence address):

- The types of managed care coverage available (*i.e.*, medical plans, dental plans)
- The specific MCOs and/or PCMs available
- The PCM's specialty
- The MCO's enrollment status:
  - ♦ Open or closed for enrollment
  - ♦ If they are accepting re-enrollments
  - ♦ What the time limits are for re-enrollment (*e.g.*, 30 days)
  - ♦ Whether or not they take Standard clients

Sometimes a managed care plan must close enrollment to new members. When attempting to enter an enrollment when a plan is closed, check KSEL to see if there is a re-enrollment

period. These are usually 30 days, but can be longer. If the client's break in enrollment was less than the number of re-enrollment days showing on KSEL, the client may be able to get back into the plan. Workers should contact DMAP's Client Enrollment Services (CES) staff to see if the client can be re-enrolled. If a case already has someone enrolled in a plan that is closed, any new or returning family members can also enroll.

1. Selection process

The MCO and PCM selection process is based on whether the client lives in a mandatory or voluntary enrollment area and how many MCOs are available. An area can be mandatory for one type of MCO (*e.g*., an FCHP) and at the same time be voluntary for another type of MCO (e.g., a DCO). Whether or not a plan is open for new enrollment and whether an area is voluntary or mandatory is determined by DMAP.

Most clients who live in a mandatory area must select a medical plan (FCHP or PCO) if one is available. If an FCHP/PCO is not available they may enroll with a PCM. They must also enroll with a dental plan (DCO). The date of enrollment in an FCHP or DCO depends on when the enrollment action is taken. Some exceptions to mandatory enrollment would be if the client has a third party resource (TPR) or proof of Native American heritage.

Note: Clients with dental TPR are still required to enroll in a dental plan. Clients with Medicare are not mandatory to enroll but can enroll if they choose.

Clients are auto-enrolled into an MHO based on their medical plan, county of residence or PCM enrollment and are therefore not required to choose a MHO.

If the client was auto-enrolled by the system or their worker chose for them, they have 30 days from the date of enrollment to notify their worker to request an enrollment change. Clients who were enrolled into the MCO and/or PCM of their choice can only change their enrollment for one of the reasons listed in Section D - *Disenrollment/Changes in Managed Care*.

Enrollment process—Mandatory area with multiple MCOs

Use this process for clients who:

- Live in a mandatory area, and
- There is more than one MCO available, and
- Either they did not choose a MCO or the MCO they chose is not available. See *Client Notification Requirement* below.

The worker must choose an MCO based on an alphabetical selection. For example, the worker would enroll the client in the first (alphabetically) available MCO. The next enrollment (in the same service area) would go to the next (alphabetically) available MCO and so on.

If the worker does not enroll the client and the client does not have an approved exemption, the client will be auto-enrolled into one of the available MCOs.
See Section 3 - *Auto-Enrollment* for more information.

Enrollment process—Mandatory area with a single MCO

Use this process for clients who:

- Live in a mandatory area, and
- There is only one MCO available.

The worker must enroll the client in the available MCO. If the worker does not enroll the client and the client does not have an approved exemption, the client will be auto-enrolled into the MCO. See Section 3 - *Auto-Enrollment* for more information.

Enrollment process—Mandatory area with no MCO available

Use this process for clients who:

- Live in a mandatory area, and
- There is no MCO available, but
- There are PCMs available.

The worker must enroll the client in a PCM. The PCM will manage the client's care, but the client will receive services on a fee-for-service basis (also known as open card). Clients are not auto-enrolled into a PCM.

Enrollment process—Voluntary area

If clients live in voluntary enrollment areas, they are not required to enroll in a MCO or PCM. However, staff should tell them that enrollment in a MCO or with a PCM can increase their access to services and also provide valuable resources.

Clients who are not enrolled in a MCO or PCM receive their services on a fee-for-service basis. The client will continue to receive services fee-for-service until the area changes to mandatory.

Client Notification

If the client chooses a managed care plan or PCM that is not available, the worker must send a notice to the client telling them:

- The name of the managed care plan or PCM they have been enrolled in, and
- They have a right to change to a different managed care plan within 30 days of the enrollment if another plan is available.

2. Service area changes

From mandatory to voluntary

When a client changes from a mandatory to a voluntary service area during their certification, their managed care enrollment status will change as follows:

- If their existing MCO or PCM also provides service in the voluntary area, the client will remain enrolled in their MCO or PCM until their recertification period.
- If their existing MCO/PCM does not provide services, the client will be disenrolled.

From voluntary to mandatory

When the client changes from a voluntary to a mandatory service area during their certification, their managed care enrollment status will change as follows:

- If the worker doesn't enroll the client in an available MCO, the client will be auto-enrolled unless they meet the criteria to be exempt from auto enroll. See Section 3 - *Auto-Enrollment* for more information.

3. Auto-enrollment

Auto-enrollment is a systematic process used by DMAP that enrolls clients in managed care plans in mandatory enrollment areas when caseworkers have not enrolled them. Effective November 1, 2007, DMAP systems began auto-enrolling affected clients on a weekly basis. Clients who have been auto-enrolled can ask (within 30 days from the enrollment) to change to a different MCO if another one is available where they live. However, they cannot go back to fee-for-service (open card) unless they have an approved exemption. DMAP sends notices to inform the client that they have been auto-enrolled and that they can request a change by contacting their caseworker. Clients who are auto-enrolled but do not request a change within 30 days, must wait until they recertify to change to a different managed care plan.

Auto-enrollment does not apply to clients who have been approved for an exemption or are in certain categories (*e.g.,* Medicare). See Section E –*Exemptions from Managed Care* in this worker guide for detailed information.

C. Effective date of MCO coverage *OHP Rule 410-141-0060*

1. New clients

MCO enrollment is done on a weekly basis (this does not apply to newborn or MHO enrollments). When MCO enrollment information is entered into the CMS system:

- **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**.

Clients receive a Medical Care ID within a few days of enrollment showing two date ranges, one for the client's fee-for-service coverage and one for MCO coverage.

Newborns are retroactively enrolled by DMAP systems back to their date of birth as long as their birth mother was enrolled in an MCO when the baby was born. This retroactive enrollment pays the managed care plan back to the baby's date of birth. The payment is made at end of month cutoff after the baby is added to the case.

2 Existing clients who have moved

When an existing client has moved out of their current MCO's or PCM's service area, the address change **must** be done in the following 2-day sequence:

- Day 1 – Update the client's new address, but DO NOT enter their new plan enrollments on the same day. That evening when DMAP systems processes the new address, the client's existing FCHP and DCO enrollments will automatically close if their existing plans don't serve their new address.

  Critical: If the new address and managed care plan enrollment changes are done on the same day, the system **does not** end the existing enrollments until the last day of the month. Managed care plans are only responsible to provide emergency services when clients are outside of the plan's service delivery area. If your client has already moved and their old plan enrollments don't change till the end of the month,

it means that the managed care plan is not responsible for routine care any more. For clients to be able to access all covered services after they move, it is critical that the address change and new plan enrollments NOT be done on the same day.

- Day 2 – Enter the client's new managed care enrollment choices. The client will be enrolled during the next weekly enrollment.

Workers needing assistance with enrollment errors that occur due to an address change should contact DMAP Client Enrollment Services (CES) for assistance.

				Managed Care Enrollment	
	Date	**Worker enters**	**Address change effective**	**Existing ends**	**New begins**
Correct	10/1/07	Address change	10/1/07	10/1/067	
	10/2/07	New managed care plan enrollments			10/8/07
Incorrect	10/1/07	Address change **and** new managed care enrollment information	10/1/07	10/31/07	11/1/07

D. Disenrollment or changes in managed care *OHP Rule 410-141-0080*

Clients may change their MCO or PCM:

- When they reapply, or
- If they move and their existing MCO or PCM does not provide service at their new address, or
- Within 30 days of an auto-enrollment in an area with multiple MCOs, or
- When approved by DMAP.

Contact CES for assistance with managed care enrollment issues. E-mail questions to dmap.ces@state.or.us. For additional assistance with managed care related issues, contact a DMAP PrePaid Health Plan Coordinator.

E. Exemptions from managed care

Exemption codes

Clients may temporarily or permanently be exempt from enrolling in a MCO if they meet certain criteria and are approved for an exemption. Some exemption codes are restricted and must be entered by CES. Some exemptions may be entered by caseworkers. Exemptions should contain a specific start and end date. Generally, an exemption may be approved to allow a client a small window of time to complete a needed medical service or procedure.

Some exemptions must be approved by the DMAP Clinical Unit, Senior and People with Disabilities (SPD) Medical Director or a DMAP PHP Coordinator. For questions regarding exemptions, contact CES.

Workers should not add an exemption code when the client has private comprehensive medical insurance to prevent auto-enrollment or while waiting for ELGX to be updated.

Workers can add an exemption in a voluntary enrollment area if the client meets the exemption criteria, however, it is only necessary if the client has the potential to move to a mandatory area. Otherwise, it is not necessary to use an exemption code if not enrolling in managed care.

Use exemptions codes for the reasons listed in this table.

ACC	**Access to Care –** Use in the rare instance when the client receives the majority of their care from a unique specialist who is out of the client's service area. For example, the client has a complicated seizure disorder and lives in Medford, however, they receive the majority of their care from a specialist in Portland.
CNT	**Continuity of Care –** Use when MCO enrollment could harm the client's health. For example, the client is receiving care for a chronic or long-term condition from a provider who is not part of an available MCO. The worker must have documentation from the client's medical provider before using this code. Documentation must be kept in the client's case file.
EXL	Only used by DMAP when a managed care plan has requested, with good cause, to have client disenrolled and **excluded** from enrollment. Some examples of good cause are threatening behavior, fraud and illegal acts. When an EXL is granted, the client receives a notification from DMAP.
HOS	This code can be used for two different reasons, read both descriptions to determine the appropriate code. This code is restricted and must be entered by HMU. 1 – Used by DMAP when the client is an inpatient in a **hospital** on the day their managed care enrollment was to begin. Client is enrolled after hospital discharge. 2 – Use for clients (adults and couples without children) who applied through the **hospital hold** process. These clients are exempt from medical plan enrollment for six months. These client would still be enrolled in a DCO and MHO
HRG	**Hearing scheduled –** Use when enrollment is delayed until after a hearing
MMC	Use only for clients who are dual-eligible (**Medicare and Medicaid**) **and** live in an area where the only medical plans available have corresponding Medicare Advantage Plans that the client does not want to enroll in.
PIH	Use when the client has proof of **American Indian/Alaska Native (AI/AN) tribal** membership or is eligible for benefits through an Indian Health Services Program – the client's case must have an HNA case descriptor. AI/AN clients can choose to enroll in a managed care organization **and** continue to receive care at an AI/AN facility OR remain fee-for-service and go to any provider who will accept their DMAP Medical Care ID
PRG	Use this code for a **pregnant woman** when she: 1 – Is in the third trimester of pregnancy when she first applies for OHP, **and** 2– She has not been enrolled in a MCO during the past three months, and 3 – Is under the care of a provider who is not contracted with an available MCO.
MED	Use when a client's **medical condition** or medical care requires special handling by DMAP, or the client was diagnosed with End Stage Renal Disease (ESRD) prior to enrollment. Contact CES to use this exemption. The exemption for ESRD clients will have an end date of 2049.

OTH	**Other reason** – Used by DMAP only. All requests for this code require authorization by DHS and will include a review of physician notes. All SPD field staff that want to use this code must make a referral to the SPD Medical Director's Office.
REL	**Religious consideration** - This is used in the rare instance when religious beliefs would prevent the client from accessing a covered service (*e.g.*, a woman's religion requires she see a female doctor and the MCO did not have female doctors)
RIF	**Rehabilitation/Inpatient/Nursing Facility** – Use for clients in the Eastern Oregon Training Center, Eastern Oregon Psychiatric Center or Oregon State Hospital and for clients in a nursing facility when the client needs to use the in-house physician of the facility, and the physician is not part of an available MCO. Documentation must be kept in the case file.
SUR	Use when the client has **surgery** scheduled and the current provider does not participate with one of the available MCOs

F. Third party resources (TPR)

Private health insurance does not automatically exempt a client from managed care. Depending on the type of private health insurance, a client may still be eligible for enrollment in an MCO or PCM. The Health Insurance Group (HIG) verifies TPR information they receive and determines if the private insurance can be a primary payer. If HIG determines the insurance meets TPR criteria, they update ELGX. They do not disenroll clients from any existing managed care enrollments. Workers who want to be notified when the TPR files have been updated (so they can enter or disenroll managed care enrollments) will have to request that HIG contact them.

The table below lists the different types of private health insurance coverage a client may have. Each type of coverage has a different code and managed care enrollment requirement. The "X" indicates that the client is required to enroll in an MCO

Note: Clients in mandatory areas with dental private health insurance are still required to enroll in a DCO if one is available where they live.

Enrollment codes for private health insurance					
Private coverage type	**Code**	**FCHP/ PCO**	**PCM[1]**	**DCO**	**MHO**
Accident	AI	X	X	X	X
Champ VA	CA	X	X	X	
Cancer	CI	X	X	X	X
Champus	CS		X	X	X
Major	H12		X	X	
Hospital	H13	X	X	X	X
Surgery	H14	X	X	X	X
Drugs	H15		X	X	X
Dental	H16	X	X	X	X
Visual	H17	X	X	X	X

Enrollment codes for private health insurance					
Private Medical	HM			X	
Medicare Supp.	MS			X	
Medicare HMO[2]	MAB			X	
Nursing Home	NH	X	X	X	X

[1] See Sections A3 - *Primary Care Managers (PCM)* and B1- *Selection Process* for PCM enrollment requirements.

[2] System will allow clients with Medicare HMOs to be enrolled in a medical plan. However, workers are ***not*** to enroll them unless the Medicare HMO is also a DMAP-contracted medical plan. Medicare clients can also be enrolled with a PCM and must be enrolled in a DCO.

If a caseworker becomes aware that a client's private health insurance is terminated, the worker *must* submit a completed DHS 415H with termination date to (HIG) and update the private health insurance (PHI) flag on the PCMS screen. If the TPR file (ELGX) contains incorrect information and it is creating a barrier to a client's ability to access care, the caseworker can contact HIG by phone, fax or e-mail and ask for expedited processing of the DHS 415H.

A case is listed on a discrepancy report if there is a difference between the PHI code and the TPR file, (*e.g.,* PHI code is "Y" and there is no private health insurance on ELGX, or the PHI code is "N" and there is private health insurance on ELGX). Discrepancy reports are sent to branch offices and HIG. Branch offices should research the discrepancies and update the client's case or submit a DHS 415H to HIG. HIG also researches the discrepancy report and requests additional information from caseworkers so cases can be updated.

Caution: The PHI field on a client's case **does not** stop or start enrollment into managed care. This field does not communicate with the TPR file. Workers need to be sure the PHI field contains correct information and send the DHS 415H to HIG. The table below may help. For more information, contact HIG.

Type of managed care enrollment for clients with TPR

This chart indicates what kind of managed care you can enroll clients in, depending on the type of private health insurance they have.

If client has:	Enroll with:			
	FCHP/PCO	PCM	DCO	MHO
Medicaid only (no TPR)	Yes[1]	Yes[1]	Yes[2]	Yes
Medicaid + managed TPR	No	No	Yes[2]	No
Medicaid + non-managed major TPR[3]	No	Yes	Yes[2]	No
Medicaid/Medicare (no private TPR)	Yes[1]	Yes[1]	Yes[2]	Yes
Medicaid/Medicare + private Medicare HMO	No	No	Yes[2]	No
Medicaid/Medicare + other managed TPR (not Medicare HMO)[3]	No	No	Yes[2]	No
Medicaid/Medicare + non-managed major TPR (not Medicare HMO)[3]	No	Yes	Yes[2]	No
Medicaid/Medicare + Medicare supplement (not Medicare HMO)[3]	No	Yes	Yes[2]	Yes[2]

[1] First preference is to enroll with a medical plan. If an MCO is not available, enroll with a PCM. New clients or clients with a break in enrollment who have End Stage Renal Disease (ESRD) or are in Medicare hospice cannot be enrolled in a medical health plan, but should be enrolled with a PCM if possible.

[2] Separate enrollment in a DCO is required in mandatory enrollment areas.

[3] Only clients with comprehensive private medical insurance, like Medicare supplements or major medical, or drug coverage may be enrolled with PCMs rather than MCOs. If the TPR is specialized, such as an accident policy, hospital policy or school insurance, enroll clients as if they had no TPR. Complete the DHS 415H and forward it to HIG.

G. Dual-eligible medical plan enrollment requirements *OHP Rule 410-141-0060*

Effective January 1, 2006, "Medicare + Choice 65" was changed to "Medicare Advantage Plan." Before enrolling a dual-eligible client into a DMAP medical plan, review the information in this section.

1. Medical plan enrollment requirements

Dual-eligible clients (someone who is eligible for both Medicaid and Medicare) can choose to enroll with any DMAP medical plan that is available in their area. However, if the DMAP medical plan has a corresponding Medicare Advantage Plan, the client must also enroll in that plan's Medicare Advantage Plan. If the client does not want to enroll in the corresponding Medicare Advantage Plan, the medical plan can request that the client be disenrolled.

If the client lives in a mandatory medical plan enrollment area, they are required to enroll in a DMAP medical plan. The client can be exempt from medical plan enrollment if the only medical plan available has a corresponding Medicare Advantage Plan that the client does not want to enroll in. For example, if a client lives in Deschutes County and chooses not to be enrolled in Clear Choice (Medicare Advantage Plan), then they cannot be enrolled in Central Oregon Independent Health Solutions (COIHS– the DMAP contracted medical plan in Deschutes County).

DMAP medical plan with corresponding Medicare Advantage Plan

The client must complete the Medicare Advantage Plan Election form (OHP 7208M) and send it to the DMAP medical plan within 30 days of DMAP medical plan enrollment. Their Medicare and Medicaid covered services will be coordinated between the Medicare Advantage Plan and the DMAP-contracted medical plan. Clients who opt out of the Medicare Advantage Plan enrollment will receive their Medicaid services on a fee-for-service basis.

Important: *Clients 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 unless they were already enrolled in the plan as a commercial member before being diagnosed with ESRD.*

DMAP medical plan without a corresponding Medicare Advantage Plan

Enroll these clients in their DMAP medical plan like all other clients. These clients would receive their health care as follows:

- Medicare services – from Medicare
- Medicaid services – through their DMAP medical plan

2. Medicare Advantage Plan election (OHP 7208M) instructions

Clients who are enrolling in their DMAP medical plan's corresponding Medicare Advantage Plan must complete the OHP 7208M. Clients not completing this form may be disenrolled from their managed health care plan. The following information is needed to complete the OHP 7208M:

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

3. Disenrollment requirements

Clients can only be in one Medicare Advantage Plan at a time. To disenroll from a Medicare Advantage Plan, the client must complete the Request to Terminate Insurance form (OHP 7209) and send it to the Medicare Advantage Plan they are disenrolling from.

H. Choice counseling

It is important for clients to choose managed care plans and/or PCMs that best meet their needs. Usually clients will make their own decisions about which MCO and/or PCM is best for them. To help them decide, DMAP includes MCO comparison charts with all new application packets. The comparison chart is a choice counseling tool and is formatted so that all MCOs in a specific area can be compared to one another.

If the client is unable to choose an MCO and/or PCM, one may be chosen for them by a holder of a power of attorney, a guardian, a spouse, a family member, a team of people, or an agency caseworker.

The checklist in this section lists major discussion areas to cover when helping a client choose a MCO and/or PCM.

Choice counseling checklist

- ❒ Does the client reside in a mandatory or voluntary enrollment area?
- ❒ Does the client's doctor (PCP) or dentist (PCD) participate with an available MCO or could they be chosen as a PCM?
- ❒ Do the client's children have a PCP? Does the PCP participate with an available MCO?
- ❒ Is the medical or dental office near the client's home or on a bus line? Can they get to their appointments easily?
- ❒ 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?
- ❒ Is the client elderly or disabled, requiring Exceptional Needs Care Coordination (ENCC)?
- ❒ What transportation is available to the client to access medical services?

I. Educating clients about health care

The case worker or case manager can help educate clients about the managed health care delivery system in these ways:

- Define truly emergent care – These are services that are needed immediately because of a 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 Client Handbook* (OHP 9035), for more information.
- Advise clients to cancel appointments at least 24 hours in advance if they can't make it to their appointments.
- Explain that there could be a one to three month wait for a routine appointments, especially with a dentist, so they should make preventive care appointments and not wait until an emergency arises,
- Primary care providers (PCPs) serve an essential function in managed care. The PCP manages the client's health care needs. The PCP works with the client to keep him or her healthy.

- If the client needs a specialist, their PCP may need to make a referral.
- Clients need to bring both their Medical ID and MCO card to all appointments. In some cases identification may be requested.
- Advise clients that some providers may not be taking new patients.
- Explain that clients need to follow the rules of their plan and respect providers and their staff.
- Tell clients to read the *OHP Client Handbook* (OHP 9035), and give a description of some of the information in the handbook. For example:
  - ♦ How to resolve billing problems.
  - ♦ How to resolve provider care problems.
  - ♦ How the appeal and grievance process works.
- Remind clients to review their Medical ID each time they receive one to ensure it contains accurate information.
- Remind clients to notify their worker of changes in their households, such as pregnancy, change of address, change of household composition.

REMEMBER: Many clients haven't had access to health care, especially dental and mental health care, and don't automatically know doctor's office etiquette. See the Rights and Responsibilities section of the *OHP Client Handbook* (OHP 9035) for more information.

Problems or questions regarding managed health care issues can be directed to the contact units listed at the end of this section.

J. Managed health care issues contact list

Who to contact ***—For DHS staff use only—***		
MCO enrollment and eligibility/billing questions No MCO message or wrong MCO on Medical ID AI/AN exemptions Medical exemptions	Client Enrollment Services Unit (CES)—DMAP Fax: 503-947-5221 or E-mail: dmap.ces@state.or.us or *CES, DMAP* in GroupWise	503-945-6295 503-945-6558 503-945-6724 503-945-6523
MCO claim problems, available services, physicians, etc.	Contact the clients managed care plan	phone number listed on client Medical ID
ELGC/ELGR and/or case coding problems	Client Maintenance Unit (CMU)—OPAR	503-378-4369
Private health insurance or third party resource (TPR)	Health Insurance Group (HIG)—OPAR	503-378-2220
Unresolved client/MCO problems	Client Services Unit (CSU) —DMAP	Clients can call: 800-273-0557
Requests for continuity of care exemptions Expedited hearing requests	Clinical Unit—DMAP	503-945-5785
Problems with Mental Health Organizations (MHO)	Addiction and Mental Health (AMHD) Division	503-947-5522
Problems with FCHP/PCO/DCO	PHP Coordinator in the DMAP Delivery Systems Unit (DSU) See DSU assignment list or call	503-945-5772

DMAP Worker Guide VI
Other Medical Resources

A. Senior Prescription Drug Assistance Program

ORS 414.342, passed by the 2001 Legislature, created the Senior Prescription Drug Assistance Program. It is a non-Medicaid program funded with state dollars. The purpose is to give seniors access to more affordable prescription drugs.

This program has two main provisions:

- The first is that DHS would set a discounted rate, not to exceed the Medicaid rate, at which pharmacies can charge eligible seniors for prescription drugs. DHS issues the senior an enrollment card to take to participating pharmacies. The senior pays DHS a $50 yearly enrollment fee. DHS does not subsidize the purchase of the prescription drug.
- The second provision is that DHS, subject to funds available, may adjust the price to subsidize up to 50% of the Medicaid price of the drug, using a sliding scale based on the income of the senior. The maximum assistance is $2000 per year. The statute funds this provision of the program with cigarette tax revenue if that revenue dedicated to the Oregon Health Plan exceeds $175 million per biennium. The program could also be funded by an appropriation.

Because the second provision of the program (subsidizing the purchase of the drugs) is not funded, DHS has only implemented the first portion of the statute (the discount portion). The discount program was rolled out in phases beginning in 2002.

All applications go to the Statewide Processing Center (Branch 5503) to determine eligibility. Seniors can either mail it to that branch or you can route it there.

1. Eligibility requirements for enrollees

Applicants must:

- ♦ Be 65 years of age or older;
- ♦ Have an income that does not exceed 185% of the federal poverty level;
- ♦ Have less than $2000 in resources not counting home or car;
- ♦ Not have been covered by any public or private drug benefit program for the previous 6 months.

After Branch 5503 decides the applicant is eligible, a contractor will send the senior a bill for $50. DHS will issue the enrollment card after we receive the entire fee. Applicants are not enrolled in the program until they pay the fee, and are issued the card. In addition to the Medicaid price of the drug, pharmacies may charge a dispensing fee. The fee is the same as for Medicaid clients.

The program also allows an additional fee of $2 if the pharmacy is a critical access pharmacy, and this fee is adjusted every April for inflation. DHS assigns pharmacies this designation if the pharmacies are in locations where access to the program would otherwise be limited or unavailable.

For additional information regarding the Senior Drug Assistance Program, contact DMAP at 1-800-527-5772 or 503-945-5772 and ask for the Senior Drug Assistance Program Manager.

B. Family Health Insurance Assistance Program (FHIAP)

FHIAP was created by the 1997 Oregon Legislature to help low-income Oregonians afford private health insurance. The program subsidizes or pays for a significant portion of a member’s health insurance premium — 95% of the premium for members earning less than 125% of the federal

poverty level (FPL) or $2,151 a month for a family of four (based on 2006 Federal Poverty Guidelines), a 90% subsidy for those earning up to 150% FPL, a 70% subsidy for those earning up to 170% FPL, and a 50% subsidy for those earning up to 185% FPL.

FHIAP is a subsidy program, not an insurance plan. FHIAP will subsidize the medical and prescription drug portion of the premium, as well as vision or dental premiums if the coverage (or benefit) is offered by the same medical insurance company. FHIAP members must pay deductibles, co-pays or any other coinsurance associated with their health insurance plan.

1. Eligibility Criteria and Enrollment

To be eligible for FHIAP, the applicant must meet the following criteria*:

- Reside in Oregon
- Be a U.S. citizen or a qualified non-citizen
- Have investments and savings of less than $10,000
- Have a three month average income of less than 185% of the FPL
- Be uninsured for the previous six months, except for those leaving OHP/Medicaid
- Must not be eligible for or receiving Medicare

* Enrollment in both OHP and FHIAP at the same time is not allowed. This does not apply to TANF clients receiving cash assistance only (no medical coverage).

FHIAP members who have health insurance available to them through an employer are required to enroll in that coverage if the employer pays for any part of the premium. Members who have insurance through an employer (also called group insurance or ESI – employer-sponsored insurance) typically have their portion of the premium withheld from their paycheck. FHIAP reimburses them the subsidy portion after receiving proof that the premium was withheld (usually a copy of the pay stub). All other members, including those self-employed, can purchase a policy in the individual health insurance market from one of FHIAP's certified insurance companies. Eligibility for FHIAP enrollees is redetermined every 12 months.

FHIAP has immediate openings for those applicants who have health insurance available through their employer. Those without access to ESI must call FHIAP to be placed on a reservation list. The waiting period varies but is currently about six months.

People who don't qualify for OHP Standard benefit package coverage because of ESI may be eligible for FHIAP. These applications should be sent to FHIAP for eligibility determination. For more information about FHIAP, call 1-888-564-9669, or TTY 1-800-433-6313.

2. FHIAP Expansion, Federal Funding and Program Information

The 2001 Oregon Legislature passed House Bill 2519. Part of this Bill directed the state to create a waiver requesting federal matching funds for the FHIAP program and to expand the program. The expansion was implemented on November 1, 2002.

In 2006, the Insurance Pool Governing Board became the Office of Private Health Partnerships (OPHP), which administers the FHIAP program. Applicants should be directed to call FHIAP at 1-888-564-9669 or TTY 1-800-433-6313, Monday through Friday, 9 a.m. to 5 p.m. Additional FHIAP information can be found on the OPHP Web site at <www.ophp.oregon.gov>.

C. Oregon Medical Insurance Pool (OMIP)

OMIP is a high-risk health insurance pool that was established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions.

OMIP also provides a way to continue insurance coverage for those who exhaust COBRA benefits and have no other options.

To apply, call the customer service department number at 800-848-7280 and ask for an "OMIP Packet" or download an application at the Web site, <www.oregon.gov/DCBS/OMIP>.

D. The Oregon Prescription Drug Plan (OPDP)

OPDP is a statewide prescription drug purchasing pool that uses a discount card. All Oregonians may join. There is no cost to enroll. Average savings are 42%. All drugs prescribed by a licensed clinican are eligible for discounts.

To enroll by phone, call toll-free, 1-800-913-4146, or download a printed application for mailing to the program. Applicants will receive an ID card within a week and can take it to a member pharmacy with their prescriptions to receive the discount. <www.oregon.gov/DAS/OHPPR/OPDP/index.shtml>.

E. Early and Periodic Screening Diagnosis and Treatment (EPSDT) for Children and Teens

The Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, formerly called Medicheck, offers “well-child” medical exams with referral for medically and dentally necessary comprehensive diagnosis and treatment for all children (birth through age 20) covered by the OHP Plus Benefit Package.

As part of the application and reapplication process, workers should:

- Inform applicants about the EPSDT Program. Repeat this information at each redetermination of medical eligibility.
- If the child or teen is covered by other insurance, inform him or her that EPSDT may cover more services (e.g., well child exams, immunizations, dental services).
- Follow the branch procedure to help the client find a doctor or to obtain transportation.
- For CAF, help the applicant check the appropriate box under “You have a right to:” in the **Rights and Responsibilities** form and the EPSDT section of the application.
- For SPD, document in the case record that EPSDT information was given to the client.

F. Disease Case Management and Medical Case Management Programs

Fee-for-service OHP clients with specified, chronic conditions and high-utilization clients receive extra help managing their health care.

1. Disease Management Program

DMAP will place clients in the Disease Management Program if they have chronic physical conditions such as diabetes, asthma, chronic obstructive pulmonary disease, congestive heart failure or coronary artery disease. Clients with multiple diagnoses may also be placed in the program. At

this point, the program is voluntary and clients may opt out, if they wish, by contacting the DMAP Client Services Unit, 800-273-0557.

Client services include:

- 24-hour nurse triage line
- Telephonic education, assessment and coordination of care
- Provider coordination for symptom management and “care alerts”
- Home visits by nurses for referred clients
- Disease-specific educational mailings.

2. Medical Case Management Program

The Medical Case Management Program is for fee-for-service OHP clients who demonstrate high utilization or high cost utilization of health care services. This program offers all the services listed above, plus

- Management through pre-authorization of services
- Management of hospital utilization and coordination of discharge needs.

3. Case Descriptors

Program participation is designated by a “DCM” or “MCM” code in the TPR field in MMIS and on the DMAP Medical ID. However, DCM and MCM are not third party insurance, rather a supplemental benefit for fee-for-service OHP clients.

NOTE: OHP clients enrolled in managed care organizations and Medicare recipients are excluded from these programs on the premise that they receive these services from another source.

G. The Oregon Breast and Cervical Cancer Program

This Oregon BCC Program helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The Oregon BCC Program provides screening funds to promote early detection of breast and cervical cancer among Oregon's medically underserved individuals.

Call 877-255-7070, toll-free, to request information about free mammograms. <www.oregon.gov/DHS/ph/bcc>.

DMAP Worker Guide VII
Payment of Private Health Insurance Premiums

- Excluded groups
- Referral to DMAP
- Determining cost-effectiveness
- Hearings
- Forms

A. DMAP Payment of Private Health Insurance Premiums

DMAP pays clients' private health insurance (PHI) premiums when:

- The client is not in an "Excluded Group," and
- The PHI premium is determined cost-effective by DMAP

Use the information in this Worker Guide to determine the clients who should be referred to DMAP for PHI premium payments, and how to make the referral.

1. Excluded Groups

DMAP will not pay PHI premiums for clients who are:

- ♦ Non-SSI institutionalized and waivered clients whose income deduction (OHI on CMS) is used for payment of health insurance premiums;
- ♦ Eligible for reimbursement of cost-effective, employer-sponsored health insurance (OAR 461-135-0990)

2. Referral to DMAP

A case must be screened for PHI premiums and opened on CMS as OHP Plus eligible before sending a referral to DMAP.

PHI premium payment referrals must be sent to DMAP on the Premium Referral form (DMAP 3073). In order to comply with HIPAA requirements, PHI referrals must only be sent by shuttle or through the mail. Send completed forms to:

PHI Coordinator – CMU
DMAP– Operations
500 Summer St NE E44
Salem OR 97301-1079

When completing the DMAP 3073, do not leave any area blank, and if an area does not apply, write N/A. DMAP will return incomplete referrals to the branch office.

The following information/documentation is needed to complete the DMAP 3073:

- ♦ Premium amount
- ♦ Type of coverage (major medical, drugs, etc.)
- ♦ Name and address of insurance company
- ♦ Policyholder's name, group and policy number
- ♦ Who the checks are made out to (insurance company, employer, etc.), and the name and address where the checks should be sent
- ♦ Client information (name, case number, etc.)
- ♦ Medical documentation/information to justify continuing premium payment
- ♦ A signed and dated original of the Authorization for Use and Disclosure of Health Information (DHS 2099). If employer-sponsored insurance, DMAP needs a completed DHS 2099 for both the employer and the insurer. When completing the DHS 2099, remember: Sections A & B require the **policyholder**'s information.

- Section B—Include either individual or employer-sponsored insurance companies here (including COBRA) and the insurance company's address
- Section C should always list the DMAP PHI Coordinator's name and address as shown above
- Section D should be signed by the **policyholder** (or rep); add branch worker's name, agency and location

3. Determining Cost-Effectiveness

DMAP determines PHI premium payment cost-effectiveness by:

- Reviewing the clients past use of medical services under medical programs, third parties, and private insurance.
- Estimating the current and probable future health status of the client based on existing medical conditions or documentation.
- Evaluating the extent/limit of coverage available to the client under any health insurance policy, and the cost of the premium.

4. Hearings

Clients have the right to a hearing to dispute the use of PHI.

All hearings comply with DHS hearings rules and procedures.

Workers schedule pre-hearing conferences for DMAP.

Hearings are held over the phone. Prior to the hearing, DMAP prepares and sends hearing summaries to the parties involved.

B. PHI Forms

The following forms are available on the **DHS forms server.**

- Premium Referral for Private Health Insurance (PHI) DMAP 3073
- Authorization for Use & Disclosure of Information DHS 2099

DMAP Worker Guide VIII
Administrative Examinations and Reports

A. Administrative Medical Examinations and Reports

An Administrative Medical Examination is an evaluation required by the Department of Human Services (DHS) to help determine eligibility and casework planning for various programs. An examination can only be requested by the client's DHS caseworker.

An evaluation must be written and must contain a diagnosis, prognosis and supporting objective findings. Functional impairments and expected duration should also be included.

An Administrative Medical Report is a request for copies of existing records from a specified date. Progress notes, laboratory tests, X-ray reports, special test results and copies of other pertinent records should be included.

This section will help you:

- Decide when an administrative exam is appropriate.
- Select the appropriate report or examination procedure.
- Select an authorized provider.
- Assist providers to order additional ancillary services for diagnosis only.
- Process the report.

Examinations for determining eligibility for unemployability and disability are accepted **only** from:

- Medical doctors
- Osteopathic doctors
- Optometrists (99172 only)
- Licensed clinical psychologists
- Physical therapists and occupational therapists (97750 only)

Do not authorize an exam from nurse practitioners, speech therapists, naturopathic physicians, chiropractors, podiatrists, dentists, hearing aid dealers; they will not be paid.

Important ELGR coding

The ELGR screen must show that the client has medical eligibility before DMAP can pay the medical provider for an administrative medical examination or report request. The worker must ensure that the client's eligibility is shown on the ELGR screen. The worker can do this in one of the following ways:

- If the worker has determined the client medically eligible and opens the medical program case, a new ELGR screen will be created or updated during overnight processing, or
- If the worker has not yet determined the client's medical eligibility, the worker must mark the client as "case denied" in the CM system. It is necessary to mark the client as "case denied" because the system **will not** create or update an ELGR screen for cases that are pended. After the client is shown as "case denied" on the CM system, a new ELGR screen will be created or updated during overnight processing. The Client Maintenance Unit (CMU) will add medical eligibility to ELGR based on the administrative examination and report payment request from the provider.

1. Client Medical Documentation

Client medical documentation is needed to:

- Determine inability to maintain or seek employment.
- Determine total disability, incapacity, or unemployability.
- Aid in casework planning by the DHS worker and to determine appropriate client services.
- Exempt a client from JOBS participation because of physical or mental impairment.

Administrative examinations are NOT used for additional Mental Health testing, except as listed above, MD requests, or information requested by other agencies.

2. Selecting the Appropriate Examination

Determine if the case is initial or ongoing.

Using the matrix table, match the type of health problem with the appropriate examination procedure code. Follow the matrix to determine the proper examination or report, and the type of provider that can be paid for that service.

If the client is currently being treated or has been treated within the last 12 months for the stated complaint:

- Obtain copies of office records, or
- If the client has been hospitalized, obtain copies of admission and discharge records.

If the client has not been seen by a medical provider recently, arrange an appointment for an examination (see guideline tables to determine appropriate examination).

3. Selecting a Provider

Obtain the name of the client's medical provider.

If this provider is not the best choice to obtain needed information or if it is a provider type who cannot be paid, choose another provider (*e.g.*, if the client complains of heart problems, send to a cardiologist).

Determine if valid Medicaid provider type by accessing PRVX and PRV1 (see Computer Guide for instructions).

Order services only from authorized providers using the guideline tables.

Do not use an out-of-state provider unless PRV1 shows an active provider number.

4. Scheduling Appointments

The client schedules a medical appointment and provides the worker with the date and time, or if needed, the worker assists the client.

5. Completion of DMAP 729 series

The DMAP form 729 is a series of seven forms (links appear at the end of this guide) used to order medical procedures. Not all DHS agencies use every form in the 729 series.

Instructions to complete the DMAP 729 are on the back of the form.

Send appropriate DMAP 729s and a release of information to the provider.

No prior authorization is needed on ELGP. The DMAP 729 is the authorization.

6. Ordering DMAP Covered Ancillary Services

An ancillary service is ordered by the provider for the purpose of completing the administrative examination report. Ancillary services can be:

- X-rays
- Laboratory tests
- MRIs
- CAT scans; or
- Other special tests needed by the medical provider to document clinical diagnosis.

Ancillary providers should bill the appropriate CPT code and use the diagnosis code V68.89.

7. Processing the Provider Report

Determine if the report is as requested.

If the report is inadequate, request more information, but **do not** authorize additional payment.

CMS 1500 (formerly HCFA 1500) or UB-04 (billing forms) are sent directly to DMAP by the provider using the addresses at the bottom of the DMAP 729.

B. Determining Which Exam to Order

Decide if you are making an eligibility determination or doing casework planning. (You as a worker need the information; NOT that it has been requested by a medical provider.)

If the decision is at the initial level, follow the “initial” line in the matrix across to the type of health problem.

If the decision is a redetermination, follow the “ongoing” line in the matrix across to the type of health problem.

C. Matrix for Administrative Medical Examinations and Reports

Effective 1/1/07		Procedure Codes		
		Physical	**Mental Health**	**Eye**
Eligibility Determination	**Initial or Ongoing**	229 500 99080 99455 or 99456 S9981	229 919 90801 and 90889 99080 S9981 96111	99172
	Follow-up	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 and 90889 96101 96111 96118 99080 S9981	99172
Casework Planning Referrals to agencies Child placement Jobs planning SPD service planning	**Initial or Ongoing**	229 500 99080 99455 or 99456 S9981	229 919 90801 and 90889 96111 99080 S9981	99172
	Follow-up	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 and 90889 96101 96111 96118 99080 S9981	99172

D. Guidelines for the DMAP 729 Series

The following guidelines are to help you decide the appropriate examination or report to order. No prior authorization is needed for administrative medical exams and reports.

<table>
<tr><td rowspan="3">Revenue Code 229

Amount to be Billed
Usual Charge

Provider Type:
Hospital (HO)</td><td>Description</td><td>Medical records copying fee, administrative. Includes copies of Admitting History/ Physical, Admission Summary, Consultations, Operative and Other Reports, and Discharge Instruction Sheet and Discharge Summary for (date)_____ admission as checked on DMAP 729D.</td></tr>
<tr><td>Guidelines</td><td>(1) Use for initial or ongoing eligibility for client with a hospital stay within the last 60 days.
(2) Use for casework planning, if appropriate.</td></tr>
<tr><td>Hints</td><td>Use of DMAP 729D is required.</td></tr>
<tr><td rowspan="3">Revenue Code 309

Amount to be Billed:
$22.00

Provider Type:
Hospital (HO)</td><td>Description</td><td>Drug screen qualitative; multiple drug classes chromatographic method, each procedure or drug screen qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class. Only for Child Welfare and OYA clients.</td></tr>
<tr><td>Guidelines</td><td>(1) Use for drug screening for Child Welfare and OYA clients and parents.</td></tr>
<tr><td>Hints</td><td>To be used when the chosen provider is an outpatient hospital laboratory.</td></tr>
<tr><td rowspan="3">Revenue Code 309

Amount to be Billed:
$45.00

Provider Type:
Hospital (HO)</td><td>Description</td><td>Drug confirmation, each procedure. Only for Child Welfare and OYA clients.</td></tr>
<tr><td>Guidelines</td><td>(1) Used if screen testing is positive.</td></tr>
<tr><td>Hints</td><td>To be used when the chosen provider is an outpatient hospital laboratory.</td></tr>
<tr><td rowspan="3">Revenue Code 309

Amount to be Billed:
$15.00

Provider Type:
Hospital (HO)</td><td>Description</td><td>Alcohol and/or other drug testing, collection and handling, only specimen other than blood. Only for Child Welfare and OYA clients.</td></tr>
<tr><td>Guidelines</td><td>(1) Use for drug screening collection for Child Welfare and OYA clients only.</td></tr>
<tr><td>Hints</td><td>To be used when the chosen provider is an outpatient hospital laboratory.</td></tr>
</table>

Note: Procedure codes on this page are for **hospitals only**. Hospitals should use the UB-04 for billing.

Guidelines for the DMAP 729 series – continued

Revenue Code 424 Amount to be Billed: **Usual Charge** Provider Type: **Hospital (HO)**	Description	Physical performance test or measurement (*e.g.*, musculoskeletal, functional capacity), with written report, each 15 minutes.
	Guidelines	(1) Use to determine physical functional impairments and/or limitations as a supplement to the medical evaluation. (2) Use for casework planning, if appropriate.
	Hints	Medical Examination must also be obtained. Do not use DMAP 729E with this evaluation.
Revenue Code 434 Amount to be Billed: **Usual Charge** Provider Type: **Hospital (HO)**	Description	Physical performance test or measurement (*e.g.*, musculoskeletal, functional capacity), with written report, each 15 minutes.
	Guidelines	(1) Use to determine physical functional impairments and/or limitations as a supplement to the medical evaluation. (2) Use for casework planning, if appropriate.
	Hints	Medical Examination must also be obtained. Do not use DMAP 729E with this evaluation.
Revenue Code 500 Amount to be Billed: **Usual Charge** Provider Type: **Hospital (HO)**	Description	Work related or medical disability examination by the treating physician. See current CPT for details. ***OR*** Work related or medical disability examination by other than the treating physician. See current CPT for details.
	Guidelines	(1) Use to determine initial or ongoing eligibility for client with medical problem. (2) Use for casework planning, if appropriate.
	Hints	(1) To be used when the chosen provider is employed by a hospital. (2) 99080 Completion of Physical Residual Function Capacity Report form DMAP 729E can be billed at the same time.

Note: Procedure codes on this page are for **hospitals only**. Hospitals should use the UB-04 for billing.

Guidelines for the DMAP 729 series – continued

Revenue Code 918 Amount to be Billed: **Usual Charge** Provider Type: **Hospital (HO)**	Description	Description determined by testing requested by worker (see 96100).
	Guidelines	(1) Use for initial or ongoing eligibility for client with mental health problems. (2) Use for casework planning, if appropriate. (3) Use for any mental health testing with narrative report per description of service and performed by psychologist or psychiatrist employed by the hospital.
	Hints	To be used when the chosen provider is employed by a hospital.
Revenue Code 919 Amount to be Billed: **Usual Charge** Provider Type: **Hospital (HO)**	Description	Description determined by examination requested by worker (see 90801 or H1011).
	Guidelines	(1) Use for initial or ongoing eligibility for client with mental health problems. (2) Use for casework planning, if appropriate. (3) Use for comprehensive evaluation with narrative report per description of service and performed by psychologist or psychiatrist employed by the hospital.
	Hints	To be used when the chosen provider is employed by a hospital.

Note: Procedure codes on this page are for **hospitals only**. Hospitals should use the UB-04 for billing.

Guidelines for the DMAP 729 series – continued

Procedure	Section	Details
Procedure Code: 97750 Amount to be Billed: **$20.50** Provider Type: **Physical Therapists, Occupational Therapists, (PT, OT, PB, IH)**	Description	Physical performance test or measurement (*e.g.,* musculoskeletal, functional capacity), with written report, each 15 minutes. Limited to 1 hour.
	Guidelines	(1) Use to determine physical functional impairments and/or limitations as a supplement to the medical evaluation (2) Use for casework planning, if appropriate.
	Hints	(1) Medical examination must also be obtained. (2) If no facility to perform PCE is available then see 99080. (3) Do not use DMAP 729E with this evaluation.
Procedure Code: 99172 Amount to be Billed: **$85.64** Provider Type: **Medical Doctors, Ophthalmologists, Optometrists (PB, OD, MD, IH)**	Description	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision, with completion of the report on eye examination (DMAP 729C). See current CPT for details.
	Guidelines	(1) Use for initial or ongoing eligibility for client with eye or vision problem. (2) Use for casework planning, if appropriate.
Procedure Code: 96101 Amount to be Billed: **$50.34** Provider Type: **Medical Doctors, Psychiatrists, Psychologists (PY, PB, MC, IH, MD w/specialty in PS, PN, CH)**	Description	Psychological testing with interpretation and report, per hour. See current CPT for details. Limited to 6 hours per day.
	Guidelines	(1) Use for initial or ongoing eligibility to determine mental retardation or ability to grasp facts and figures. (2) Use for casework planning, if appropriate.

Guidelines for the DMAP 729 series – continued

Procedure Code: 90801 Amount to be Billed: **$207.60** Provider Types: **Medical Doctors, Psychiatrists, Psychologists (PY, PB, MC, PB, MD w/specialty in PS, PN, CH)**	Description	Psychiatric diagnostic interview, examination. See current CPT and CPT Assist Volume II, Issue 3, March 2001 for details. Narrative report (90889) per recommended outline in Comprehensive Psychiatric or Psychological Evaluation (DMAP 729A). OR Use for psychosexual evaluation including assessment of history and degree of offending behavior, cognitive distortions, empathy, hostility, compulsivity and impulsivity. Only for Child Welfare, OYA, and DD Services clients.
	Guidelines	(1) Use for initial or ongoing eligibility for client with mental health problem. (2) Use for casework planning, if appropriate.
	Hints	99080 Completion of Mental Residual Function Capacity Report DMAP 729F and or Rating of Impairment Severity Report DMAP 729G can be billed at the same time.
Procedure Code: 99080 Amount to be Billed: **$31.20** Provider Types: **Medical Doctors, Psychiatrists, Psychologists (PY, PB, IH, MC, MD)**	Description	Special reports. See current CPT for details. Use for Physical Residual Function Capacity Report (DMAP 729E). Use for Mental Residual Function Capacity Report (DMAP 729F). Use for Rating of Impairment Severity Report (DMAP 729G). Used during examinations or based on existing records.
	Guidelines	(1) Use to determine initial or ongoing eligibility for GA, or (2) Use to determine initial or ongoing eligibility for disability. (3) Not paid in addition to 90801, 90889.
	Hints	(1) If used during an examination, can only be used in conjunction with 99455 or 99456. (2) Use of DMAP 729E and/or DMAP 729F and/or DMAP 729G is required

Guidelines for the DMAP 729 series – continued

<table>
<tr><td rowspan="3">Procedure Code: S9981

Amount to be Billed:
$18.00

Provider Types:
(PB, MD, CR, CP, SC, PY, MC)</td><td>Description</td><td>Medical records copying fee, administrative. Include progress notes, laboratory reports, X-ray reports, and special study reports since (date)_______. Include recent hospital admission records if available.</td></tr>
<tr><td>Guidelines</td><td>(1) Use for initial or ongoing eligibility when client has been in the hospital or has had a history and physical in the last 60 days.</td></tr>
<tr><td>Hints</td><td>Use of DMAP 729D is optional.</td></tr>
<tr><td rowspan="3">Procedure Code: 99455

Amount to be Billed:
$151.02

Provider Types:
Medical Doctors, Osteopaths, Psychologists, Ophthalmologists, Optometrists (MD, PB, IH)</td><td>Description</td><td>Work related or medical disability examination by the treating physician. See current CPT for details. May be paid in addition to 99080.</td></tr>
<tr><td>Guidelines</td><td>(1) Use to determine initial or ongoing eligibility for client with medical problem.
(2) Use for casework planning, if appropriate.
(3) Use for referral to specialist for consultation.</td></tr>
<tr><td>Hints</td><td>(1) Have the client make appointment with physician and notify worker. Or, if possible, make a doctors appointment at time of interview with client.
(2) 99080 completion of Physical Residual Function Capacity Report form DMAP 729E can be billed at the same time.</td></tr>
<tr><td rowspan="3">Procedure Code: 99456

Amount to be Billed:
$151.02

Provider Types:
Medical Doctors, Osteopaths, Psychologists, Ophthalmologists, Optometrists (MD, PB, IH)</td><td>Description</td><td>Work related or medical disability examination by other than the treating physician. See current CPT for details. May be paid in addition to 99080.</td></tr>
<tr><td>Guidelines</td><td>(1) Use to determine initial or ongoing eligibility for client with medical problem.
(2) Use for casework planning, if appropriate.
(3) Use for referral to specialist for consultation.</td></tr>
<tr><td>Hints</td><td>(1) Have the client make appointment with physician and notify worker. Or, if possible, make a doctors appointment at time of interview with client.
(2) 99080 completion of Physical Residual Function Capacity Report form DMAP 729E can be billed at the same time.</td></tr>
</table>

Guidelines for the DMAP 729 series – continued

Procedure	Field	Details
Procedure Code: 96118 Amount to be Billed: **$50.34** Provider Types: **Psychologists (MD, PY, PB, MC, IH)**	Description	Neuropsychological testing battery (*e.g.*, Halstead-Reitan Neuropsychological battery, Wechsler memory scales and Wisconsin card scoring test) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing report.
	Guidelines	(1) Use to determine initial and ongoing eligibility to determine extent of brain damage in severely affected clients through neuropsychological testing. (2) Use for casework planning, if appropriate. (3) Paid in combination with 90801, 90889 if required.
Procedure Code: 96111 Amount to be Billed: **$99.39** Provider Types: **PY**	Description	Development testing, extended with interpretation and report, per hour, up to 5 hours. See current CPT for details.
	Guidelines	(1) Use for eligibility or casework planning to determine if an individual is a person with mental retardation. (2) Only for DD clients. (3) May be combined with 96100 (cognitive testing) only if needed to determine mental retardation, and only then when approved by the worker's supervisor or program policies. (4) Current results of both tests (96100 cognitive testing & 96111 adaptive testing) are needed for diagnosis of mental retardation, one or the other may have been completed by school, psychiatric hospital, or other providers of residential services. Request records.
Procedure Code: 90889 Amount to be Billed: **$50.00** Provider Types: **PY, MD, MC, IH, CR, CP**	Description	Preparation of report of patient's psychiatric status, history, treatment or progress. See current CPT for details. Use in conjunction with 90801 only.
	Guidelines	(1) Use for eligibility or casework planning. (2) Must request in conjunction with 90801 only.

Guidelines for the DMAP 729 series – continued

Procedure	Field	Details
Procedure Code: PIN02 Amount to be Billed: **$154.92** Provider Types: **PP, MM**	Description	Polygraph testing by licensed polygrapher with narrative report.
	Guidelines	(1) Polygraphers must be enrolled with OMAP and licensed by the Bureau of Police Standard and Training. (2) Signed consent forms may be required. Refer to Child Welfare Policy I-D.6.2.
Procedure Code: 54240 Amount to be Billed: **$206.56** Provider Types: **PY, PB, MD, MC, CR, CP**	Description	Penile Plethysmography.
	Guidelines	(1) Signed consent forms may be required. Refer to Child Welfare Policy I-D.6.2. (2) Only for Child Welfare, OYA, and DD Services clients.
Procedure Code: 80100 Amount to be Billed: **$22.00** Provider Types: **PB, NP, ND, MD, IL, IH, CR, AS**	Description	Drug screen qualitative, multiple drug classes, chromatographic method, each procedure. Only for Child Welfare and OYA clients.
	Guidelines	(1) Use for drug screening for Child Welfare or OYA clients and parents. (2) Paid in combination with H0048 if required.
Procedure Code: 80101 Amount to be Billed: **$22.00** Provider Types: **PB, NP, ND, MD, IL, IH, CR, AS**	Description	Drug screen qualitative, single drug class method, each drug class. Only for Child Welfare and OYA clients.
	Guidelines	(1) Use for drug screening for Child Welfare or OYA clients and parents. (2) Paid in combination with H0048 if required.
Procedure Code: 80102 Amount to be Billed: **$45.00** Provider Types: **PB, NP, ND, MD, IL, IH, CR, AS**	Description	Drug confirmation, each procedure. Only for Child Welfare or OYA clients.
	Guidelines	(1) Use if screen testing is positive. (2) Use for Child Welfare or OYA clients and parents.

Guidelines for the DMAP 729 series – continued

Procedure Code: H0048 Amount to be Billed: **$15.00** Provider Types: **PB, NP, ND, MD, IL, IH, CR, AS, AC**	Description	Alcohol and/or other drug testing; collection and handling, only specimen other than blood. Only for Child Welfare or OYA clients.
	Guidelines	(1) Use for drug screening collection for Child Welfare and OYA clients and parents. (2) Paid in combination with 80100 and/or 80101 if required.
Procedure Code: H1011 Amount to be Billed: **$250.00** Provider Types: **Medical Doctors, Psychiatrists, Psychologists (PY, PB, IH, MC, MD w/specialty in PS, PH, CH)**	Description	Family assessment by licensed behavioral health professional for state defined purposes. Use in combination with 96100 if needed. Only for Child Welfare and OYA clients.
	Guidelines	(1) Use to evaluate parenting abilities for ASFA determinations and other Child Welfare and OYA programs. (2) Paid in combination with 96100 if needed.

E. DMAP 729 Series Forms

The 729 series of forms are found on the DHS forms server**.**

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

DMAP Worker Guide IX
Prior Authorization

- PA authorities and contact numbers
- Authorizing services on the computer system
- MMIS screens

A. Prior Authorization

Some medical services and equipment require prior authorization (PA) by various DHS agencies or the client's managed care plan before they can be delivered to a client. These services and equipment include:

- Non-emergency medical transportation (including client mileage, meals and lodging)
- 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
- Some transplants
- Out-of-state services
- Some surgeries

1. Where to get prior authorization

The charts on the next pages list services requiring prior authorization and who can authorize those services for which populations. Procedures for processing PAs are the same for all benefit packages, except when a client is in a managed care organization (MCO) that covers the service. If a client belongs to an MCO, the provider should contact the plan directly for prior authorization on health care services covered under the client's benefit package.

If a primary care provider refers a client to an out-of-state provider, be sure that service has the needed prior authorization.

Client Group	Services Authorized	Responsible Authority
All clients enrolled in an MCO when the service is included in the plan's contract	All services for which the plan receives a capitation payment	Managed Care Organization (MCO)
DHS clients for non-emergency medical transportation (for clients enrolled in an FCHP or PCO, the plan is responsible for all ambulance, including non-emergency)	Transportation	Local contracted transportation brokerage or DHS branch staff in counties where no brokerage is contracted
Children in subsidized adoption	Medical Transportation; Administrative Exams	DMAP Claims Management
SPD clients not enrolled in an MCO	Medical Transportation	SPD branch staff
All clients not enrolled in an MCO Any client receiving a therapeutic class 7 or 11 drug	Drugs related to National Drug Codes (NDCs); Oral nutritional supplements	First Health Services
CAF and SPD clients not enrolled in an MCO or Medically Fragile Children[1] and DHS FFS Medical Case Management[2] clients	Durable Medical Equipment (DME) and Supplies (for specific items, see OAR 410-125); Physical/Occupational Therapy (OAR 410-131);Private Duty Nursing Home Health (OAR 410-132); Speech and Hearing (for specific items see OAR 410 Division 129); Visual Services (OAR 410-140); Home Eneral/Parenteral IV (OAR 410-148)	DMAP Medical Unit
DHS clients not enrolled in a Dental Care Organization or an MCO which covers dental	Dental services	DMAP Dental Coordinator
DHS clients not enrolled in an MCO	Transplants Out-of-state services	DMAP Clinical Unit
DHS clients not enrolled in an MCO	Surgeries and services listed in OAR 410 Division 130 and Supplement as requiring Acumentra prior authorization	Acumentra (formerly OMPRO)
Children case managed by the MFCU and identified with a case descriptor MFC	All medical services requiring prior authorization, except transportation, transplants, out-of-state services, dental and visual services	[1] Medically Fragile Children's Unit
DHS FFS Medical Case Management[2] clients	All medical services requiring prior authorization	[2] Innovative Care Management (ICM)

Prior Authorization Contacts
Fee-for-service, FFS or “open card”

(*i.e.,* for services *not* covered by a Managed Care Organization)

Service	PA Authority	Phone/Fax
Dental	DMAP Dental Coordinator	800-527-5772 or 503-945-6506
Drugs/pharmacy and EPIV oral nutritional supplements only	First Health Managed Access Program (MAP)	800-344-9180 800-250-6950 Fax
Durable medical equipment/supplies Hearing aid services Home health (nursing only) Home enteral/parenteral (except oral supplements) Physical/occupational therapy Speech, hearing, audiology	**Medically Fragile Children:** FMC Unit **Medical Case Management clients:** Innovative Care Management (ICM) 10117 SE Sunnyside Rd, Box F409 Clackamas, OR 97015 **All other clients:** DMAP Medical Unit	971-673-2985 or 971-673-3000 971-673-2971 Fax 800-862-3338 or 503-654-9447 503-654-8570 Fax 800-642-8635 or 503-945-6821 503-378-5814 Fax
Out-of-state services	DMAP Clinical Unit	503-945-5802
Surgical procedures	**Medical Case Management clients:** Innovative Care Management (ICM) 10117 SE Sunnyside Rd, Box F409 Clackamas, OR 97015 **All other clients:** Acumentra Health 2020 SW Fourth Ave, Ste 520 Portland 97201	800-862-3338 or 503-654-9447 503-654-8570 Fax 800-452-1250 or 503-279-0159 from outside Oregon 800-325-8933 503-279-0190 Fax
Transplants	**Medical Case Management clients:** Innovative Care Management (ICM) 10117 SE Sunnyside Rd, Box F409 Clackamas, OR 97015 **All other clients:** DMAP Clinincal Unit	800-862-3338 or 503-654-9447 503-654-8570 Fax 503-945-6488
Transportation	Local transportation brokerage or branch	See DMAP Worker Guide XII
Vision	DMAP Medical Unit	800-642-8635 or 503-945-6821 503-378-5814 Fax

B. Authorizing Services on Computer System

For medical services branch staff must:

- Determine if the client is eligible.
- Determine the client's benefit package.
- Determine if the client is in a managed health care plan and, if so, which plan (ELGX and KON1 screens).
- Determine if procedure codes and diagnosis codes are valid; (LVL3-DIAG screen).
- Check the list to find out where the diagnosis/treatment pair is in relation to the OHP Prioritized List cutoff line (HSCX screen).

How It Works

Step 1 – Is the client medically eligible and does the client's Benefit Package include the service being requested? (ELGR)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to Step 2.

Step 2 – Is the client enrolled in a managed care plan? (ELGX)

No – Go the step 3.

Yes – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Step 3 – Is the client in a long-term care facility? (ELGF)

No – Go to Step 4.

Yes – Review the provider guide to determine if the service is in the all inclusive rate. If it is in the all inclusive rate, deny the request. (See Section 10-denial codes) If it is not all inclusive, proceed to step 4.

Step 4 – Is the procedure code valid? (LVL3)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 5.

Step 5 – Is the diagnosis code valid? (DIAG)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 6.

Step 6 – Is the service covered by the Oregon Health Plan prioritized list and included in the client's benefit package? (Use HSCX to determine if diagnosis/treatment pairing is a benefit according to the Health Services Commission Prioritized List. Prioritized List reflects diagnosis and procedures that may not be a covered benefit for DMAP.)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 7.

Step 7 – Process the request using the appropriate MMIS screen (ELGP) and provider rules.

C. MMIS Screens

The following screens are used in prior authorizing services for OHP clients. Please refer to the *CAF Computer Guide*, Chapter XXII, for specific screen information.

- OHPS – A menu of OHP screens.
- HSCX – Entering a diagnosis and procedure code for the date of service identifies whether a treatment is above or below the line. However, the diagnosis and procedure code must be verified on the DIAG and LVL3 screens and indicate an active status for MMIS payment.
- ELGR – To verify Medicaid eligibility and benefit package.
- ELGX – Indicates whether a client is enrolled or is being enrolled in a plan or has private insurance.
- KON1 – The names and pertinent information on plans.
- ELGP – Prior authorization screen. The computer will automatically furnish the PA number and generate a notice of approval or denial to the client, provider, and branch.
- DIAG – Indicates if this diagnosis code has an active status for MMIS payment.
- LVL3 – Indicates if this procedure code has an active status for MMIS payment.
- XREF – To locate a client by name or Social Security number.
- ELGF – Long Term Care indicates current and historical information about a client's stay in a nursing facility.
- MEDC – Indicates medical criteria that affect the adjudication of claims.
- PRVX – To locate a provider by name.
- PRV1 – Used to identify provider eligibility.

DMAP Worker Guide X
Service Denial Codes

A. Service Denial Codes

When you deny a medical service, including medical transportation, you can use the ELGP screen to send the denial. These are the codes used to send the denial.

Dental—page 2

DME—page 5

General Rules/OHP—page 16

Home Health/EPIV—page 20

Medical Transportation—page 22

Therapy Services (OT, PT, Speech)—page 24

B. Dental Denial Codes

Code	Description
L01	The client is not currently eligible for medical assistance coverage. The provider must verify that the individual receiving services is eligible on the date of service and for the service provided. (General rules OAR 410-120-1140, OAR 410-120-1320)
L02	The diagnosis for which the dental services were requested is not covered by the Oregon Health Plan. (OHP Admin. Rules – OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)
L03	The dental services requested are not covered under the OHP Standard Benefit Package. Services are limited to emergency dental services requiring immediate treatment. (Dental Services – OAR 410-123-1085, OAR 410-123-1670, Table 123-1670-1, General Rules OAR 410-120-1210)
L04	DMAP will not pay for dental services when the client is enrolled in a DCO. Please contact the client's *dental* plan. (Dental Services – OAR 410-123-1160, OAR 410-123-1600, OHP Administrative Rules OAR 410-141-0420, General Rules – OAR 410-120-0250, OAR 410-120-1140)
L05	DMAP will not pay for services when the client is enrolled in a *prepaid health plan* that covers the service. Please contact the client's plan. (General Rules OAR 410-141-0420)
L06	DMAP will not cover dental treatment for the client's condition when the prognosis is unfavorable, treatment impractical or there is a less costly procedure that would achieve the same ultimate result. (Dental Services – OAR 410-123-1100, OAR 410-123-1260, General Rules OAR 410-120-1200)
L07	The clinical information provided does not support the treatment or services requested. (Dental Services – OAR 410-123-1100, OAR 410-123-1260, General Rules OAR 410-120-0000)
L08	Dental Services provided outside of an Emergency Department Hospital setting are not covered for CAWEM clients, even if they are seeking emergency services. (General Rules – OAR 410-120-1210)

Code	Description
L09	DMAP did not receive the required documentation from the provider to determine eligibility for the requested dental services. (Dental Services – OAR 410-123-1100, OAR 410-123-1160, OAR 410-123-1260, General Rules – OAR 410-120-1320, OAR 410-120-0000)
L10	The service requested is not covered separately as it is considered minimal, included in the examination, part of another service, or included in routine post-op or follow-up care. (Dental Services - OAR 410-123-1200)
L11	DMAP does not cover the requested procedure(s). (Dental Services – OAR 410-123-1220, Table 123-1260-1)
L12	Payment for crowns for posterior teeth, permanent or primary is limited to stainless steel crowns. (Dental Services, OAR 410-123-1260(10)
L13	Payment for preparation of the gingival tissue for crown placement is not separately payable. (Dental Services, OAR 410-123-1260(10)
L14	Crowns are covered only when there is significant loss of clinical crown and no other restoration will restore function. The documentation provided does not support that this criteria has been met. (Dental Services, OAR 410-123-1260(10)
L15	Crown replacement is limited to one every five years per tooth unless exception criteria in OAR 410-123-1260(10) are met.
L16	The endodontic treatment (root canal therapy) requested is not covered because it does not meet the criteria allowing coverage in OAR 410-123-1260(11).
L17	Retreatment of a root canal is not covered for bicuspid or molars. (Dental Services – OAR 410-123-1260)
L18	Retreatment is limited to anterior teeth and only when criteria in OAR 410-123-1260(11) are met.
L19	Root canal therapy is not covered for third molars. (Dental Services – OAR 410-123-1260)
L20	Dentures (partial, complete or immediate) are limited to clients age 16 or older. (Dental Services – OAR 410-123-1260)

Code	Description
L21	Replacement of dentures and partial dentures is limited to once every five years and only if dentally appropriate. This limitation applies regardless if the client is enrolled in a dental care organization or fee-for-service. (Dental Services OAR 410-123-1260)
L22	Replacement of partial dentures with full dentures is payable five years after the partial denture placement, unless the client meets the exception criteria in OAR 410-123-1260(13).
L23	Cast partial dentures are not covered if stainless steel crowns are used as abutments. (Dental Services – OAR 410-123-1260)
L24	Cast partial dentures must have one or more anterior teeth missing or four or more posterior teeth missing per arch. Third molars are not a consideration when counting missing teeth. (Dental Services – OAR 410-123-1260)
L25	Orthodontia services are limited to eligible clients with a diagnosis of cleft palate with cleft lip. (Dental Services – OAR 410-123-1260)
L26	This service is not covered by DMAP for clients with Citizen/Alien-Waived Emergency Medical (CAWEM) coverage. (General Rules OAR 140-120-0000, OAR 140-120-1200, OAR 410-120-1210, Dental – OAR 410-123-1000, OAR 410-123-1540)
L27	The criteria allowing coverage for hospital dental services have not been met. (Dental Services – OAR 410-123-1490, OHP Admin. Rules – OAR 410-141-0480)

C. Durable Medical Equipment (DME) and Supplies Denial Codes

Code	Description
D01	Invalid or missing order for requested item. The written order must include all elements identified in OAR 410-122-0020. (DME OAR 410-122-0020)
D02	The OHP client is enrolled in a prepaid health plan. Please contact the prepaid health plan for authorization procedures. (DME OAR 410-122-0040, OHP Admin. Rules OAR 410-141-0420)
D03	DMAP did not receive the required documentation from the provider to determine eligibility for this item/service. A request was sent to the provider for additional information. (General Rules OAR 410-120-1320, OAR 410-120-0000, DME OAR 410-122-0184, OAR 410-122-0186)
D04	Prior Authorization is not required for Medicare covered services. (General Rules OAR 410-120-1340, DME OAR 410-122-0040)
D05	No documentation provided of timely appeal with Medicare. If Medicare denies coverage on appeal, DMAP criteria will apply in determining coverage. (DME OAR 410-122-0080)
D06	Prior authorization request for services provided after hours was not submitted within five working days from the initiation of service. (DME OAR 410-122-0040)
D07	The items/supplies requested are not covered by the OHP Standard Benefit package. The OHP Standard benefit package limits coverage for durable medical equipment, prosthetics, orthotics and supplies to those items/supplies identified in OAR 410-122-0055, Table 122-055. (DME OAR410-122-0055, General Rules OAR 410-120-1210)
D08	DMAP does not pay for durable medical equipment, prosthetics, orthotics or medical supplies that have not been approved for marketing by the Food and Drug Administration (FDA) as safe and effective for the purpose intended. (DME OAR 410-141-0080, General Rules OAR 410-120-1200)
D09	The requested item is not covered as the diagnosed medical condition for which the item was requested does not appear on a funded line of the Prioritized List of Health Services. (OHP Admin. Rules OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520, DME OAR 410-122-0080)

Code	Description
D10	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item or the use of the item is not primarily medical in nature. (DME OAR 410-122-0080)
D11	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item or the use of the item is for personal comfort or convenience of the client or caregiver. (DME OAR 410-122-0080)
D12	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item is inappropriate or unsuitable for home use. (DME OAR 410-122-0080)
D13	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item is a self-help device. (DME OAR 410-122-0080)
D14	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item or the use of the item is not therapeutic or diagnostic in nature. (DME OAR 410-122-0080)
D15	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item or the use of the item is for precautionary reasons. (DME OAR 410-122-0080)
D16	DMAP does not cover durable medical equipment, prosthetics, orthotics, or medical supplies when the item or the use of the item is for a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines. (DME OAR 410-122-0080)
D17	DMAP does not cover DME, prosthetics, orthotics, or medical supplies included in the all-inclusive nursing facility rate, part of a home and community based care waiver service, or by any public, community or third party resource. (OAR 410-122-0080, OAR 410-120-1340, OAR 411-070-0085)
D18	The information submitted does not substantiate the item/service is the least costly alternative that will meet the client's medical needs. (General Rules 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, DME OAR 410-122-0186)

Code	Description
D19	The information submitted does not substantiate the medical appropriateness for the service provided/requested. (General Rules – OAR 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, DME OAR 410-122-0080)
D20	Medical supplies are not separately payable to a DMEPOS provider while a client with Medicare Part A coverage is under a home health plan of care and covered home health care services. (DME OAR 410-122-0080, Hospice -OAR 410-142-0120)
D21	Medical supplies are not separately payable while a client is under a hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, DMAP or other carrier. (DME OAR 410-122-0080)
D22	The requested item is excluded from coverage. The items listed in Table 122-0080 do not meet the requirements under DMEPOS rules for purchase, rent or repair of equipment or items. (DME OAR 410-122-0080, General Rules OAR 410-120-1200, OHP Admin. Rules OAR 410-141-0480, OAR 410-141-0500)
D23	Incorrect/No HCPCS code provided with this request. The appropriate HCPCS code must be used to identify the items requested. (DME OAR 410-122-0180, OAR 410-122-0190)
D24	These procedure codes are bundled within another code and are not separately payable. (DME OAR 410-122-0180, OAR 410-122-0080)
D25	This item is considered to be paid after 13 consecutive months of rental by the same provider or when purchase price is reached. (Legend – OAR 410-122-0182)
D26	DMAP does not cover repairs that exceed the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need. (DME OAR 410-122-0184)
D27	DMAP does not cover repairs to equipment when the skill of a technician is not required; or the equipment has been previously denied; or the equipment is being rented; or parts and labor are covered under a manufacturer’s or supplier’s warranty. (DME OAR 410-122-0184)

Code	Description
D28	DMAP does not cover walker gliders, oxymiser cannulas, hydraulic bathtub lifts, or heavy duty or extra-wide rehab shower/commode chairs for client's residing in a nursing facility. (Miscellaneous Durable Medical Equipment and Supplies – OAR 410-122-0190, Table 122-0190, Legend – OAR 410-122-0182)
D29	DMAP does not cover maintenance/service for rented equipment. (DME OAR 410-122-0184)
D30	The criteria allowing coverage for a pulse oximeter and/or related items has not been met. (Pulse Oximeter - OAR 410-122-0200)
D31	The criteria allowing coverage for a continuous positive airway pressure device (CPAP) and/or CPAP related accessories has not been met. CPAP System - OAR 410-122-0202, Table 122-0202, Legend – OAR 410-122-0182)
D32	CPAP cannot be converted to purchase without recent documentation of efficacy and compliance from the physician. (CPAP – OAR 410-122-0202)
D33	This request exceeds limitations for CPAP and BiPAP accessories. Maximum number of services approved per limitations specified in rule. (CPAP - OAR 410-122-0202, Respiratory Assist Devices – OAR 410-122-0205, Legend - OAR 410-122-0182)
D34	The criteria allowing coverage for oxygen and oxygen equipment has not been met. (Oxygen and Oxygen Equipment – OAR 410-122-0203, Table 122-0203, Legend - OAR 410-122-0182)
D35	Oxygen therapy is not covered for this diagnosed medical condition. (Oxygen and Oxygen Equipment – OAR 410-122-0203)
D36	The criteria allowing coverage for respiratory assist devices and/or supplies has not been met. (Respiratory Assist Devices – OAR 410-122-0205, Table 122-0205-1, Table 122-205-2, Table 122-207, Legend – OAR 410-122-0182)
D37	The criteria allowing coverage for a ventilator and/or supplies has not been met. (Ventilators - OAR 410-122-0210, Table 122-0210, Legend - OAR 410-122-0182)
D38	The criteria allowing coverage for an apnea monitor for infants has not

Code	Description
	been met. (Apnea Monitors for Infants – OAR 410-122-0240, Table 122-0240, Legend – OAR 410-122-0182)
D39	The criteria allowing coverage for a breast pump has not been met. (Breast Pumps – OAR 410-122-0250)
D40	The criteria allowing coverage for bilirubin light therapy and/or supplies has not been met. (Light Therapy – OAR 410-122-0300, Table 122-0300, Legend - OAR 410-122-0182)
D41	The criteria allowing coverage for a manual wheelchair has not been met. (Manual Wheelchair Base – OAR 410-122-0320, Table 122-0320, Legend - OAR 410-122-0182)
D42	DMAP does not reimburse for another wheelchair if the client has a medically appropriate wheelchair that meets his/her needs. (Manual Wheelchair – OAR 410-122-0320, Power Wheelchair – OAR 410-122-0325, POV – OAR 410-122-0330, Pediatric Wheelchair – OAR 410-122-0720)
D43	The client's living quarters must be able to accommodate and allow for effective use of the requested wheelchair/POV. (Manual Wheelchair OAR 410-122-0320, Power Wheelchair OAR 410-122-0325, POV - OAR 410-122-0330, Pediatric Wheelchair OAR 410-122-0720)
D44	DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. (Manual Wheelchair Base – OAR 410-122-0320, Power Wheelchair – OAR 410-122-0325, Pediatric Wheelchairs – OAR 410-122-0720,Wheelchair Options/Accessories – OAR 410-122-0340)
D45	The records provided indicate the client does not meet the criteria allowing coverage for a manual adult tilt-n-space wheelchair. (Manual Wheelchair Base – OAR 410-122-0320, Table 122-0320, Legend – OAR 410-122-0182)
D46	The records provided indicate the client does not meet the criteria allowing coverage for a lightweight wheelchair. (Manual Wheelchair Base – OAR 410-122-0320, Table 122-0320, Legend – OAR 410-122-0182)
D47	The records provided indicate the client does not meet the criteria allowing coverage for a high-strength lightweight wheelchair. (Manual Wheelchair

Code	Description
	Base – OAR 410-122-0320, Table 122-0320, Legend - OAR 410-122-0182)
D48	The records provided indicate the client does not meet the criteria allowing coverage for a heavy-duty wheelchair. (Manual Wheelchair – OAR 410-122-0320, Table 122-0320, Legend – OAR 410-122-0182)
D49	The records provided indicate the client does not meet the criteria allowing coverage for an extra heavy-duty wheelchair. (Manual Wheelchair – OAR 410-122-0320, Table 122-0320, Legend – OAR 410-122-0182)
D50	DMAP will not cover a wheelchair or POV for use only outside the home. Coverage is determined by the client's mobility needs within the home. (Manual Wheelchair - OAR 410-122-0320, Power Wheelchair - OAR 410-122-0325, POV - OAR 410-122-0330 Pediatric Wheelchair - OAR 410-122-0720)
D51	DMAP did not receive the required documentation from the provider to determine eligibility for the requested wheelchair or POV. (OAR 410-120-1320, OAR 410-120-0000, OAR 410-122-0320, OAR 410-122-0325, OAR 410-122-0330, OAR 410-122-0720)
D52	The criteria allowing coverage for a motorized/power wheelchair has not been met. (Power Wheelchair – OAR 410-122-0325, Table 122-0325, Pediatric Wheelchair – OAR 410-122-0720, Legend – OAR 410-122-0182)
D53	No documentation or written report provided showing the treating physician conducted a face-to-face examination of the client before writing the order and prior to delivery of the equipment. (Power wheelchair – OAR 410-122-0325, POV – OAR 410-122-0330)
D54	The criteria allowing coverage for a power-operated vehicle (POV) has not been met. (POV – OAR 410-122-0330, Table 122-0720, Legend – OAR 410-122-0182)
D55	The criteria allowing coverage for the requested wheelchair accessories has not been met. The client must have a wheelchair that meets DMAP criteria, and requires the accessories to accomplish their mobility-related activities of daily living in the home. (OAR 410-122-0340, OAR 410-122-0010, OAR 410-122-0720, Table 122-0340, OAR 410-122-0182)
D56	The criteria allowing coverage for the requested wheelchair options/accessories has not been met. (Wheelchair Options/Accessories –

Code	Description
	OAR 410-122-0340, Pediatric Wheelchairs – OAR 410-122-0720, Table 122-0340, Table 122-0720, Legend – OAR 410-122-0182)
D57	DMAP did not receive the required documentation from the provider to determine eligibility for the requested wheelchair options/accessories. (General Rules OAR 410-120-1320, OAR 410-120-0000, Wheelchair Options/Accessories – 410-122-0340, Pediatric Wheelchairs – OAR 410-122-0720)
D58	DMAP does not cover a standing or positioning aid if the client already has one that meets his/her medical needs, regardless of who obtained it. (Standing and Positioning Aids – OAR 410-122-0365)
D59	The criteria allowing coverage for standing frame systems, prone standers, supine standers or boards and accessories for standing frames has not been met. (Standing and Positioning Aids – OAR 410-122-0365, Table 122-0365, Legend – OAR 410-122-0182)
D60	The criteria allowing coverage for sidelyers and custom positioners has not been met. (Standing and Positioning Aids – OAR 410-122-0365, Table 122-0365, Legend – OAR 410-122-0182)
D61	The criteria allowing coverage for the requested standing and positioning aids accessory has not been met. (Standing and Positioning Aids – OAR 410-122-0365)
D62	DMAP did not receive the documentation required in OAR 410-122-0380 to determine eligibility for the requested hospital bed (OAR 410-120-1320, OAR 410-120-0000, OAR 410-122-0380)
D63	The criteria allowing coverage for a heavy duty or extra heavy duty hospital bed has not been met. (Hospital Beds – OAR 410-122-0380, Table 122-0380, Legend – OAR 410-122-0182)
D64	The criteria allowing coverage for pressure reducing support surfaces has not been met. (Pressure Reducing Support Surfaces – OAR 410-122-0400, Table 122-0400-1, Table 122-0400-2, Legend – OAR 410-122-0182)
D65	DMAP does not cover foam overlays or mattresses without a waterproof cover since these are not considered durable. (Pressure Reducing Support Surfaces – OAR 410-122-0400, Table 122-0400-1, Table 122-0400-2, Legend – OAR 410-122-0182)

Code	Description
D66	DMAP does not cover pressure reducing support surfaces and services for the prevention of pressure ulcers or pain control. (Pressure Reducing Support Surfaces – OAR 410-122-0400, Table 122-0400-1, Table 122-0400-2, Legend – OAR 410-122-0182)
D67	DMAP did not receive the required documentation to determine eligibility for the requested pressure reducing support surface. (Pressure Reducing Support Surfaces – OAR 410-122-0400, Legend – OAR 410-122-0182)
D68	Trapeze bars with grab bar, attached to a bed, are covered only when it is an integral part of or used on a hospital bed and both the hospital bed and trapeze bar are medically appropriate. (OAR 410-122-0420, Table 122-0470, Legend – OAR 410-122-0182)
D69	Cosmetic support panty hose (i.e. Leggs, No-Nonsense, etc) are not covered. (Supports and Stockings – OAR 410-122-0470)
D70	DMAP does not cover electrical osteogenesis stimulators for the medical condition submitted with this request. (Osteogenesis Stimulators – OAR 410-122-0510, Legend – OAR 410-122-0182)
D71	DMAP does not cover an ultrasonic osteogenic stimulator for the medical condition submitted with this request. (Osteogenesis Stimulators – OAR 410-122-0510)
D72	DMAP did not receive the required documentation to determine eligibility for the requested osteogenesis stimulator. (Osteogenesis Stimulators – OAR 410-122-0510)
D73	Inadequate/no justification received to authorize request for diabetic supplies greater than allowed by rule. Maximum number of services approved per limitations specified in rule. (Diabetic Supplies – OAR 410-122-0520, Table 122-0520, Legend – OAR 410-122-0182)
D74	The criteria allowing coverage for an external insulin infusion pump and/or supplies has not been met. (External Insulin Infusion Pump – OAR 410-122-0525, Table 122-0525, Legend – OAR 410-122-0182)
D75	DMAP did not receive the required documentation to determine eligibility for the requested external insulin infusion pump and/or supplies. (External

Code	Description
	Insulin Infusion Pump – OAR 410-122-0525, Legend – OAR 410-122-0182))
D76	DMAP does not cover incontinent supplies for the diagnosis of nocturnal enuresis or for children under the age of three. (Incontinent Supplies – OAR 410-122-0630)
D77	DMAP did not receive the required documentation to determine eligibility for the requested incontinence supplies. The provider must submit documentation of the medical reason for incontinence. (General Rules OAR 410-120-1320, OAR 410-120-0000, Incontinence Supplies – OAR 410-122-0630)
D78	Inadequate/no justification received to authorize services greater than allowed by rule. Maximum number of services approved per limitations specified in rule. Diapers and protective underwear/pullons are limited to 220 units per month. (Incontinence Supplies – OAR 410-122-0630)
D79	Inadequate/no justification received to authorize services greater than allowed by rule. Disposable underpads are limited to 100 units per month; reusable/washable underpads are limited to 8 units in a 12 month period. (Incontinence Supplies – OAR 410-122-0630)
D80	Inadequate/no justification received to authorize services greater than allowed by rule. Washable protective underwear is limited to 12 units in a 12 month period. (Incontinence Supplies – OAR 410-122-0630)
D81	DMAP does not cover disposable underpads when reusable/washable underpads have been authorized for the client. (Incontinence Supplies – OAR 410-122-0630)
D82	Non-sterile gloves are limited to 4 units (200 pairs) per month and are covered only when directly related to usage of incontinent supplies. Maximum number of services approved per limitations specified in rule. (Incontinence Supplies – OAR 410-122-0630)
D83	The requested orthotic/prosthetic is not covered by DMAP. (Orthotics and Prosthetics – OAR 410-122-0660, Table 122-0660)
D84	The requested orthotic/prosthetic is not covered for clients residing in a nursing facility. (Orthotics and Prosthetics – OAR 410-122-0660, Table 122-0660)

Code	Description
D85	The criteria allowing coverage for a negative pressure wound therapy pump and/or supplies has not been met. (Negative Pressure Wound Therapy Pumps – OAR 410-122-0700)
D86	DMAP did not receive the required documentation to determine eligibility for the requested negative pressure wound therapy pump and/or supplies. The provider must submit all documentation required in OAR 410-122-0700. (Negative Pressure Wound Therapy Pumps – OAR 410-122-0700)
D87	The documentation provided indicates the client does not meet the criteria allowing coverage for the pediatric wheelchair requested. (Pediatric Wheelchairs – OAR 410-122-0720, Table 122-0720, Legend – OAR 410-122-0182)
D88	DMAP did not receive the required documentation to determine eligibility for the requested pediatric wheelchair. The provider must submit all documentation required in OAR 410-122-0720. (Pediatric Wheelchairs – OAR 410-122-0720, Table 122-0720, Legend – OAR 410-122-0182)
D89	The documentation provided indicates the client does not meet the criteria allowing coverage for the pediatric tilt-n-space wheelchair requested. (Pediatric Wheelchairs – OAR 410-122-0720, Table 122-0720, Legend – OAR 410-122-0182)
D90	The criteria allowing coverage for a TENS unit has not been met. (DME - OAR 410-122-0500)
D91	DMAP did not receive the documentation required to determine eligibility for the requested TENS unit. The provider must submit all documentation required in OAR 410-122-0500. (DME – OAR 410-122-0500)
D92	The criteria allowing coverage for a rehab shower/commode chair has not been met. (Bath Supplies – OAR 410-122-0580
D93	DMAP did not receive the documentation required to determine eligibility for the requested rehab shower/commode chair. The provider must submit all documentation required in OAR 410-122-0580. (Bath Supplies – OAR 410-122-0580)
D94	The requested lift is not covered because the records provided do not support that transfers require the assistance of more than one person and,

Code	Description
	without the use of a lift, the client would be bed confined. (Patient Lifts - OAR 410-122-0590)
D95	The requested lift is only covered for clients who weigh 450 pounds or more. (Patient Lifts – OAR 410-122-0590)
D96	The requested DME item/service was not authorized prior to dispensing/delivery as required. Client may not be billed unless the appropriate waiver was signed by the client prior to receiving the service. (OAR 410-120-1320, OAR 410-120-1280, OAR 410-122-0040)

D. General Rules—OHP Rules Denial Codes

Code	Description
R01	The client is not currently eligible for medical assistance coverage. The provider must verify that the individual receiving services is eligible on the date of service and for the service provided. (General rules OAR 410-120-1140, OAR 410-120-1320)
R02	The requested item/service is not covered. The diagnosed medical condition for which the item/service was requested does not appear on a funded line of the Prioritized List of Health Services. (OHP Admin. Rules OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)
R03	The requested treatment is not covered as the diagnosis and treatment do not pair on a funded line of the Prioritized List of Health Services. (OHP Admin. Rules OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)
R04	DMAP will not pay for services when the client is enrolled in a prepaid health plan that covers the service. Please contact the client's plan. (General Rules OAR 410-141-0420)
R05	The information submitted does not substantiate the item/service is the least costly alternative that will meet the client's medical needs. (General Rules 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, Durable Medical Equipment OAR 410-122-0080)
R06	The OHP client's benefit package does not cover acupuncture, chiropractic or osteopathic manipulation. (General Rules OAR 410-120-1210)
R07	Hospital services for this diagnosis are not covered under the OHP Limited Hospital Benefit Package for OHP Standard clients. (General Rules OAR 410-120-1210, Hospital Services OAR 410-125-0147)
R08	Insufficient/No documentation received to determine medical appropriateness of the service. Only services which are Medically Appropriate and for which the required documentation has been supplied may be authorized. (General Rules – OAR 410-120-0000, OAR 410-120-1200, OAR 410-120-1320)

Code	Description
R09	DMAP does not pay for services that are not considered reasonable or necessary for the diagnosis and treatment of disability, illness or injury. (General Rules OAR 410-120-0000, OAR 410-120-1200)
R10	DMAP does not pay for services which are not expected to significantly improve the basic health of the client. (General Rules OAR 410-120-1200)
R11	DMAP does not cover items or services which are for the convenience of the Client and are not medically or dentally appropriate. (General Rules OAR 410-120-1200)
R12	DMAP does not cover items or services which are primarily intended to improve appearance. (General Rules OAR 410-120-1200)
R13	Services or items provided by friends or relatives of a client are not covered. (General Rules OAR 410-120-1200)
R14	DMAP does not cover medical expenses incurred by a client, regardless of age, who is in the custody of a law enforcement agency or an inmate of a non-medical public institution. (General Rules OAR 410-120-1200)
R15	Immunizations prescribed for foreign travel are not covered. (General Rules OAR 410-120-1200)
R16	DMAP will not pay for purchase, repair or replacement of materials or equipment when loss or damage is due to the adverse action of the client. (General Rules OAR 410-120-1200)
R17	DMAP does not cover services related to establishment or reestablishment of fertility or pregnancy or for the treatment of sexual dysfunction, including impotence. (General Rules - OAR 410-120-1200)
R18	Transsexual surgery or any related services are not covered. (General Rules OAR 410-120-1200)
R19	DMAP does not cover routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health (i.e., exams for employment or insurance purposes). (General Rules OAR 410-120-1200)

Code	Description
R20	DMAP does not pay for services that are considered experimental or investigational, or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy. (General Rules OAR 410-120-1200)
R21	DMAP does not cover items or services that are requested by or for a Client whom DMAP has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services. (General Rules OAR 410-120-1200)
R22	DMAP does not pay for services that were not properly prescribed by a licensed practitioner practicing within his/her scope of practice or licensure. (General Rules OAR 410-120-1200)
R23	DMAP does not cover radial keratotomy. (General Rules OAR 410-120-1200)
R24	DMAP does not cover recreational therapy. (General Rules OAR 410-120-1200)
R25	DMAP does not cover weight loss programs or food supplements used for weight loss. (General Rules OAR 410-120-1200)
R26	DMAP does not pay for non-emergency out-of-state medical services unless DMAP authorizes the service in advance and the services are not available in the State of Oregon. (General Rules – OAR 410-120-1180)
R27	DMAP does not pay for services which are provided outside the United States except for those countries operating a medical assistance Title XIX program. (General Rules OAR 410-120-1180)
R28	DMAP will not pay for dental services when the client is enrolled in a DCO. Please contact the client's dental plan. (OHP Administrative Rules OAR 410-141-0420)
R29	This service is not covered by DMAP for clients with Citizen/Alien-Waived Emergency Medical (CAWEM) coverage. (General Rules OAR 140-120-0000, OAR 140-120-1200; OAR 410-120-1210)

Code	Description
R30	DMAP will not provide authorization for services after 90 days from the date of service unless documentation is provided showing that authorization could not have been obtained within 90 days of the date of service. (General Rules OAR 410-120-1320)
R31	Items included in the nursing facility all-inclusive rate are the responsibility of the nursing facility. (General Rules - OAR 410-120-1340; Pharmaceutical Services - 410-121-0625; SPD - OAR 411-070-0085)
R32	This service is not covered by DMAP for clients with only QMB coverage. Coverage is limited to services which are covered by Medicare. (General Rules OAR 410-120-1210)
R33	Prior Authorization is not required for Medicare covered services. (General Rules OAR 410-120-1340, DME OAR 410-122-0040)
R34	Request denied with manual denial notice noting the reason for the denial and the law or rule under which the request was denied.
R35	Insufficient/No documentation submitted to show criteria in the Prioritized List of Health Services guideline notes for this condition have been met. (OHP Admin Rules – OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)
R36	This provider is not currently enrolled in the Medical Assistance Program. Authorization may not be given to providers who are not enrolled. (General Rules – OAR 410-120-1260, OAR 410-120-1340)

E. Home Health and EPIV Denial Codes

Code	Description
N01	The home health services requested are not covered for clients receiving the OHP Standard Benefit package. (Home Health Services – OAR 410-127-0055, OAR 410-127-0060, General Rules – OAR 410-120-1200)
N02	Skilled nursing visits are limited to two visits per day. (Home Health Services – OAR 410-127-0060, OAR 410-127-0020)
N03	Home health therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy, and speech or language pathology services. (Home Health Services – OAR 410-127-0060)
N04	OMAP did not receive the required documentation from the provider to determine eligibility for the requested home health or EPIV service. (Home Health Services – OAR 410-127-0020, OAR 410-127-0080, Home EPIV Services – OAR 410-148-0020, General Rules OAR 410-120-1320, OAR 410-120-0000)
N05	The therapy plan of care submitted with this request is missing one or more of the elements required in OAR 410-127-0020 and OAR 410-127-0040. (Home Health Services)
N06	OMAP does not cover home enteral/parenteral nutrition and IV services outside the client's place of residence, i.e., home or nursing facility. (EPIV Services – OAR 410-148-0020)
N07	Training and/or education for home enteral/parenteral and IV services is included in the payment for the nursing visit or the hospital, therefore not payable separately. (EPIV Services – OAR 410-148-0040)
N08	Nursing assessment and nursing visits not directly related to the administration of home enteral/parenteral nutrition and intravenous services are not covered for clients receiving the OHP Standard Benefit Package. (OAR 410-148-0090)
N09	Drugs that are usually self-administered by the patient such as an oral pill form or self-injected medications, are not covered for clients receiving the OHP Standard Benefit Package. (OAR 410-148-0090)

Code	Description
N10	Oral nutrition services and supplies are not covered for clients receiving the OHP Standard Benefit Package, except when the nutritional supplement meets the criteria specified in OAR 410-148-0260(3), and is the sole source of nutrition for the client. (OAR 410-148-0090)
N11	DMAP did not receive documentation to support that the requested home enteral/parenteral or IV services is medically appropriate. (OAR 410-148-0040, OAR 410-148-0060)
N12	No/insufficient documentation received with the request for enteral/parenteral or IV infusion pumps, showing that other (non-pump) methods of delivery do not meet the client's needs. (OAR 410-148-0060)
N13	Request for oral nutritional supplements must be submitted to DMAP's Pharmacy Benefits Manager, First Health Services. (OAR 410-148-0060)
N14	Home enteral/parenteral nutrition and IV services outside of the client's home or place of residence are not covered. (OAR 410-148-0100)
N15	DMAP does not cover nursing visits for enteral/parenteral services, oral nutritional supplements that are in addition to consumption of food items or meals, or supplies and items covered in the nursing facility All-Inclusive Rate, for clients residing in a nursing facility. (OAR 410-148-0120)
N16	The criteria allowing coverage for oral nutritional supplements have not been met. (OAR 410-148-0260)

F. Medical Transportation Denial Codes

Code	Description
M01	DMAP does not cover non-emergency medical transportation that was not prior authorized by the local medical transportation broker or the local branch office. (Medical Transportation Services - OAR 410-136-0300)
M02	DMAP does not cover medical transportation to a specific provider based solely on client preference or convenience. (Medical Transportation Services - OAR 410-136-0160, General Rules – OAR 410-120-1200)
M03	DMAP does not cover non-emergency medical transportation outside the client's local area. The non-emergency medical transportation requested may be obtained locally. (Medical Transportation Services - OAR 410-136-0160)
M04	The requested non-emergency medical transportation is not the least expensive mode of transportation that will meet the medical needs of the client. (Medical Transportation Services - OAR 410-136-0160, OAR 410-136-0300)
M05	The client has been suspended from obtaining non-emergency medical transportation services and will not be eligible for these services until the suspension expires. (Medical Transportation Services - OAR 410-136-0160)
M06	The OHP client is eligible to receive services covered by the OHP Standard Benefit Package. This benefit package does not cover non-emergency medical transportation. (General Rules OAR 410-120-1210)
M07	Retro. authorization for medical transportation will only be made for clients needing urgent medical care on weekends, holidays, or after normal branch office hours, and if medically appropriate. (OAR 410-136-0300)
M08	DMAP does not cover non-emergency medical transportation for a non-covered medical service/condition under the Oregon Health Plan. (Medical Transportation Services - OAR 410-136-0300)
M09	DMAP does not cover non-emergency transportation if the client has resources available to provide appropriate transportation without cost or at a lesser cost to DMAP (Medical Transportation Services OAR 410-136-0300)

Code	Description
M10	DMAP does not cover transportation to return a client from any foreign country to any location within the United States even though the medical care needed by the client is not available in the foreign country. (Medical Transportation Services - OAR 410-136-0300)
M11	DMAP does not cover transportation to return a client to Oregon from another state or provide mileage, meals, or lodging, unless the client was in the other state obtaining services approved by DMAP or the client's prepaid health plan. (Medical Transportation Services - OAR 410-136-0300)
M12	DMAP does not cover out-of-state medical transportation if the service to be obtained is not covered under the client's benefit package, the service is available in-state, and/or the service has not been authorized in advance by DMAP. (Medical Transportation Services - OAR 410-136-0300, General Rules - OAR 410-120-1180)
M13	DMAP does not cover transportation to or from court-ordered services. (Medical Transportation Services - OAR 410-136-0300, General Rules – OAR 410-120-1200)
M14	DMAP does not cover reimbursement for client mileage, meals, and/or lodging if the service was not approved by the regional transportation brokerage or the client's local branch office in advance. (Medical Transportation Services - OAR 410-136-0800)
M15	DMAP will only cover reimbursement for client mileage, meals and/or lodging when accessing medical services covered under the Oregon Health Plan. (Medical Transportation Services - OAR 410-136-0800)
M16	DMAP does not cover wheelchair services for transportation of ambulatory clients. (Medical Transportation Services - OAR 410-136-0070)
M17	The criteria allowing coverage for meals, lodging, or attendant have not been met. (Medical Transportation Services - OAR 410-136-0820)

G. Therapy Denial Codes (Occupational, Physical and Speech Therapies)

Code	Description
T01	The diagnosis for which physical therapy, occupational therapy, and/or speech therapy services were requested is not covered by the Oregon Health Plan. (OHP Admin. Rules – OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)
T02	The DMAP member has received the maximum number of physical therapy and/or occupational therapy visits allowed for this medical condition. (OHP Admin. Rules - OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)
T03	Inadequate/No documentation received to authorize services greater than allowed by rule. Maximum number of services approved per limitations specified in rule. (OHP Admin. Rules - OAR 410-141-0520 – guideline note)
T04	DMAP did not receive the required documentation from the provider to determine eligibility for the requested physical and/or occupational therapy services. (Physical and Occupational Therapy - OAR 410-131-0080, OAR 410-131-0120, OAR 410-131-0140, General Rules OAR 410-120-1320, OAR 410-120-0000)
T05	The therapy plan of care submitted with this request is missing one or more of the required elements: Client’s name, diagnosis, and the type, amount, frequency and duration of the proposed therapy. (Physical and Occupational Therapy Services – OAR 410-131-0080)
T06	The therapy plan of care submitted with this request does not include individualized, measurably objective short-term and/or long-term functional goals. (Physical and Occupational Therapy Services – OAR 410-131-0080)
T07	The therapy plan of care submitted with this request does not address implementation of a home exercise program. (Physical and Occupational Therapy Services – OAR 410-131-0080)
T08	The therapy plan of care submitted with this request does not include dated signature of the therapist or the prescribing practitioner. (PT and OT Services – OAR 410-131-0080, Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0060, General Rules OAR 410-120-1320, OAR 410-120-0000)

Code	Description
T09	The therapy plan of care submitted was not reviewed and signed by the prescribing practitioner. (Physical and Occupational Therapy Services – OAR 410-131-0140)
T10	Physical therapy and Occupational Therapy services are not covered under the OHP Standard Benefit Package. (Physical and Occupational Therapy Services – OAR 410-131-0275, General Rules OAR 410-120-1210)
T11	DMAP will only reimburse for the lowest level of service which meets the client's medical need. (Physical and Occupational Therapy Services – OAR 410-131-0020, Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0010, General Rules – OAR 410-120-1200, OAR 410-120-0000, OAR 410-120-1320)
T12	Therapy services requested are maintenance therapy. DMAP does not cover maintenance therapy services. (Physical and Occupational Therapy Services – OAR 410-131-0100, OAR 410-131-0120, Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0040)
T13	Insufficient/No information on the written prescription to determine if the therapy services requested are covered. (Physical and Occupational Therapy Services – OAR 410-131-0140, Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0060)
T14	Physical and Occupational therapy services for DMAP clients with Medicare do not require payment authorization for Medicare covered services. (Physical and Occupational Therapy Services – OAR 410-131-0160)
T15	DMAP did not receive the required documentation from the provider to determine eligibility for the requested speech therapy services. (Speech-Pathology, Audiology and Hearing Aids – 410-129-0020, OAR 410-129-0060, General Rules OAR 410-120-1320, OAR 410-120-0000)
T16	The DMAP member has received the maximum number of speech therapy visits allowed for this particular condition. (OHP Admin. Rules - OAR 410-141-0480, OAR 410-141-0500, OAR 410-141-0520)

Code	Description
T17	Speech-language pathology services are not covered under the OHP Standard Benefit Package. (Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0195, General Rules OAR 410-120-1210)
T18	Hearing aids, hearing aid repairs, examinations and audiological diagnostic services to determine the need for or the appropriate type of hearing aid(s) are not covered under the OHP Standard Benefit Package. (Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0195)
T19	DMAP did not receive the required documentation from the provider to determine eligibility for the requested hearing aid(s). (Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0060, General Rules OAR 410-120-1320, OAR 410-120-0000)
T20	The speech-generating/augmentative communication system or device requested is not the least costly that will meet the basic functional communication and medical needs of the client. (Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0010, OAR 410-129-0220)
T21	DMAP did not receive the required documentation from the provider to determine eligibility for the requested speech generating or augmentative communication system or device. (Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0220, General Rules OAR 410-120-1320, OAR 410-120-0000)
T22	The criteria allowing coverage for a speech generating or augmentative communication system or device have not been met. (Speech-Pathology, Audiology and Hearing Aids – OAR 410-129-0220)
T23	Reimbursement is limited to one (monaural) hearing aid every five years for adults. (Speech-Pathology, Audiology and Hearing Aids - OAR 410-129-0070)
T24	Reimbursement is limited to two (binaural) hearing aids every three years for children when criteria in OAR 410-129-0070 is met. (OAR 410-129-0070)
T25	DMAP did not receive a prescription/written order from the prescribing practitioner for the requested therapy services. (Physical and Occupational Therapy - OAR 410-131-0140, Speech Therapy - OAR 410-129-0060)

Code	Description
T26	The requested hearing aid(s) is not covered as the criteria for a hearing aid(s) has not been met. (Speech-Pathology, Audiology and Hearing Aids - OAR 410-129-0070)
T27	DMAP will only cover two hearing aids for adults when the hearing loss criteria is met, the client has vision correctable to no better than 20/200, and it is necessary for safety purposes. (OAR 410-129-0070)

DMAP Worker Guide XI
Client Rights and Responsibilities

- Billing of clients
- Health care complaint process
- Hearings
- Form

A. Client Rights and Responsibilities

Clients who receive Medical Assistance programs have specific rights and responsibilities:

- Rights and Responsibilities is part of a client's application for medical assistance. Clients are asked to sign this form to be sure they are aware of their rights.
- Part of a client's rights involve billing. DMAP has very specific rules for billing clients.
- Clients also have grievance rights and rights to a hearing under administrative rules.
- Plans must have a complaint process for clients.

B. Billing of Clients *General Rules 410-120-1280 and 410-141-0420*

A provider must not seek payment from a Medical Assistance client or any financially responsible relative or representative of that individual for any service covered by Medicaid except under the circumstances described below.

- The health service or item is not covered by the Medical Assistance program. The client must be informed in writing in advance of the receipt of the specific service that is not covered, the estimated cost of the service, and that the client or the client's family is or may be financially responsible for payment for the specific services.
- The client is not eligible for Medical Assistance at the time the service(s) or item(s) were provided, and is not made eligible retroactively.
- The charge is for a copayment when a client is required to make a copayment as outlined in DMAP General Rules 410-120-1230.
- The client did not tell the provider that he/she had Medical Assistance Program coverage either at the time the service was provided or subsequent to the provision of the service and, as a result, the provider could not bill the Medical Assistance Program in accordance with the Timely Submission of Claims rule. The provider must document attempts to obtain information from the client on potential Medical Assistance Program coverage.
- The client did not tell the provider that he/she had Medical Assistance Program coverage prior to the delivery of the service, the service required authorization prior to the delivery of the service, and Medical Assistance Program staff will not retroactively authorize.
- The client did not tell the provider that he/she had other insurance coverage and the third party insurer will not make payment because of lack of timeliness or lack of prior authorization. The Medical Assistance Program will not make payment on a service which would have been covered by another insurer if the client had informed the provider in a timely manner of the other insurance.

  NOTE: Indian Health Services or Tribal Health Clinics are not Third Party Resources and are the payor of last resort.

- A third party resource makes payments directly to the client for medical services.
- The provider is not enrolled with the Oregon Medical Assistance Program.
- The client entered into a payment arrangement before or at the time service was provided. The provider must document the payment terms and client acceptance of the terms under which treatment is being provided and payment responsibility before the service is provided.

  NOTE: If clients report that they are receiving bills for a covered Medicaid service, branch staff should ask the client if they have told the provider that they have Medicaid coverage.

If the provider is aware of the client's Medicaid coverage but still bills the client, fax copies of the bills to the DMAP Client Advisory Services Unit at (503) 945-6898 or mail the copies to DMAP, Attention: CASU Billing.

C. Health Care Complaint Processes

OHP Rules 410-141-0260 and 410-141-0261

There will be times when clients are not satisfied with a health care decision made by their providers or their managed health care plan.

All clients may seek assistance with health care concerns or complaints through DMAP's Client Advisory Services Unit. Clients may call the unit toll-free at 1-800-273-0557. Clients may also use the OHP 3001 Complaint Form to submit a complaint in writing to the Client Advisory Services Unit. This form is especially useful if the client wants to attach backup documentation such as a denial of service or bills from providers. A copy of the OHP 3001 form is contained in this section.

Clients in managed health care plans should be encouraged to use the complaint process outlined below:

1. Talk to the Primary Care Provider. The client should ask the physician or other provider to attempt to resolve the problem.

2. Contact the Plan's Customer Service Representative. The plan's telephone number is on the client's monthly Medical Identification Form. Clients may also use the OHP 3001 Complaint Form to register complaints with a managed care plan.

Clients over 65 and those with disabilities can also seek help from their plan's Exceptional Needs Care Coordinator (ENCC) who can be reached at the same telephone number.

3. Ask for a Review by the Plan. If the decision is unsatisfactory, the client can request a review of the decision by the managed care plan's board of directors, quality assurance committee, or other responsible party. The plan must respond in writing within 30 days.

D. Hearings

General Rule 410-120-1860
OHP Administrative Rule 410-141-0262 and 410-141-0264

Managed Care Plan Clients

Clients enrolled in a managed care plan who have been denied a service must first appeal the decision through their plan before they may request an administrative hearing through DHS. Clients should follow the instructions on the Notice of Action (initial denial notice) to complete the appeal process through their plan.

Once the managed care plan has completed the appeal process, the plan will send the client a Notice of Appeal Resolution stating the plan's decision. If the client is not satisfied with the outcome, they may then elect to follow the instructions on the Notice of Appeal Resolution to request an administrative hearing through DHS.

Please ensure that clients enrolled in a managed care plan have completed the appeal process through their plan before giving them a DHS 443 form and Notice of Hearings Rights form.

Fee-for-service Clients

Clients who are fee-for-service (also known as "open card"), may request an administrative hearing through DHS at the time they receive the Notice of Action (initial denial notice).

Submitting the DHS 443 to DMAP Hearings:

Managed Care Plan Clients

Please ensure that the client has fully completed the DHS 443. Please ask the client for a copy of the Notice of Appeal Resolution (decision notice) from the managed care plan to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to DMAP.

Fee-for-service Clients

Please ensure that the client has fully completed the DHS 443. Please ask the client for a copy of the Notice of Action (denial notice) to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to DMAP.

Forward all DMAP hearing requests, with attachments, to:

Division of Medical Assistance Programs
500 Summer St. NE, E-49
Salem, OR 97301-1079

DMAP Worker Guide XII
Medical Transportation Reimbursement

- Authorizing transports
- Special circumstance transports
- Client reimbursed travel
- Place of service codes
- Volunteer transports
- Forms

A. Medical Transportation

Staff will find detailed instructions for the authorization process in this section of the manual. In addition, anyone who authorizes non-emergency medical transportation should be knowledgeable of Medical Transportation Services Administrative Rules (OAR 410-136 *et al*). This section of the DMAP Worker Guide includes:

- State requirements and authority
- Covered transports
- Authorizing the transport, including:
  - Branch/agency standards
  - Using a brokerage
  - Eligibility screening
  - Procedures to complete DMAP 405T, Medical Transportation Order
  - After hours rides
- Special circumstance transports, including:
  - Out-of-state transports
  - Special transports within Oregon
  - Out-of-state transports to obtain DMAP approved medical services
  - Helpful hints for lodging and meals
  - Hospital to hospital, home or other facility transports
- Not covered transports and related services
- Client reimbursed travel, meals, lodging
  - Attendant meals and lodging
  - Fee schedule for client travel
  - Revolving fund procedures and instructions for completing CMS-1500 Form
- Place of service codes
- Volunteer transports
- Samples of forms Requirements/Authority

Federal regulations 42 CFR 431.53 requires the State to "assure necessary transportation to recipients to and from providers".

Further, 42 CFR 440.170(3) states: "Travel expenses" include:

> *(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;*
>
> *(ii) The cost of meals and lodging in route to and from medical care and while receiving medical care; and*
>
> *(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, and lodging.*

In addition, Part 6 - General Program Administration of the Medical Assistance Manual concerning Transportation of Recipients (6-20-00) reads:

1. **Administrative Controls**

States have an obligation to assure that:

- Transportation will be available for recipients to and from medical care;
- Payment is made only where transportation is not otherwise available;
- Payment is made for the least expensive available means suitable to the recipient's medical needs; and
- Transportation is available only to get individuals to qualified providers who are generally available and used by other residents of the community.

DMAP Administrative Rule 410-136-0160 – Non-Emergency Medical Transportation (Without Need For An Emergency Medical Technician) states:

- DMAP will not make payment for transportation to a specific provider based solely on client or client/family preference or convenience. For purposes of authorizing non-emergency medical transportation, the medical service or practitioner must be within the client's local area. Local area is defined as "in or nearest" the client's city or town of residence. If the service to be obtained is not available locally, transportation may be authorized to a practitioner within the accepted community standard or the nearest location where the service can be obtained or to a location deemed by DMAP to be cost-effective to DMAP.
- A Branch may not authorize and DMAP will not make payment for non-emergency medical transportation outside of a client's local area when the client has been noncompliant with treatment facility refusing to provide further service or treatment to the client. In the event supporting documentation is submitted to DMAP that demonstrates inadequate or inappropriate services are being (or have been) provided by the local treatment facility or practitioner, transportation outside of the client's local area may be authorized on a case-by-case basis.
- If a managed care client selects a Primary Care Physician (PCP) or Primary Care Manager (PCM) outside of the client's local area when a PCP or PCM is available in the client's local area, transportation to the PCP or PCM is the client's responsibility and is not a covered service.
- The client will be required to utilize the least expensive mode of transportation that meets their medical needs and/or condition. Ride-sharing by more than one client is considered to be cost effective and may be required unless written medical documentation in the branch record indicates ride sharing is not appropriate for a particular client. The written documentation will be made available for review upon request by DMAP. Mileage reimbursement will be made to one of the clients who are sharing a ride. Payment will not be made to more than one client for each ride.

2. **Covered Transports**

DMAP will reimburse for medical transportation, for eligible Title XIX and Title XXI (for exceptions see *Not Covered Transports* in this guide) and TANF eligible clients (unless non-emergent transportation is excluded from the client's benefit package), when the following occurs:

- It has been determined by the branch authority that the client has no other means of transportation available; and

- When a properly completed Medical Transportation Order (DMAP 405T) or its equivalent has been forwarded to the transportation provider; AND
- The transportation provider is actively enrolled with DMAP as a provider of Medical Transportation services and the service to be obtained is one of the following covered services:
  - Administrative Medical Exam (Branch must complete the DHS 729 form before transportation can take place)
  - Adult day care service, where medical services are provided
  - Ambulatory Surgical Center service
  - Chemotherapy
  - Chiropractic service
  - Day treatment for children (DARTS)
  - Dental/denturist service
  - Diabetic/self-monitoring training and related services
  - Family sex abuse therapy, when provided by a mental health clinic
  - Federally Qualified Health Care Center service
  - Hemodialysis
  - Hospital service. (Includes inpatient, outpatient, and emergency room.)
  - Maternity management service. (Reimbursement for transportation is for client transport only. These services are provided for pregnant women and are provided only at medical offices, hospitals, public health departments and other medical facilities.)
  - Mental health and alcohol and drug service. (When provided by mental health organizations, mental health clinics or other providers subcontracted with prepaid health plans to provide mental health and/or alcohol and drug services.)
  - Naturopathic service
  - Nurse practitioner service
  - Nursing facility service
  - Pharmaceutical service*
  - Physical and occupational therapy
  - Transports to swimming pool therapy will be reimbursed only if the therapist is providing therapy "one-on-one" in the pool with the client and the therapy has been prior authorized.
  - Physician service
  - Podiatrist service
  - Prosthetic/orthotic repair/adjustments
  - Special transports to obtain out-of-state services not available in Oregon. Must be authorized by the DMAP Out-of-State Services Coordinator and Medical Transportation Program Manager or the managed care contractor.
  - Speech/hearing/audiology service
  - Transplant. Must be authorized by the DMAP Transplant Coordinator or the client's prepaid health plan.
  - Vision service (including ophthalmic services)

- ♦ Waivered service as follows: DMAP will reimburse for transportation from a nursing facility to a Title XIX waivered living situation (i.e., AFC, SLC, RCF, Group Home) or from one Title XIX waivered living situation to another Title XIX waivered living situation or nursing facility.
- ♦ Transports to Title XIX psych hospitals for inpatient or outpatient psych services (covered for clients of all ages)

Remember: Some pharmacies may provide free delivery of prescriptions. Also, the OHP contracted home-delivery pharmacy services are available for those clients who are on maintenance medications and who can reasonably utilize home delivery services. OHP Home-Delivery includes a 3-month supply instead of a one-month supply on most medications, and shipping is free to the client's home or clinic.

Wellpartner is the contracted home delivery pharmacy for DMAP. Contact Wellpartner at 1-877-935-5797 for more information. Prescription order forms and additional information are available from the DHS Web site at <http://www.oregon.gov/DHS/healthplan/clients/mailrx.shtml>

3. **Covered Transports Provided by Volunteers**

(These are Title XIX matchable.) DMAP will reimburse a DHS Volunteer for a transport provided to any of the above listed services and to the following services as well:

- Family sex abuse therapy
- Transportation to Shriners Hospital for Children or Doernbecher Children's Hospital
- Transportation to Stepping Stones A&D facility for outpatient treatment
- Transportation to Veterans Administration facilities. (Unless the transport is from one Veterans facility to another Veterans facility. Generally, the Veterans Administration contracts with taxi or ambulance providers to provide these rides.)

NOTE: *Volunteers may also be reimbursed for mileage expenses incurred when the client fails to keep the appointment. In addition, volunteers using State Motor Pool cars may be reimbursed for miles driven in their personal vehicle from home to the Motor Pool and from the Motor Pool to home.*

4. **Miscellaneous**

A client's family member may be reimbursed for mileage for medically necessary treatment or follow-up visits to Shriners, Doernbecher, or VA Hospitals. (Services provided by these are considered to be cost effective.)

Reimbursement for medical transportation is NOT included in spousal support payments. If a person receiving spousal support requests reimbursement for mileage, it may be approved.

OAR 410-136-0160, Medical Transportation Services, clearly states that client reimbursed travel requires authorization in advance. The rule also defines when retroactive authorization may be made. Once authorized initially, client reimbursement for mileage may be approved for ongoing trips after the fact but only after the client has

provided verification of all medical trips taken. Payment for such trips shall be at the rate calculated by the original authorization.

Do not authorize continuing trips beyond 30 days in advance.

B. Authorizing the Transport

1. Branch/Agency Standards

The branch or agency shall not deny an individual services based on grounds of race, color, sex, religion, national origin, creed, marital status, or the presence of any sensory, mental or physical disability.

Each branch or agency will designate a primary contact and backup person for the purpose of authorizing non-emergency medical transportation.

The branch or agency will inform clients regarding:

- The availability of non-emergency medical transportation, and
- The administrative rules regarding authorization of non-emergency medical transportation, and
- The procedures the client must follow to obtain non-emergency medical transportation.

The branch or agency will ensure that the client has actually received the services for which transportation has been authorized. Branch or agency should attempt to confirm with the medical provider that the client actually received services on the date of the transportation for each ride authorized or trip reimbursed.

The branch or agency will ensure that if any request for non-emergency medical transportation is denied, the client receives a written denial notice. Clients will also be informed about the fair hearing process.

The branch or agency should require the client to call with medical transportation requests as soon as medical appointments are made. Clients who call with “same day” requests may be asked to reschedule their appointment if the appointment is not urgent or not essential to maintaining continuity of care or monitoring of client medical condition.

2. Brokerage

Most regions in the state are within brokerage areas now. These brokerages are consolidated call centers that will verify client eligibility and provide the most cost-effective ride suitable to the client’s needs. All requests for transportation originating within a brokerage region, except for ambulance services and client meals and lodging, should first go through the brokerage (this includes client mileage requests).

In some brokerage areas, the brokerage also has the authority to prior authorize mileage, meals, and lodging for clients, DHS volunteers and foster care parents. Check with the brokerage to ensure that the proper prior authorizations are requested.

Coordinate with the local brokerage, by phone, e-mail, etc. when providing client reimbursements in order to ensure that the client is not double dipping by getting a ride from the brokerage at the same time.

Clients who are sent into brokerage areas from non-brokerage areas and need return transportation must have their eligibility information provided by the branch to the appropriate brokerage so the brokerage can arrange for the transportation originating within their area. Clients from one brokerage area going to another brokerage area will be coordinated between the brokerages.

3. Brokerage locations

Broker/Call Center	Phone/Fax	Counties
Central Oregon Intergovernmental Council **Cascades East Ride Center**	**541-385-8680** 1-866-385-8680 Fax 541-548-9548 TDD 1-800-735-2900	Baker Crook Deschutes Grant Harney Jefferson Malheur Wallowa Union
Oregon Cascades West Council of Governments **Cascades West Ride Line**	**541-924-8738** 1-866-724-2975 Fax 541-791-4347 TDD 541-928-1775	Benton Linn Lincoln
Lane Transit District	Pending	Lane
Sunset Empire Transportation District **Northwest Ride Center**	**503-861-7433** 1-866-811-1001	Clatsop Columbia Tillamook
Rogue Valley Transportation District **TransLink**	**541-842-2060** 1-888-518-8160 Fax 541-618-6377	Coos Curry Douglas Jackson Josephine Klamath Lake
Mid-Columbia Council of Governments **Transportation Network**	**541-298-5345** 1-877-875-4657 Fax 541-296-5674 TDD 7-1-1 Relay Service	Gilliam Hood River Morrow Sherman Umatilla Wasco Wheeler

Salem Area Mass Transit District **Trip Link**	**530-315-5544** 1-888-315-5544 Fax 503-315-5144	Marion Polk Yamhill
Tri-Met **Transportation Services**	**503-802-8700** 1-800-889-8726 TDD 7-1-1 Relay Service	Clackamas Multnomah Washington

C. Authorization Process

The following information suggests minimal processes that must take place in the authorization of any non-emergency transport. Different client populations and their unique needs or circumstances mean that the process will vary. Certain procedures are required, however, regardless of the client or the specific level of need. This worker guide contains a recommended Medical Transportation Screening Form, which the branch may choose to adopt. Regardless of the form used, a "paper trail" clearly documenting the client's need for medical transportation services, including miles, meals and lodging, must be available for review by DMAP Quality Assurance Audit staff. If the branch is currently using the AFS 405M, that form is also appropriate.

1. Eligibility Screening

- Determine client eligibility for reimbursable transportation. The client must actually be eligible, not pending eligibility, for any non-emergent medical transportation, including client reimbursement. Rides associated with Administrative Examinations would be the exception.
- Has Transportation Screening or Rescreening interview been conducted?
- Is completed Transportation Screening form (or equivalent) in branch record? (The form only needs to be completed for those clients who have requested ongoing Medical Transportation Services.)
- Have all special needs of the client been identified on the form?
- Is the client requesting transport to an eligible (covered) Title XIX service?
- If the Transportation Screening form (or equivalent) indicates "other transportation resources are available," has the client attempted to find transportation other than through the branch?
- Is volunteer transportation available?

NOTE: re-screenings should be conducted at least semi-annually to ensure the client's transportation needs (or level of need) are ongoing.

In all instances, the branch has the responsibility to ensure that the least expensive mode of transportation (suitable to the client's needs) is authorized. When a client requests transportation to medical services out of the client's local area, it is the branch's responsibility to determine medical appropriateness (*i.e.*, has client been referred out of area by primary care physician rather than going to the provider of their choice?). Written documentation supporting the authorization should be retained in the branch record for DMAP audit review.

2. Eligibility Screening - Children in the Care of DHS

Children in the care and custody of DHS are not considered to have familial, financial or other resources available to them for medical transportation. The monthly Foster Care Maintenance payment does not include moneys to cover the costs of transportation to medical appointments. Many children who are under the jurisdiction of DHS have a high volume of medical appointments for counseling, therapies, etc. More often than not, these children are extremely difficult to place. Refusal to make moneys available to the foster parent could potentially jeopardize the child's placement.

Keeping in mind that mileage reimbursement is nearly always the least expensive mode of medical transportation, DMAP's position is as follows:

- Where the foster parent has approached the caseworker and made a request for mileage reimbursement, the moneys should be provided in the same manner as described in the guidelines for client reimbursed mileage. It remains the caseworker's responsibility to ensure the appointment is a covered Title XIX service. In addition, there should be a written statement on the AFS 405M (or whatever screening form is used) to the effect that "Foster parent has requested reimbursement for medical transportation provided to (child's name and prime number). Child has no other resource available."
- If a DHS (or other) branch arranges the reimbursement aspect or otherwise arranges the transportation they should ensure that the caseworker has forwarded a written request containing the above (or similar) statement. All paper documentation is to be retained in the branch record. If DHS handles all aspects of the reimbursement, the paper documentation should be retained in the branch record.

IT IS IMPORTANT TO REMEMBER that while we are required to ensure client access to needed medical services, medical transportation moneys are not considered to be an "entitlement." If the foster parent is willing to provide the transportation and has not requested reimbursement for such, the foster parent is considered to be a resource. Requests for reimbursement on the part of the foster parent should not be encouraged or solicited.

Medical transportation for DHS children in subsidized adoptions should be arranged through DMAP's Claims Management Unit at (503) 945-6522.

3. Procedures for Completing the Medical Transportation Order

The Medical Transportation Order (OMAP 405T) or an equivalent form that includes all DMAP required information must be completed for ALL non-emergency provider transports. The branch is to initiate the order. The provider is only to initiate orders when the ride has been provided "after hours." The VP883 form is required for DHS volunteer transports.

The following information must be included on all Medical Transportation Orders for DMAP Quality Assurance Audit:

- Provider Name or Number
- Pickup Address
- Client Name and Prime Number
- Destination Name and Address

- Trip Information, indicate:
  - 1 way
  - Round trip
  - 3 way
- Mode of Transportation
  - Ambulance
  - Taxi
  - Stretcher Car
  - Wheelchair Van
  - Stretcher Car by Ambulance
  - Other (use for secured transports, ambulatory (able to walk) or other special transports - buses, trains, etc.)
- One Time Trip, indicate:
  - Appointment Date
  - Appointment Time
  - Pickup Time
- On-Going Trips (should not exceed a period of 30 days in advance), indicate:
  - Begin Date
  - End Date: Sun Mon Tues Wed Thurs Fri Sat
  - Appointment Time
- $ Authorized (if special, secured transport, or the total for an on-going period)
- Today's Date
- Branch Number
- Wkr/Clk ID

Each Branch will need to add specific instructions to the Medical Transportation Order that are unique to the needs of the individual client. If a Secured Transport is being authorized, then ensure this level of transport was medically appropriate and that the client was taken to a Title XIX facility. Indicate on the lower portion of the Order the reason secured level is required. The only acceptable reasons for secured transport are: a risk to self (suicidal) or others (assault). A flight risk is not considered appropriate for secured transport. Enter the name and phone number of the medical professional requesting the secured level.

The Medical Transportation Order should be faxed, mailed or routed at the end of each work day to the selected provider. If the branch currently batches and routes requests to providers on a weekly (or other) basis, that process can remain in place, but remember the provider cannot bill DMAP until the Order is received.

Urgent (same day) transports: A phone call to the selected provider should be made immediately, followed up by a completed Medical Transportation Order. A copy of all Medical Transportation Orders (regardless of the form used) must be retained in the branch record for the period of time described in the General Rules.

4. Additional Client Transport – Same Ride

The fact that more than one DMAP client has been transported during the same ride is not always known to the branch. (Many nursing facilities, etc., contact providers directly to arrange rides.) When this happens the branch is required to verify client eligibility for the ride, etc., and forward a new (or changed) transportation order to the provider. (Administrative Rules require the provider to have branch authorization for EACH client transported. The rules also address those provider types that can bill DMAP for an additional client - same ride.)

5. After Hours Rides

Unless the client resides in a brokerage area, the provider will generally initiate the Transportation Order for "after hours" rides. (This is the only time a provider can initiate an order.) The rules instruct the provider to submit the partially completed order to the branch within 30 calendar days after the services was provided. After confirming the ride was appropriate, the branch is required to return the completed Order to the provider within 30 calendar days after receipt of the Order.

6. Helpful Hints for Completing the Medical Transportation Order

For Taxi, Wheelchair Van/Lift/Stretcher Car/Ambulance/Secured Transports and Other:

- Be sure to complete all required information.
- Be sure to fill in the client's prime number (not case number).
- Circle either: one-way, round trip or three-way in the Trip Info box. (Number of Base Rates and miles is no longer required on the order. The number of base rates and miles billed to DMAP will be reviewed by DMAP Audit staff at the time of provider audits.)
- Volunteers are usually authorized mileage only. On occasion, however, meals and/or lodging may be authorized in addition to mileage. Refer to the Client Reimbursed Travel in this worker guide for general guidelines and criteria.
- Special Instructions - Complete as needed based on client needs. Include on the order all information the volunteer or provider might need to know to provide the best transport possible for the client.
- The Medical Transportation Order must be retained in the branch record for audit purposes for the time described in General Rules.

NOTE: By ordinance, Stretcher Cars are not allowed to operate in all areas in Oregon. In the case where a client is required to travel in a supine position, arrangements can be made with an ambulance to provide the transport. Certain ambulance providers will provide these transports at Stretcher Car rates, and the Order should indicate Stretcher Car Ride. The provider should bill DMAP directly using the Stretcher Car Procedure Codes. If the ambulance provider is NOT willing to provide the stretcher car transport at stretcher car rates, the Order should indicate "Stretcher Car by Ambulance". The provider should be instructed to bill DMAP directly using the new procedure codes listed in the Guide.

D. Special Circumstances Transports

1. Out-Of-State Transfers

Occasionally, due to deteriorating condition/prognosis or other client circumstances, a client (or their family member) may request a transport to leave Oregon. These are generally nursing home clients with poor medical prognosis who want to relocate nearer to next of kin or other family members. It is often a reasonable request with obvious advantages for the client, their family and DMAP.

In order to facilitate a move of this nature DMAP has established basic protocol that must be adhered to in order to complete the successful transfer of a client to another state. That process consists of:

- The client or the client's family must express in writing a desire and a commitment to make the transfer. *
- The case manager must provide assurance that the receiving state has the necessary services the client requires.
- The family and case manager must make the appropriate contacts with the receiving state. Whenever possible, written confirmation from the receiving state is desirable. *
- Any necessary medical documents must be made available to the receiving state to assist that state in the determination of client eligibility.
- A written statement from the client's attending physician that the client is capable of making the transfer (traveling) without any detrimental effects to his/her medical status. *
- If going to a facility, written confirmation from the receiving facility acknowledging their willingness to accept the client and that a bed is available. *
- Determine the appropriate mode of transport*, i.e.*, is the client bed-bound? If so, is ground transport more appropriate than air? If air transport is necessary, the appropriate ground transport must be arranged at the departure and destination points. Obtain written cost estimates from all providers contacted. *

* *Any of the above information with an asterisk (*) must be routed (or faxed) to the DMAP Medical Transportation Program Manager for final approval. Retain a copy of all information in the branch record.*

Once the transport has been approved by DMAP, the branch will be notified as soon as possible.

Remember: DMAP does not reimburse moving a client's personal belongings, furniture, medical equipment or for the services of an escort or an attendant. The client's family will be responsible for providing escort/attendant services, and moving of any medical equipment, furniture, etc.

2. Special Transports Within Oregon (Bid Rides)

Occasionally, due to client medical condition, circumstance or length of transport, an DMAP provider may be unwilling to provide a non-emergency transport at DMAP rates. When this happens, the following must occur:

- Determine the reason for the refusal. Is it simply DMAP rates are too low?
- Is there another reason? For example, is the patient extremely obese? Provider does not have vehicle or sufficient extra attendants to facilitate transport?
- Are other providers available in the area that would provide the transport at DMAP rates?
- Do staff in another branch (in the same area) know of any provider who might provide the service?

If at all possible, obtain the transport at DMAP rates. If absolutely no provider can be found who will accept DMAP rates, obtain three written estimates from various providers (if possible). Select the lowest estimate provider that can meet the client's medical need. Authorize as you would any other transport. (DMAP does not need to be contacted in advance for in-state transports.) Ensure the dollar amount authorized is entered in the lower right box of the Order if the OMAP 405T is used. If another form is used, ensure the authorized amount is indicated on the form. Also include the reason the special rate was authorized. Rides to services in the provider's local service area are not considered to be special transports, and shall not be authorized as such.

Retain a copy of all estimates, the billing and the Transport Order in the branch record.

NOTE: For clients residing in brokered areas, the broker will arrange for and provide these transports. Non-emergency ambulance transports will still be arranged by the branch, however.

3. Out-of-State Transportation to Obtain DMAP Approved Medical Services

a. Managed Care: If a Prepaid Health Plan subcontracts for services to be provided to a client out of state, and that service is available in-state, the Prepaid Health Plan is responsible for transportation and all associated costs (*i.e.*, meals and lodging for both the client and any required attendant. (DMAP Administrative Rule 410-141-0420 (11)).

If a Managed Care Plan approves out-of-state services for a client because the services are not available in-state, the Managed Care Plan should send a copy of the approval to the branch for branch client records. Upon receipt of the letter of approval, the branch will be authorized to disburse non-emergency transportation funds (including per diem) as required.

If a client's Primary Care Case Manager or fee-for-service practitioner requests out-of-state services, the request must be submitted to the DMAP Out-of-State Coordinator for prior authorization.

If DMAP approves an out-of-state service, a letter of approval will be sent to the branch by the DMAP Out-of-State Coordinator. Upon receipt of the letter of approval, the branch will be authorized to disburse non-emergency transportation funds (including per diem) as required.

NOTE: Providers within 75 miles of the Oregon border are not considered out-of-state.

4. Secured Transports

If the branch is presented with a need for a secured transport, a 405T must be completed to indicate the reason for the need *(e.g.*, suicidal tendencies; a flight risk is not considered appropriate for secured transport). A provider of secured transport is selected by calling three (if possible) available DMAP secured transport providers and accepting the most cost efficient bid for the transport. The 405T is sent to the provider and the transport of the client takes place.

Ensure that the client is Title XIX eligible, that the facility being transported to is a Title XIX provider (if in doubt call the facility and get the six digit Medicaid Provider Number), and that the client is not in the custody of the police/court.

5. Miscellaneous Information

The worker may be able to obtain free or reduced airfare for a client (usually a child) through one of the following resources:

- Air Life Lines (1-916-446-0995)
- American Airlines Miles For Kids
- Make a Wish Foundation (The Medical Social Worker at the receiving hospital may have this information.)
- Angel Flight (1-888-426-2643) or <www.angelflight.org> (Provides *free* non-emergency medical air transport.)

Often the receiving hospital (Medical Social Worker or Nurse Coordinator) has additional information regarding transportation and “special agreements” they have with various organizations for flight and lodging.

It will be the branch’s responsibility to determine the least costly mode of travel (*i.e.*, the use of family vehicle, train, bus).

If the client is a child, DMAP may provide transportation for the child and one parent or escort. Most airlines will not charge for the escort, or will discount the escort’s rate, if the medical need is known.

6. Helpful Hints

- Lodging
  - ♦ Is there a Ronald McDonald house at the hospital?
  - ♦ Is there free (or reduced) lodging at or near the hospital that the hospital can recommend? Costs?
- Meals
  - ♦ Does the hospital provide a meal ticket (or card) or subsidized meals for clients being seen on an outpatient basis? For parents while the child is being hospitalized?
- Where the client/parent/escort will remain at the facility for a lengthy period of time, the branch may want to make arrangements to send incremental amounts of money to the client in the form of checks made payable to the client. This type of arrangement can be made through the Hospital Social Worker.

- Where the branch has a concern for the client or parent/escort's ability to budget funds over a period of time, arrangements can be made with the Hospital Social Worker to disburse incremental amounts as needed to the client, parent or escort.

Additional information for ordering out-of-state transports can be found in *Client Reimbursed Travel, Meals and Lodging* of this worker guide.

7. Hospital to Hospital, Home or Other Facility Transports

a. Hospital to Other Hospital and Return

Certain hospitals may have admitted a client but not have equipment for certain services, testing, or X-rays ordered by the client's attending physician. The client may have to be transported to another hospital where the testing or service can be provided. In these instances, and where the client is transported back to the admitting hospital within 24 hours, the provider must bill the hospital for the transports. No authorization by the branch is appropriate for these transports since the hospital reimburses the transportation provider directly.

b. Hospital to Hospital Transfer

An attending physician may transfer a client directly from one hospital to another hospital for further inpatient care. It is the responsibility of the transportation provider to determine from the hospital if the client has Medicaid coverage and to obtain prior authorization from the branch (or PHP) for these non-emergency transports.

c. Hospital Discharge to Home or Nursing Facility

As above, the Hospital Discharge Planner is responsible (per Hospital Rules) to contact the branch, or request the transportation provider contact the branch to let the branch know the client is being discharged and needs a transport. If the hospital chooses to pay the transport provider without obtaining authorization from the branch, no reimbursement will be made by DMAP to the hospital.

8. Not Covered Transports and Related Services

Following are examples of services/situations where DMAP will NOT reimburse for medical transportation:

- Transportation for a client whose benefit package excludes non-emergency transportation (*e.g*., OHP Standard).
- Transportation for a client who resides in a brokerage area without prior brokerage knowledge or authorization (this does not include ambulance transport).
- Transportation reimbursement for mileage and per diem in those brokerage areas that by contract are to be authorized solely by the brokerage (check with the brokerage in your area to ensure compliance).
- Secured transports to non-Title XIX facilities. Branch must research prior to completion of Transportation Order.
- Secured transports to return a client to their home or place of residence UNLESS written documentation stating the circumstances is signed and submitted by the treating physician. (OAR 410-136-0240) This written documentation must be retained in the branch record for DMAP review.

- Return a client from any foreign country to any location within the United States even though the medical care needed by the client is not available in the foreign country. (OAR 410-136-0300)
- Return a client to Oregon from another state unless the client was in another state for the purpose of obtaining DMAP approved services and/or treatment. (OAR 410-136-0300)
- Transportation for QMB clients
  - Program P2 or M5 clients where the only "Q" Case Descriptor on eligibility segment is "QMB". (DMAP only pays the Medicare premiums, coinsurance and deductible on services that Medicare covers. Medicare does not pay for any transportation other than emergency ambulance; rarely does Medicare cover non-emergency ambulance.)
- Transportation for SMB clients
  - Program P2 or M5 clients where the only Case Descriptor present on the eligibility segment is "SMB". (DMAP pays only the Medicare premium for these clients. They do not get a Medical Identification form and DMAP does not pay for any medical services.)
- Transportation to medical services before spend-down is met.
- Non-emergency medical transportation for undocumented non-citizens (CAWEMs) —except for Admin Exams.
- Out-of-state transportation to obtain services that are not covered by the client's benefit package, even though the client may have Medicare or other insurance that covers the service to be obtained.
- Transportation to a specific provider based solely on client preference or convenience, when the service to be obtained is available from a provider in or nearer the client's city (or town) of residence.
- Transportation to obtain primary care physician/case manager services in a service area outside of the client's local area when a primary care physician/case manager is available in or nearer the client's city (or town) of residence (OAR 410-136-0160).
- Numerous transports to obtain services that could reasonably be scheduled on the same day for the same client or for more than one (1) family member.
- Transportation to recreational activities (*e.g.*, asthma camp), even when doctor prescribed.
- Transports for court-ordered services of any kind (e.g., urinalysis for drug testing).
- Transports occurring while client in custody of law enforcement agency, juvenile detention center, or non-medical public institution.
- Transports to medical facilities where Title XIX dollars cannot be used to reimburse the facility for treatment or services.
- Non-emergency transports not authorized in advance by the client's branch office or brokerage, including client/attendant, private car mileage, meals and/or lodging (in non-brokerage areas and those areas where the brokerage does not by contract have authority to approve).

- Transports provided by a provider not enrolled with DMAP, or a provider who refuses to enroll with DMAP or is unwilling to accept DMAP scheduled or negotiated rates.
- "After hours" transports where the branch office was not notified within 30 days of the transport.
- Transports where no actual client transport occurred even though the transport may have been authorized by the local branch office.
- Transports to non-covered services, non-medical services, school or social activities, parenting classes or relief nurseries provided while parents are attending parenting classes, weight loss or anger management classes, WIC, Citizen's Review Board Hearings, YWCA, YMCA, Alcoholics Anonymous, Narcotics Anonymous, Pioneer Trails, etc. Transportation to Ponderosa Residential Facility or J Bar J Residential Facility in Bend may only be authorized if a client is going to or being returned from a covered medical service.
- Transports for visitation purposes.
- Transports for visits to the client's 'DD' caseworker for group or individual counseling or other sessions. (Transports for MH and A & D are allowed).
- Transportation of a client for the purpose of picking up purchased or repaired durable medical equipment. Administrative rules for DME stipulate that pick-up or delivery of purchased/repaired equipment is included in the purchase or repair price of the item. This does not include prosthetic/orthotic repair or adjustments.
- Additional paid transports should not be authorized for clients when the branch has already issued a monthly bus pass. (Note: change in client level of need or other circumstances would be an exception.)
- Transports to visit sick infant/child or critically ill/injured spouse with poor prognosis.
- Transport of Medicaid clients when those same transports are available at no cost to the general public or when the general public is being transported in the same vehicle at no cost.
- Transports provided to ineligible clients. Always verify client eligibility prior to authorizing transports.
- Transportation to obtain an exam ordered by Social Security, VRD, etc. For Title XIX purposes, these exams are not considered to be medically necessary. VRD has funding to pay for transports to exams required by VRD.
- Transports for the sole purpose of nursing facility "shopping"; i.e., client already in the nursing facility, is looking for another. Exceptions would be a "step-down" to a lower level of care, or "step-up" to a higher level of care with the prior approval of the DMAP Transportation Program Manager.
- Moving client's personal possessions, (*e.g.*, TV or furniture) from home or facility to another facility, or transports for the purpose of picking up a deceased client's medical equipment purchased by DMAP. (This equipment becomes a part of the estate of the deceased.)
- Transports to obtain prescriptions from a pharmacy that offers free delivery.
  - ♦ See DMAP Worker Guide, Section 14, for information on the Home-Delivery (Mail Order) Pharmacy Program.

- Transports of any nature after a client is deceased. The above list is not intended to be all inclusive but is provided for illustrative purposes only.

E. Client Reimbursed Travel, Meals, Lodging

1. **Guidelines** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services. Coordinate with the local brokerage, by phone, e-mail, etc. when providing client reimbursements to ensure that the client is not double dipping by getting a ride from the brokerage at the same time.)

   After verifying that appointments scheduled by clients are for covered medical services, and when the client has indicated and the branch has verified the need for financial assistance to access those services (see *Brokerages* section), the branch is authorized to issue a check payable directly to the client (or guardian, etc.) for travel expenditures. Occasionally, the client may need to travel away from their local area. In this case, it may be appropriate for the branch to provide financial assistance for meals and lodging. (See *Attendant* and *Meals [Client/Attendant]* sections.) In all instances, however, it remains the branch's responsibility to ensure the abuse of services does not occur, and to ensure the required screening documentation is completed for retention in the branch record. As with all non-emergency medical transportation, client mileage (including gas only), meals and lodging must be authorized in advance by the branch.

   Reimbursements under the amount of $10.00 shall be accumulated until the minimum of $10.00 is reached.

2. **Mileage/Gas Only** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services. Coordinate with the local brokerage, by phone, e-mail, etc. when providing client reimbursements to ensure that the client is not double dipping by getting a ride from the brokerage at the same time.)

   All non-emergency medical transportation must be authorized by the DHS branch in advance of the transportation and the actual transportation should occur prior to reimbursement. DHS branches cannot retroactively reimburse clients for trips taken without prior authorization. However, once the DHS branch has authorized the reimbursement, if the client has no other means of making the trip prior to reimbursement, the DHS branch may provide the reimbursement in advance of the trip. Periodic checks by branch personnel should be made to ensure that non-emergency medical transportation disbursements are, in fact, for trips to and from covered medical services.

   DHS branch offices may either issue gas vouchers/tickets or direct mileage reimbursement to clients seeking assistance. Any such reimbursement shall be based on the following formula: Total miles multiplied by $.25 per mile.

   An exception to this reimbursement policy is a DHS Volunteer, who will be reimbursed at the current rate of represented state employees.

   For the purpose of calculating client reimbursed mileage, miles should ordinarily be calculated on a "city limit to city limit" basis. However, a client's destination may be to

a service or facility 10-15 miles inside or beyond the city limit, particularly in the Tri-County area, Salem, and Eugene. A client may also be required to travel additional miles to access a main highway or freeway in order to reach their destination. (Example: There is no direct route from Gold Beach to Sutherlin, so a client may be allowed additional mileage for having to travel an indirect route).

3. **Common Carrier Transportation** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   When deemed cost effective and providing the client can safely travel by common carrier transportation, (e.g., inter/intra-city bus, train, commercial airline) reimbursement can be made either directly to the client for purchase of fare or the branch may purchase the fare directly and disburse the ticket (and other appropriate documents) directly to the client. (OAR 410-136-0840)

4. **Personal Care Attendant (PCA)** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   If a PCA is required to accompany either an eligible child or an eligible adult who is unable to travel alone, payment is allowed for the PCA's **transportation***, and meals. Lodging for the PCA may be reimbursed if the PCA does not share the same room with the client. If the client and PCA share the same room, $40.00 per night is still the maximum payable. If the client is required to stay at the site of medical care, payment can be made for the PCA's return trip by the most appropriate mode available.

   ***Transportation** (if mileage) is payable to either the client or PCA, but not both. DMAP does not reimburse for escort or PCA services. As a rule, the branch should use the following criteria to determine if a PCA is necessary:

   - Client is a minor child.
   - Client is mentally/physically unable to get to medical appointment alone.
   - Client's attending physician has signed a statement indicating the need for a PCA because of the medical/mental condition of the client.
   - Client is unable to drive self home after treatment or service.

   NOTE: Reimbursement for meal allowances provided under the Medical Transportation program are to be treated as "extra expenses" and are not considered to be an expense paid by program benefits. These reimbursement moneys should therefore be excluded from calculation of the client food stamp benefit. (Refer to *FSM, Counting Client Assets*, OAR 461-145-0440).

5. **Meals (Client/Attendant)** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   Client/attendant meals may be reimbursable when a client is required to travel for a minimum of four hours out of their local geographical area, and when the course of that travel spans the recognized "normal meal time". For reimbursement purposes meal allowance will be made when:

   - Breakfast (allowance) - travel begins before 6:00 a.m.
   - Lunch (allowance) - travel begins before 11:30 a.m. or ends after 1:30 p.m.

- Dinner (allowance) - travel ends after 6:30 p.m.

The branch should monitor repeat requests for single day meal allowances closely to ensure the client is not requesting meal allowance excessively. Counseling on appointment scheduling should occur.

6. **Lodging (Client/Attendant)** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

Occasionally a client's medical appointment may necessitate a overnight stay. Lodging is reimbursable for the client when the travel must begin before 5:00 a.m. in order to reach a scheduled appointment or when the travel from a scheduled appointment would end after 9:00 p.m. Again, lodging is payable for the attendant only when the shared room is not with the client.

The branch should determine the actual lodging costs. Lodging may be available below DMAP's reimbursement rate (*e.g.*, Ronald McDonald House is available for $10.00 per night.) When lodging is available below the allowance rate, the branch should only reimburse for the actual cost of the lodging. Reimbursement may only be authorized for one escort, attendant or parent.

NOTE: If lodging is available closer to the facility where the medical service is being provided, it may be more cost effective to reimburse at the full allowance for lodging, if staying at Ronald McDonald House would necessitate an additional taxi ride to the service. The branch needs to look at these options closely.

7. **Miscellaneous**

When ordering out-of-area/out-of-state transportation, remember that the client has to get to the airport, train depot, etc.

Consider the least costly/most appropriate means of transportation; *e.g.*, family, volunteers, bus, cab, stretcher car, etc. Determine from the client (or attendant) if there are special needs:

- Oxygen
- Wheelchair
- Early loading
- Reclining position
- Any other condition which would be a problem for transportation provider

If client is going out of state, work with local travel agents. They can get a better price on tickets, and travel agents are usually aware of the price of shuttles, taxi fares, etc., at the destination point.

Make sure treatment has been approved by the DMAP out-of-state coordinator (if client is going out-of-state).

Contact social work department at the medical facility to be used. They can help the client obtain a room(s) at local Ronald McDonald Houses or other low cost housing in the area.

In the case of a transplant, it is sometimes less expensive for the client/attendant to rent an apartment near the facility than to pay $40 a day for lodging. When renting an apartment on a weekly or monthly basis, the daily allowable amount for lodging is for one person. The allowable amount does not double because of the escort/parent.

Remember to make allowances for transportation to and from the hospital for the attendant.

If the client is released from the hospital, but must remain in the area for further treatment, food and lodging can be paid for the client as well as the attendant, if necessary.

An eligible client (or attendant) from another branch may need meals and/or lodging unexpectedly. (Example: The client may have had a medical evaluation and the attending physician is preparing to admit them to a hospital the following day.) When these situations occur, be prepared (after communication with the client's worker) to disburse moneys from your branch for meals and lodging. Always check with the client's local branch first, however, to ensure moneys have not already been provided to the client. In some cases, ongoing appointments are needed. Rather than providing mileage/food/lodging moneys to the client on a piecemeal basis, and after initial branch approval the branch has the option to request the client to submit reimbursement requests on a monthly basis. When this situation occurs, the client is required to provide the following documentation:

- Date of appointment
- Time of appointment
- Actual miles traveled (odometer)
- Doctor/hospital/clinic name
- Lodging receipts (if stays were overnight)

All documentation must be retained in the branch record. The meals and lodging criteria defined above apply to DHS Volunteers also.

8. Fee Schedule - Client Travel

Procedure Code	**Allowance**	**Or**
A0090 – Private Car Mileage	$.25 per mile	Breakfast 3.00
A0190 – Client Meals	12.00 per day	Lunch 3.50
A0210 – Attendant Meals	12.00 per day	Dinner 5.50
A0180 – Client Lodging	40.00 per night	
A0200 – Attendant Lodging	40.00 per night (if staying in separate room)	
A0110 – Bus, i.e., Greyhound		
A0140 – Airplane (commercial)		

NOTE: Common carrier transportation such as bus, train or airplane, should be made for the least expensive mode suitable to the client's needs.

9. Revolving Fund Procedures

Each DHS branch is able to complete an DMAP 409, which explains the reasons for the services to be paid, and use the SPL1, SPL2 screens to order a check on-line to be prepared and mailed to the client or attendant. Or, the branch may decide to write the check in their branch (especially when there is no time to wait for the check to be issued from Salem) and then complete the information to reimburse the branch for that revolving fund check.

The DMAP 409 form has instructions on the backside of the form. The Computer Guide has the instructions for the SPL screens. When the branch does a revolving fund check, the Financial Accounting Unit must have the revolving fund tissue copy of the check written, in order to reconcile the Revolving Fund account. Reconciled revolving fund checks will appear on the RCIQ check record.

The DMAP 409 with a copy of the AFS 288 Supporting Document Transmittal and the Revolving Fund check tissue copy are sent to:

MicroImaging Unit
P.O. Box 14006
Salem, OR 97309

- If the branch (or you) originated an on-line check to be sent from Salem to the client, the DMAP 409 copy remains in the branch record. The DMAP 409 copy is intended as the branch record of that service.
- If preparation of a CMS 1500 sent to Salem to Financial Accounting to reimburse the branch is necessary, then:
- Route the completed original CMS 1500 to the financial clerk designated in the branch for preparation of the RF check. After the RF check has been typed:
  - ♦ Obtain the client's (or their agent) signature on the third (tissue) copy of the RF check. Retain this copy in the financial clerk files.
  - ♦ Give RF check to client (or their agent) after presentation of identification.
  - ♦ Attach the second (tissue) of the RF check to the completed CMS 1500.
  - ♦ Route all CMS 1500s via completed AFS 288 (Revolving Fund Check & Supporting Document Transmittal) to:

    MicroImaging Unit
    P.O. Box 14006
    Salem, OR 97309

Retain the copy of the CMS 1500 and the yellow copy of the AFS 288 with all supporting documentation in the branch record.

NOTE: Examples of the AFS 288 and CMS 1500 are located at the end of this section.

F. Place of Service Codes

E – Home to Medical Practitioner

F – Home to Hospital

G – Home to Nursing Facility

H – Home to Other (Specify)

J – Nursing Facility to Medical Practitioner
K – Nursing Facility to Hospital
L – Nursing Facility to Home
M – Nursing Facility to Other (Specify)
N – Hospital
P – Hospital to Nursing Facility
Q – Hospital to Other Hospital
R – Hospital to Other (Specify)
S – Medical Practitioner to Hospital
T – Medical Practitioner to Nursing Facility
U – Medical Practitioner to Home
V – Medical Practitioner to Other (Specify)
W – Other (Document in Client Record) to Hospital
X – Other (Document in Client Record) to Other (Document in Client Record)

G. Volunteer Transports (if available in your Service Delivery Area)

1. **Branch Referrals/Responsibility** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   The branch authority is to determine that the client has no other means of transportation available and public transportation is not an option, then consider the DHS volunteer driver program as a resource for the provision of medical transportation to obtain covered services for eligible clients.

   - Ensure that the medical service the client is being transported to is a covered medical service.
   - Use the lowest cost transport that meets the client's needs.
   - Confirm client eligibility.
   - Submit a completed written ride request on the appropriate form to the volunteer driver program office.

2. **DHS Volunteer Coordinator Responsibility**

   The DHS Volunteer Coordinator will review the ride request form and match it to an appropriate volunteer driver.

   The ride request will be denied if:

   - The service is not an appropriate volunteer activity.
   - The ride request form is not completed.
   - A volunteer driver is not available.
   - The transport is not a Title XIX service.

H. Forms <http://dhsforms.hr.state.or.us/forms/databases/FMPRO?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany >

- Revolving Fund Check & Supporting Document Transmittal (AFS 288)
- Example of CMS-1500
- Medical Transportation Screening/Input Document (DMAP 409)
- Medical Transportation Screening Documentation (DMAP 410)
- Medical Transportation Eligibility Screening and Medical Transportation Order (DMAP 406)
- Medical Transportation Order (DMAP 405T)

State of Oregon
Department of Human Services
Adult and Family Services Division

Revolving Fund Check and Supporting Document Transmittal

Send To: Microfilm
P. O. Box 14006
Salem, Oregon 97309

Date: ______________________

From: ______________________ Branch AFS Cost Center: ______________________

1 Name & SSN if Payroll Check	2 Reason	3 Check No.	4 Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
Attach Tissue Copies & Documents for Listed Checks		Total	$

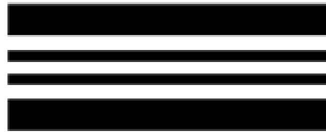
For Administrative Payment Unit Use Only

1. REASON may include 'void' or 'cancel'.
2. List attached checks in numerical sequence.
3. List dollar amounts for checks written to '0' for voids and cancels. (Voids will have stub and check. Cancels have check only.)

Distribution: Original, Microfilm Unit -- Copy, Branch File.

[illegible]

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare#) (Medicaid#) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN # GRP #

PHYSICIAN OR SUPPLIER INFORMATION

MF/N90-1B

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Pick-up (enter date)	mm/dd/yyyy
Mail-by (enter date)	mm/dd/yyyy

Medical Transportation Screening / Input Document

For payments made directly to client/ attendant (see reverse for instructions)
Complete all information applicable

I Client Info

Pgm _____ Branch _____ Wkr ID _____ Case # _____
Client Last, First MI Prime # _____
Home Address Street, City, State ZIP SSN # _____
Phone #
Mail Address Street or POB, City, State ZIP DOB _____
Payee (if other than client) GRDN on SPL2 GRDN CD

II Reason/ Resource Info

Reason (medical necessity) for travel/trip: _____

Is public transportation, or transportation by a relative or friend, available at no cost to OMAP? ☐Yes ☐No

III Appointment Info

Destination _____

Appt. Date mm/dd/yyyy Time HH:MM am/pm Verified by _____

Depart mm/dd/yyyy Time HH:MM am/pm Return mm/dd/yyyy Time HH:MM am/pm

Ongoing Trips: Begin mm/dd/yyyy End mm/dd/yyyy ☐ M ☐Tu ☐W ☐Th ☐F ☐S ☐Su

IV Trip Information (see reverse side for criteria)

Round Trip Mileage	#_____	Miles	@ $0.25/mile	$0.00
Client Meals/ Lodging	#_____	Breakfast(s)	@ $3.00 ea	$0.00
	#_____	Lunch(es)	@ $3.50 ea	$0.00
	#_____	Dinner(s)	@ $5.50 ea	$0.00
	#_____	Nights Lodging	@ *$40.00 ea *or less if available	$0.00
Attendant Meals/ Lodging	#_____	Miles	@ $0.25/mile	$0.00
	#_____	Breakfast(s)	@ $3.00 ea	$0.00
	#_____	Lunch(es)	@ $3.50 ea	$0.00
	#_____	Dinner(s)	@ $5.50 ea	$0.00
	#_____	Nights Lodging	@ *$40.00 ea *or less if available	$0.00

Other: ☐Commercial Airline ☐Intercity Bus ☐Train ☐Bus Pass / Tickets $0.00

Procedure Code = 35

TOTAL $0.00

V Data Entry & Authorization

Terminal Entered by _____ Date mm/dd/yyyy
Revolving Fund Check # Attach tissue copy
Worker/ Requestor _____ Date mm/dd/yyyy
Branch Authorizing Signature _____ Date mm/dd/yyyy

INSTRUCTIONS

Disposition

Pick-up - Enter date.
Mail-by - Enter date.

Section I – Client Info

PGM – Enter client program number.
Branch – Enter branch number.
Wkr ID – Enter worker ID number.
Case # – Enter case number.
Client – Enter full name of client.
Prime # – Enter client prime number.
SSN # – Enter client Social Security number.
Address – Enter client home address, city, state.
Home mail Address - Enter client mailing address, city, state (if different).
Phone # – Enter client phone number.
Client DOB - Enter client date of birth.
Payee – Enter payee name on check, if other than client. (GRDN, Guardian, on SPL2. Then enter "G" as GRDN Code)

Section II – Reason/Resource Info

Enter reason (medical necessity) for travel/trip.

- Mark **Yes** or **No** to indicate what resources are available.
- If resource is available but not used, state reason.

Section III – Appointment Info

Destination – Enter doctor, hospital name, address, city, state, and phone number, if known.
Appt. Date & Time – Enter date and time of appointment.
Verified by – Enter name of branch worker who verified appointment.
Departure Date – Enter date and time (complete only if meals or lodging authorized).
Return Date – Enter return date and time (complete only if meals or lodging authorized).
Ongoing Trips – Enter beginning and ending dates of ongoing rides. Mark appointment days.

Section IV – Trip Information

Round Trip Mileage – Enter total # of miles. Enter total mileage reimbursement ($) authorized.
Client Meals & Lodging – Enter total # of meals and nights lodging. Enter reimbursement ($) authorized.
Attendant Meals & Lodging – Enter total # of meals and nights lodging. Enter reimbursement ($) authorized.
Procedure Code – Enter 35.
Other - Mark one, enter reimbursement ($) authorized.
TOTAL – Enter total $ authorized this transaction.

Section V – Data Entry & Authorization

Terminal Entered By – Enter name of entry operator and date entered.
Revolving Fund Check # – Enter number of RF check and attach tissue copy.
Worker/Requestor – Enter name of person making request and date of request.
Branch Authorizing Signature – Obtain signature of branch authority and date of signing.

Meals (Client/Attendant)

Client/attendant meals may be reimbursed when client is required to travel for a minimum of four (4) hours out of their local geographic area AND when the course of travel spans the recognized "normal" meal time. For reimbursement purposes, meals are allowed when:

Breakfast – travel BEGINS before 6:00 a.m.

Lunch - travel BEGINS before 11:30 a.m. OR ends after 1:30 p.m.

Dinner – travel ENDS after 6:30 p.m.

Lodging (Client/Attendant)

Client/attendant lodging will be allowed when the travel must BEGIN before 5:00 a.m. in order to reach a scheduled appointment OR when the travel from a scheduled appointment would END after 9:00 p.m. If lodging is available for LESS than the allowed rate, the lesser amount must be authorized.

Attendant

Use the following criteria to determine if an attendant is necessary:

- Client is a minor child.
- Client is mentally/physically unable to get to medical appointment alone.
- Client is unable to drive self home after treatment or service.
- Client's attending physician has signed a statement indicating the need for an attendant because of medical/mental condition of the client.

State of Oregon
Department of Human Services
Office of Medical Assistance Programs

Next Screening Due Date ______________

MEDICAL TRANSPORTATION SCREENING DOCUMENTATION

Client: ___________________________ Transportation Code: ______________

Prime ID: __________ DOB: ____________ Prgm: ___ Wrkr: ________

Address: ____

Phone: ____

Contact Person (if applicable): ____

Today's Date: ________________ Completed By: _______________________

Mobility Equipment used:

❐ Wheelchair ❐ Hightop ❐ Extra Wide ❐ Needs transfer assist

❐ Folding Walker ❐ Non-Folding Walker

❐ Other ____

Special Information (eg., needs exceptional assist, behavior problems, extreme obesity, etc.) ____

____

Does client have transportation resources available (eg., car, motorized cart, friend/relative who can provide transportation)?

❐ Yes ❐ No ❐ On Occasion

Why is prior method of transportation no longer usable?

❐ No longer available ❐ Physical/mental condition worsened

❐ Other ____

Transportation Needs (Transportation Code):

___ 0. Not eligible for medical transportation.

___ 1. Can travel (walk, use wheelchair, etc.) up to 1/4 mile (approx. 5 blocks) and board bus/MAX.

___ 2. Can travel (walk, use wheelchair, etc.) to curb unassisted and board LIFT or other vehicle.

___ 3. Needs assistance from home to vehicle to inside clinic/office.

___ 4. Must travel in reclining position (eg., stretcher car).

___ 5. Must have ALS/BLS treatment/intervention/monitoring during transport.

___ 6. Transportation not covered by client's medical insurance.

Branch: Retain in Branch Record

OMAP410(11/99)

tate of Oregon
epartment of Human Resources
ffice of Medical Assistance Programs

Today's Date ____________

MEDICAL TRANSPORTATION ELIGIBILITY SCREENING AND MEDICAL TRANSPORTATION ORDER

Route, Mail or Fax to: Prov Name ________________________ Prov # _____________

Fax # (503) ________________________

Client Name ______________________________ DOB ________ Phone ____________
Last First

Person Submitting Request ____________________________ Phone ______________

Prime ID # [| | | | | | |] Prg _____ Wkr ID______ ❒ Check box if client has no other transportation available for this appointment

Trip Info: ❒ 1 Way ❒ Round Trip ❒ 3 Way ❒ Ongoing ❒ Change to Ongoing

Mode: ❒ Taxi ❒ WC ❒ SC ❒ Ambulance ❒ SC by Ambulance* ❒ Other

Pick Up Address ____________________________ Apt # ____ City ______________

Destination _______________________ Address _________________________________

2nd Destination ____________________ Address _________________________________

Appt Date _______ Pick-up Time ______ Appt Time ______ Return Time ______

Complete for Ongoings Only

Begin Date _______ End Date ________ Sun Mon Tues Wed Thurs Fri Sat
Circle days of week

Ambulatory

Check all that apply

- ❒ Needs assistance from home to vehicle to inside office/clinic
- ❒ Can walk up to 1/4 mile and board bus/MAX
- ❒ With cane
- ❒ With walker

Wheelchair

Check all that apply

- ❒ Can travel to curb or up to 1/4 mile unassisted and board lift or other vehicle

Wheelchair ❒ Has ❒ Needs the following:
Hi-Top Manual Power Reclining Stretch Chair
(circle)

Wheelchair Transferable. Circle if:
By Self With Minimal Assist

Other

Check all that apply

- ❒ Requires treatment/monitoring enroute
- ❒ Has oxygen
- ❒ Has attendant
- ❒ Other Special Instructions ___________

____
____
____
____
____
____
____

Branch Info

$ Authorized (if special or secured transport) $ __

Branch ID ____________________________

Wkr/Clk ID ___________________________

Wkr/Clk Phone _________________________

Provider: Retain in Documentation File Branch: Retain in Branch Record

*Detailed information must be attached for all secured transports

State of Oregon
Department of Human Resources
Office of Medical Assistance Programs

MEDICAL TRANSPORTATION ORDER

Fax to: ______________________________
Transportation Provider

____
Transportation Provider #

____
Fax #

Client Name Last First	Prime #
Pick-Up Address Apt # City	
Mode: Taxi WC SC Ambulance Other* SC by Ambulance (Circle One)	Trip Info: 1-way Rnd Trip 3-Way (Circle One)
Destination (Dr/Clinic Name)	Destination Address
2nd Destination	Address

One-Time
Appt Date: ________ Pick-up Time: _____ am pm Appt Time: ______ am pm Return Time: ______ am pm
$ Authorized ________________ (If Special Transport)

Ongoing
Begin Date: ___________ End Date: ________________ Sun Mon Tue Wed Thu Fri Sat *(Circle Days Needed)*
Pick-up Time: _________ am pm Appt Time: ___________ am pm Return Time: __________ am pm

Today's Date	Branch #	Wkr/Clk ID Phone #

*Special Instructions

***(Detailed Information Is Required For All Secured Transports)**

IMPORTANT! Provider: Retain in Documentation File Branch: Retain in Branch Record

OMAP 405T (11/98)

DMAP Worker Guide XIII

Processing Claims

A. Processing Claims Overview

DMAP's claims processing system is highly automated. It handles approximately 1 million claims per month. This total number of claims includes capitation payments, point-of-sale, EMC, paper claims and nursing home claims (turn-around document or TAD). If all information is correct, providers who input claims electronically by 2:00 p.m. on Friday could receive a check for payment the following week.

Branch staff members are vital to the smooth working of this system.

DMAP depends on field workers to enter timely and accurate eligibility information on clients. Two of the most common errors are that a client changes their name and it is not updated right away or a newborn is not added for medical coverage as soon as possible. If there is an error on a claim, such as a misplaced code or blank field, the claim could suspend or deny. Then the claim will be reviewed by a staff person, causing a delay in payment of several weeks.

Questions about billings - managed care plan clients

Clients who are covered by a managed care plan should contact their plan if they have questions about billings.

Questions about billings - fee-for-service (open card) clients or clients with a Primary Care Manager (PCM)

Clients who are fee-for-service or have a PCM should contact DMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 if they have questions about billings. It is necessary for CASU to have a copy of the bill in order to answer questions and identify possible solutions. Workers may fax, or have the client fax, a copy of the bill to CASU Billing at 503-945-6898.

B. How a Medicaid Claim is Processed

When a provider submits a fee-for-service claim to DMAP, it is processed primarily by a computer—the Medicaid Management Information System (MMIS). Unlike most private insurance companies, the DMAP claims processing system is highly automated. Claims are entered into the system prior to verification or visual checks for clerical errors. Because of this automation and the high claim volume, a misplaced code or a blank field can cause the claim to suspend or deny.

Here's How it Works:

1. Paper claims submitted by mail go first to the Office of Forms and Document Management (OFDM) Imaging Unit. Here the claim is micro-imaged, given an internal control number (ICN), and batched. Depending on volume, the mail intake and the ICN assignment process may take from one to five working days.
2. Claims are then delivered to the Data Entry Unit, where operators manually enter the information appearing on the claims into the MMIS processing system. ONLY required fields of information are keyed into MMIS. Data entry operators can process a single claim in 45 seconds. Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms, or take the time to read and annotate notes or written explanations attached to claims.

3 Providers who bill electronically, by using a modem, computer disks, or tapes, bypass these first two steps and their data is entered directly into the system. It is not uncommon for providers to bill using electronic media claims (EMC) by 2:00 p.m. on Friday and have a check the next week.

4. From this point on, the claim is not seen by any DMAP staff member unless it suspends for specific medical or administrative review. The only way staff can immediately access submitted claim information is to check certain MMIS screens.

5. When a claim suspends, in essence, MMIS is saying that it cannot make a decision — a claims analyst will have to review the data. It is also possible that internal files need to be updated before the claim can be paid; for example, patient eligibility is the most common reason for internal file discrepancy. Since eligibility is determined and updated at the local DHS branch level, DMAP depends on caseworkers to supply accurate and timely eligibility information to MMIS. If the claim has suspended for this reason, two weeks are allowed to pass. Then, if DMAP files still show "no eligibility for patient," the system will automatically deny the claim. Providers receive a denial notice on their remittance advice with an explanation of benefits (EOB) message, such as "Patient ineligible on date of service."

6. There are more than 900 potential questions MMIS may ask about a claim before it can make a payment decision. The computer will try to match data from the claim entered into the system with information about this recipient entered previously.

7. Most paper claims are processed within 30 days. Providers receive a remittance advice explaining payments and denials. The fewer questions the computer asks, the more quickly the claim can be processed.

8. Most claims are denied because of incomplete or incorrect patient or provider data. Please be sure your case information is complete and accurate. Only those procedures which require "cost documentation" or "by report" will suspend for medical review. The Medical Unit analyzes those claims.

The chart on the next page shows how a claim is processed.

Paper Claim

Electronic Claim

The first two steps of a paper claim may take 1-5 working days.

CMS 1500 or UB 92 received in mailroom

↓

Form is Microfilmed and an Internal Control Number (ICN) is assigned

↓

Data Entry Operators feed information from the claim into MMIS

Electronic claims skip the first two steps that a paper claim goes through.

Transmit claims electronically

[Rest of steps are the same for a paper or electronic claim.]

Computer compares info from claim with MMIS reference files

→ Claim suspends; not enough information. Is manually reviewed

Claim **does not** meet Payment Criteria

↓

Computer Denies Claim

Claim meets Payment Criteria

↓

Computer Makes Payment based on fee schedules

Paper claims take about 30 days to process.

Remittance Advice Form sent to provider explaining action

Electronic Claims submitted by 2:00 p.m. on Friday may be paid by the following week.

DMAP Worker Guide XIV

Premiums, Copayments and Special Requirements

- Who pays premiums?
- Non-payment of premiums
- Copayments
- Home-delivery pharmacy
- Pharmacy management program

A. Premiums Overview

Some clients must pay premiums for their OHP benefits. This section will tell you who must pay, how they pay, when they pay, what happens if they don't pay, and whom to call if you or the client has questions about premium payments.

1. Who Pays Premiums?

OHP Standard clients, who are eligible under the OHP-OPU program, are required to pay premiums unless they are exempt. The following OHP-OPU clients (also referred to as HPN persons or OHP Standard clients) are exempt from paying premiums:

- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- CAWEM clients
- Clients with income at or below 10 percent of the Federal Poverty Level (FPL)

2. Premium Rate Schedule

Premium rates are based on the number of people in the household who must apply together for OHP, the number of people who are required to pay premiums and their total countable income. **For the actual premium amounts, refer to CAF Rule OAR 461-155-0235.**

3. Premium Billings and Payment

The Oregon Health Plan Premium Billing Office collects the OHP premiums. The current contractor is Chaves Consulting, Inc, but workers should always refer to it as the "OHP Premium Billing Office."

DMAP sends data to the billing office monthly. Premium billings are sent to clients during the first week of each month. **Payments are due by the 20th of the current month.**

Clients should pay their premiums using the return envelope that comes with their billing. The address is: OHP Premium Billing Office, P.O. Box 1120, Baker City, OR 97814-1120. They may pay in person at 1705 Main Street, Suite 300, Baker City. Staff will accept cash only if presented in person. Anyone may pay premiums on behalf of a client (OAR 410-120-1390). Payments should be made by check, money order or cashier's check. Tell clients who come to a branch office wanting to pay their premiums to send payments to the above address. **Their premium billing includes a return envelope.** The payment coupon should be included with the payment.

4. Nonpayment of Premiums

Clients do not lose OHP coverage during their six-month enrollment period for non-payment of required premiums. However, clients must pay all billed premiums before they can qualify for the subsequent six months of OHP coverage. If a client's income has dropped to 10 percent or less FPL at recertification, you may waive their past-due premium obligation. If clients with income higher than 10 percent FPL fail to pay their billed premiums at the deadline imposed at recertification, they will not be eligible for OHP-OPU. When the OHP Standard program is closed to new enrollees, these clients risk losing coverage altogether by failing to pay their premium debts. Only OHP-OPU clients are affected by not paying their premium debt.

American Indians or Alaska Natives who have proof of tribal membership or are eligible for benefits through an Indian Health Program and CAWEM clients are exempt from paying premiums. Clients who earn 10 percent or less of the FPL are also exempt. Refer to the CAF Family Services Manual for specifics (OAR 461-135-1100, 461-135-1120, and 461-135-1130).

If the Department is notified that a member of the filing group has filed for bankruptcy and the arrearage is a debt that has been stayed in a bankruptcy proceeding, DHS can adjust the arrearage. The decision whether or not arrearage is adjusted or waived, or only part of the arrearage, depends upon the bankruptcy chapter as well as the period of time the bankruptcy covers. Contact a CAF Medical Program Analyst for further information.

The Department will not attempt collection on any arrearage that is more than three years old. The OHP Billing Office automatically makes this system adjustment.

5. Premium Questions

For questions about the billing (whether a payment was received, balance due, etc.), contact the OHP Premium Billing Office between 7 a.m and 6 p.m:

- Toll-free, 888-647-2729 or (888) OHP-2PAY
- Baker City local number, 541-523-3602
- TTY, 866-203-8931
- Fax, 541-523-2145
- Web site, <www.OHPBilling.com>
- E-mail, support@OHPBilling.com

A client who has questions about whether he or she must pay premiums (*i.e.*, eligibility), should call his or her worker. The worker's name and branch telephone number appears on each client's DMAP Medical Care ID.

B. Copayments *General Rule 410-120-1230*

DHS charges some OHP clients a copayment for prescription drugs and/or outpatient services, depending on their eligibility level and benefit package. Copayment information is shown on the client's Medical Care ID in Fields 7a and 7b.

1. Exemptions

OHP Plus clients who are enrolled in a managed health care plan, including dental and mental health plans, do not have to pay copayments for services covered by their plan. Drugs for mental illness are not covered by managed care plans and require a copayment.

The following clients also do not have to pay a copayment:

- Pregnant women
- Children under age 19
- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- Any client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- CAWEM clients

2. OHP Plus – Copayment Information

Some OHP Plus clients must pay the following copayments:

- $2 for generic prescription drugs
- $3 for brand name prescription drugs
- $3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider. There is no additional copayment for services rendered by the provider, such as immunizations, lab tests, or x-rays.

Providers cannot deny services to a client solely because of an inability to pay an applicable copayment. This does not relieve the client of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayments from the client.

Services Requiring a Copayment

The following are services for which an OHP Plus client would be charged a copayment:

- Office visits, per visit for physician/specialist, nurse practitioner, physician assistant or alternative care providers (*i.e.*, chiropractors, naturopaths, acupuncturists)
- Dental services (except for dental diagnostic and preventive routine checkups)
- Mental health and/or chemical dependency (outpatient service)
- Preventive care, per visit for physician/specialist
- Hospital, per visit for outpatient treatments (including surgery) and non-Emergency Room visits (waived if admitted to inpatient care)
- Physical, occupational, or speech therapy services
- Home health services
- Private duty nursing visit and shift
- Enteral/Parenteral IV

Services Exempt from Copayment

OHP Plus clients do **not** have to pay a copayment for the following services:

- Administrative exams and reports
- Dental diagnostic and preventive routine checkups
- DME supplies
- Emergency services
- Family planning services
- Hospice services
- Routine immunizations
- Total blood cholesterol screenings (men age 35-65, women age 45-64)
- X-ray and lab services (*i.e.* mammograms, pap smears, fecal occult blood tests, diagnostic sigmoidoscopy [over age 50])

OHP Plus clients do **not** have to pay a copayment for the following drugs:

- Prescription drugs for family planning services, such as birth control pills
- Prescriptions obtained through the Home-Delivery (Mail Order) Pharmacy Program

3. OHP Standard – Copayment Information

Copayments for clients on the OHP Standard Benefit Package were eliminated June 19, 2004. (OAR 410-120-1230)

C. Home-Delivery (Mail Order) Pharmacy Program

Clients who have ongoing prescription needs and a stable medication regimen may receive their prescriptions through the OHP Home-Delivery Pharmacy Program. Clients do not have to make copayments on drugs ordered through this program. Clients 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). Mental health clients may use the home-delivery services only for drugs their mental health plan does not cover.

Home-Delivery Pharmacy Program is currently contracted through Wellpartner. Prescription order forms are available from the DMAP Web site at:

<http://www.oregon.gov/DHS/healthplan/clients/mailrx.shtml>

Mail first-time prescriptions and completed order forms to Wellpartner, Inc., P.O. Box 5909, Portland, OR 97228-5909. Clients may enroll themselves by calling Wellpartner at 1-877-935-5797. Health care providers can fax the prescription to 1-866-624-5797. (This fax number should only be used by the doctor or health care provider).

D. Pharmacy Management Program

1. Overview

The purpose of the Pharmacy Management Program is to minimize drug-seeking behavior by identifying and monitoring high drug utilization and to provide better coordination and management of prescription drugs for beneficiaries. Some clients will be restricted to the pharmacy of their choice to receive prescription drugs.

NOTE: Although clients will be enrolled in a single walk-in pharmacy or chain, they can use the Home-Delivery (Mail Order) Pharmacy Program in addition to the walk-in store.

2. Selection

Clients are restricted to a single pharmacy, per household, once First Health processes a pharmacy claim and it shows adjudicated at DMAP. First Health sends a weekly file to DMAP by Thursday of each week. The client's TPR file (ELGX) is automatically updated to show the restricted pharmacy for the entire household and a new Medical ID card is generated. The client will also receive a system-generated notice explaining the program and allowing a 30-day window to change pharmacies. Clients are restricted to one pharmacy per household.

The designated pharmacy shows on ELGX effective the following Monday, after the Thursday transmission from First Health. If a client selects a pharmacy that is located in multiple locations throughout the State (chain), they may access any pharmacy belonging to that chain, regardless of geographical location within Oregon and contiguous service areas.

3. Who is Enrolled?

All clients who are fee-for-service receiving Medicaid benefits, who are not exempt, are enrolled into the Pharmacy Management Program.

4. Exemptions from Pharmacy Management Program

Enrollment into the Pharmacy Management Program will be mandatory unless the client:

- Is enrolled in a Fully Capitated Health Plan (FCHP)
- Has private major medical insurance policy
- Has proof they are American Indian or Alaska Native
- Has proof of eligibility for benefits through Indian Health Services
- Is a child in DHS care and custody
- Is an inpatient in a hospital, long-term residential care facility, or other medical institution

5. Changes to a Client's Pharmacy Management Program

Clients may change their pharmacy selection at any time for one of the following reasons:

- They move
- They are reapplying for OHP benefits, or
- They are denied access to pharmacy services by their selected pharmacy

For changes, the worker can either contact DMAP's Client Enrollment Services (CES) with the client's pharmacy choice or the client may call the Client Services Unit (CSU) directly at 1-800-273-0557. CSU will be responsible for giving the information to CES to update the client's TPR file. The system generates a new Medical ID each time a change is made to the client's TPR file.

Branch workers may fax, telephone or mail the client's pharmacy choice to CES. Branch workers can call CES directly at (503) 945-6523. Fax to (503) 945-6873 or mail to:

DMAP Client Enrollment
500 Summer Street NE, E44
Salem, OR 97301-1079