Office of
Medical Assistance Programs

Worker Guides

Contains updates through 2/1/2006

DHS
**Oregon Department
of Human Services**

OMAP Worker Guides

Revision Record

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

Rev#	Rev Date	Rev#	Rev Date
1	04/01/00	21	02/01/06
2	07/01/00	22	
3	10/01/00	23	
4	10/01/00	24	
5	01/01/01	25	
6	04/01/01	26	
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9	**01/01/02**	29	
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OMAP Worker Guide #1

OMAP/Medicaid Overview

A. OMAP/Medicaid Overview

The Office of Medical Assistance Programs (OMAP) is an office of the Department of Human Services, Health Services cluster, which:

- Determines policy and rules for medical assistance program services 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 medical assistance covered services.
- Contracts with prepaid health plans (PHP) for the OHP.

Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD), and the Oregon Youth Authority (OYA) are the direct link 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 PHPs in mandatory enrollment areas.
- Provide choice counseling to clients when needed regarding the selection of PHPs available in their area.
- Enter eligibility data into the computer system.
- Order replacement Medical Care Identifications (ID) on ELGH, or issue temporary Medical IDs on MID1, when needed. Although this is usually called a medical card, it is actually a letter-sized sheet of paper. See samples of the Medical ID in Worker Guide #3.
- Arrange for and prior authorize transportation, when needed, to access health care services.

When health services are delivered to the client, the provider completes a claim form and submits it to OMAP unless the client is in a PHP. OMAP processes claims through the Medicaid Management Information System (MMIS), a computerized claims processing system. Provider checks are issued weekly, accompanied by a remittance advice which includes an explanation of benefits.

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

B. Where to Send Information

DHS 148
CMU – CAF
FAX to (503) 373-0357 or send as a
Groupwise attachment to
MAINTENANCE, Client

DHS 415H
HIG – CAF
PO Box 14023
Salem, OR 97309
(also on-line SYSM)

DHS 451, DHS 451NV
PIL – Admin. Svcs.
PO Box 14512
Salem, OR 97309

OMAP 502 and 502N
OMAP Claims
PO Box 14951
Salem, OR 97309

OMAP 505
OMAP Claims
PO Box 14015
Salem, OR 97309

CMS-1500
OMAP Claims
PO Box 14955
Salem, OR 97309

CMS-1500 *(admin exams)*
OMAP Claims
PO Box 14165
Salem, OR 97309

CMS-1500 *(private duty nurse)*
OMAP Claims
PO Box 14018
Salem, OR 97309

CMS-1500 *(death with dignity)*
OMAP Claims
PO Box 992
Salem, OR 97308-0992

OMAP 3073 (private health insurance
premium referral)
HFO – OMAP
500 Summer St. NE, E-44
Salem, OR 97310-1014

UB-92
OMAP Claims
PO Box 14956
Salem, OR 97309

DHS 443 Hearing Requests *(medical)*
OMAP Hearings Unit
500 Summer St. NE, E-49
Salem, OR 97301-1079

OMAP 501-D or ADA Form
OMAP Claims
PO Box 14953
Salem, OR 97309

C. OMAP Field Resources

AIS – Automated Information System (client eligibility info)
    Provider Services Unit – OMAP 1-800-522-2508

Billing Questions (for medical providers only, not clients)
    In State: HFO – OMAP...1-800-336-6016
    Out-of-State: CMU – OMAP ....(503) 945-6522

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

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

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

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

Health Insurance Group
    HIG – Admin Services...(503) 378-2220

Hearings and Expedited Hearings (medical service issues)
    OMAP Program and Policy ....(503) 945-5785

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

Insurance Premiums
    HIP – CAF ....(503) 945-6135
    Private Health Insurance (premium referral) – OMAP.......................(503) 945-6562

Interpreter for the Deaf (medical appointment/care)

    ODC/DHHAP 1-800-521-9615

Medical Payment Recovery

    MPR – Admin Services ....(503) 947-4250

OHP Application Requests

    OHP Telecommunication Center... 1-800-359-9517 or

    ....TTY: 1-800-621-5260

OHP Benefits RNs

    Medical Unit – OMAP... 1-800-393-9855 or

    ....(503) 945-5772

OMAP Forms

    Order through CICS.. Order on FBOS

Out-of-State Medical

    Prior authorization – OMAP Medical Director ....(503) 945-6488

    Emergency Claims – OMAP Claims Mgmt Unit ....(503) 945-6522

Premium Billing Questions

    OHP Premium Billing Office...1-800-922-7592

Prepaid Health Plan (questions/problems on managed care enrollment)

    OMAP – Health Management Unit (HMU) .... (503) 945-5772 or

    OMAP.HMU@state.or.us, or *HMU, OMAP* in Groupwise

Pharmacy Management Program

    OMAP – HMU... (503) 945-5772 or

    OMAP.HMU@state.or.us, or *HMU, OMAP* in Groupwise

Transportation

    Policy – OMAP Policy Unit ....(503) 945-6493

    Authorization – Local Branch Offices

Transplant Services

    OMAP Medical Director...(503) 945-6488

Personal Injury Liens

    PIL – Admin Services...(503) 947-9970

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

OMAP Worker Guide 2

The Oregon Health Plan

A.   The Oregon Health Plan

The goal of the Oregon Health Plan (OHP) is to ensure that most low-income Oregonians have access to medical care. The plan was a cooperative effort by health care providers, health care consumers, business, labor, insurers, and lawmakers.

To make this plan work, Oregon devised a new way to provide medical services to the greatest number of people. Instead of limiting the number of people eligible for medical assistance to the extent that most states do, Oregon limits which medical services are covered. Oregon had to obtain federal waivers to make these changes.

After extensive work, public hearings around the state, and revisions to meet federal objections, the Oregon Health Services Commission produced a list of nearly 750 health conditions and their treatment, prioritized from the most to the least effective. The legislature determined what services it could pay for and set the cutoff point on the list. Those services above the cutoff point are funded, while items below the line are not funded.

Extensions to this waiver have been granted to continue running the OHP.

Phase I of the Medicaid demonstration project started February 1, 1994. This meant changes in benefits and service delivery for most current Medicaid clients and new coverage for about 120,000 low income men, women, and children.

On January 1, 1995, Phase II brought additional populations into the managed health care system: the aged, blind or disabled, foster children, and children under the jurisdiction of the Oregon Youth Authority.

Additionally, benefit packages were changed under Phase II. Outpatient alcohol and drug (chemical dependency) treatment was provided through the managed health care system, and expanded mental health services were provided to medical assistance clients.

In 1998 several policy changes were made to the OHP in the areas of eligibility for higher education students, domestic violence survivors, and self-employment income. The income guidelines for pregnant women were also expanded and the Children's Health Insurance Program (CHIP) was implemented which allowed coverage for more children under 19 years of age.

In 2002, Oregon received approval from the federal Centers for Medicare and Medicaid Services (CMS) to implement a five-year Oregon Health Plan 2 (OHP2) demonstration project. OHP2 was designed to stabilize the existing Medicaid demonstration project and to enable Oregon to expand health coverage to more uninsured Oregonians at no additional cost to taxpayers or the State.

As the first phase of OHP2, Oregon began receiving federal funds to provide medical coverage to eligible clients through the Family Health Insurance Assistance Program (FHIAP). FHIAP is a program that subsidizes employer-sponsored and individual health insurance premiums. FHIAP's income guidelines were also expanded slightly. This first

phase of OHP2 went into effect on November 1, 2002. Expansion on the FHIAP side is expected to help thousands of additional Oregonians gain medical coverage.

On January 1, 2003, Oregon implemented a legislative directive separate from OHP2. OHP and other medical assistance programs began requiring copayments for prescription drugs and outpatient services for certain clients.

On February 1, 2003, the second phase of the OHP2 demonstration project took effect (for medical assistance programs administered by the Department of Human Services).

First, income guidelines for pregnant women and some children qualifying for the OHP Plus benefit package were increased slightly to enable more Oregonians to gain coverage.

In addition, the OHP Basic Benefit Package was replaced with two new benefit packages: OHP Plus and OHP Standard. Both of these benefit packages were based on the Prioritized List of Health Services adopted by the State Legislature. Existing OHP clients were transferred to one of these two benefit packages based on their qualifications for medical assistance.

The OHP Standard benefit package was designed to more closely resemble private health insurance. Specifically, it was designed to cover less benefits than OHP Plus and to require mandatory premium payments and higher copayments for many services.

On March 1, 2003, the OHP Standard benefit package experienced cuts that included dental services, outpatient mental health treatment, outpatient chemical-dependency treatment, and durable medical equipment and supplies. The legislature authorized these cuts in order to balance the state budget.

Significant changes continued to occur in 2004 for the OHP Standard benefit package. Effective June 19, 2004, all copayments were eliminated for the OHP Standard benefit package as the result of a court ruling. However, individuals receiving OHP Standard were required to continue paying monthly premiums for coverage.

In early 2004, Oregon voters rejected Ballot Measure 30, which would have authorized a temporary income-tax increase. The failure of Ballot Measure 30 led to a decision to use no state general-fund dollars to support the OHP Standard benefit package starting August 1, 2004.

Efforts were undertaken to preserve a limited OHP Standard program using legislatively approved provider tax revenue. Budget constraints made it necessary to reduce the population served under this limited OHP Standard program. OHP Standard closed to new eligibles on July 1, 2004, as a first step in meeting these new budget constraints. People already on OHP Standard were notified that they must continue to pay their premiums monthly and reapply in a timely manner.

Clients on the Citizen/Alien-Waived Emergency Medical (CAWEM) benefit package who qualified using the same criteria as OHP Standard clients (except for citizen or alien status) will be treated the same way as other OHP Standard clients. If they qualify for CAWEM based on Standard program eligibility requirements before July 1, 2004, there

will be no change for them as long as they reapply on time and are found eligible. If they lose medical coverage, they will not be able to qualify for the OHP Standard program until enrollment re-opens. When an individual applies for medical coverage, regardless of whether enrollment for OHP Standard is open or closed, eligibility for all open medical programs will be explored.

On August 1, 2004, OHP Standard benefits were reconfigured once again, as directed by the 2003 legislative assembly. Certain services were reinstated to the OHP Standard benefit package, including outpatient mental health, outpatient chemical dependency, an emergency dental package, and limited medical equipment and supplies. Other services were cut from OHP Standard, including acupuncture (except for the 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, and speech therapy.

OMAP Worker Guide #3

Medical Care Identification

A. Medical Care Identification

The OMAP 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 prepaid health plan (PHP) 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 an OMAP contracted PHP, the first Medical ID they receive may not show their PHP. Until their PHP 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 PHP is listed on the Medical ID, clients must get their care through their selected PHP.

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. Replacement Medical IDs can be ordered by a worker 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 (OMAP 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 OMAP Medical Care ID (front and back) is shown on pages 2 and 3. A sample of the temporary IDs (OMAP 1086 and MID1) are shown on pages 4, 5 and 6.

① ②

③

OMAP Medical Care Identification (ID)

④ Branch Name Division ⑤ Worker ⑥ Phone

⑦a **Copay 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

⑨a **Benefit Package**

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

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.

⑦ᵦ 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.

⑧ᵦ 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.

⑨ᵦ 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)

DHS
Oregon Department
of Human Services

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 $3 for outpatient services not paid for by your Plan (listed in 2b)

B $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)

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                    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
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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)

OMAP Worker Guide #4

Benefit Packages

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.

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.

   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 OMAP 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 OMAP's home deliver (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
If premiums are not paid on time, the client may lose coverage before the end of their six month enrollment.

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-L	OHP with Limited Drug
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-L	OHP with Limited Drug
4, D4	Aid to the Disabled	See Computer Guide section 3-L	OHP with Limited Drug
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	NCP	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

OMAP Worker Guide #5

Managed Health Care

A. Managed Health Care Systems

OMAP contracts with prepaid health plans (PHP) to provide services to Medicaid clients in exchange for a monthly capitation payment for each enrolled client. The following types of managed care are considered PHPs:

- Fully Capitated Health Plans (FCHP)
- Physician Care Organizations (PCO)
- Dental Care Organizations (DCO)
- Mental Health Organization (MHO)

When the client has been enrolled into a PHP, the PHP 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 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 services which are paid for by the PHP. A comparison chart is included in the OHP application packet (not included in reapplication packets) and describes the PHPs available in the area where the client lives and what coverage each plan will provide.

Important –Medical Case Management (MCM) and Disease Case Management (DCM) are not types of managed care. The clients who are part of the MCM and DCM programs have certain health conditions (i.e., athsma, diabetes). MCM or DCM contractors are listed in field 8a "Managed Care/TPR" of the Medical ID, however, 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.

1. Fully Capitated Health Plans (FCHP)

The most common delivery system is the fully capitated health plan (FCHP). OMAP pays the FCHP a monthly capitation fee 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 drugs. FCHPs provide exceptional needs care coordination (ENCC) for the special needs of the aged and disabled populations in the OHP. Clients in the adults/couples category 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 detailed information.

2. Physician Care Organization (PCO)

OMAP pays the physician care organization (PCO) a monthly capitation fee 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 in the adults/couples category 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 detailed information.

3. Primary Care Managers (PCM)

In areas where there are not enough medical plans to provide coverage for all clients, OMAP contracts with providers to be primary care managers (PCM). PCMs manage a client's health care for a nominal monthly case management payment and bill OMAP on a fee-for-service basis for services provided to the client. Clients with major medical private health insurance also choose a PCM, as will some other clients who have special care needs. PCMs may be physicians, physician assistants, nurse practitioners with a physician backup, or naturopathic physicians with a physician backup. 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.

4. Dental Care Organizations (DCO)

Dental care organizations (DCO) are prepaid dental plans that provide dental services to qualified medical assistance clients. OMAP pays the DCO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's dental care.

5. Mental Health Organizations (MHO)

Mental health organizations (MHO) provide mental health services to qualified medical assistance clients. A client's MHO enrollment is determined by the medical plan the client chooses. OMAP 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:

- An OMAP Medical Plan (FCHP or PCO) or PCM (if no medical plans are available), and
- An OMAP Dental Plan (DCO), and
- An OMAP Mental Health Plan (MHO)

In certain situations, clients may be either temporarily or permanently exempt from managed care enrollment. Before enrolling a client into managed care, check to see if the client qualifies for an exemption. See section E –*Exemptions from Managed Care in this worker guide for detailed information*.

PHPs and PCMs serve clients throughout the state, each serving clients in different service areas. Each service area is made up of one or more counties. Service areas are considered "mandatory" or "voluntary" based on the number of PHPs and PCMs available. Clients who live in a mandatory service area are required to enroll in a PHP and/or PCM. Enrollment in voluntary service areas is not required, however, it is preferred. The ENRC screen shows mandatory and voluntary enrollment areas.

The KSEL screen gives the following information (based on zip code):

- The types of managed care coverage available (i.e., medical plans, dental plans)
- The PHPs and/or PCMs available
- Information about services covered by the PHP and the PCM's specialty
- The PHP's enrollment status:
    - ♦ Open for enrollment
    - ♦ Accepting re-enrollments
    - ♦ Time limits are for re-enrollment

Sometimes a managed care plan must close enrollment to new members. When a plan is closed, check KSEL to see if there is a re-enrollment period. Re-enrollment periods are usually 30 days. If the client was enrolled in a plan that is now closed and it has been less than the number of days showing for re-enrollment between their end date and when the worker is doing the enrollment action, the client may be able to get back into the plan. Workers should contact HMU to request the client be enrolled in the closed plan. If a family already has a member in a plan that is closed, any new or returning family members can also be enrolled in a closed plan.

1. Selection Process

The PHP and PCM selection process is based on whether the client lives in a mandatory or voluntary enrollment area.

In determining the appropriate PHP and/or PCM selection process, it is important to understand that an area can be a mandatory and voluntary area as well as a single and multiple plan area at the same time. For example, the client lives in an area with multiple medical plans available but only one available dental plan. The worker would use the "multiple PHP" enrollment process for selecting the medical plan and the "single PHP" enrollment process for the dental plan. This reasoning applies to mandatory and voluntary areas as well.

Clients who live in a mandatory area must select a medical plan (FCHP or PCO) or PCM (if a medical plan is not available) and a dental plan (DCO). Clients are auto-enrolled into an MHO based on their medical plan or PCM enrollment and are therefore not required to choose a MHO.

Clients can only change their enrollment (within 30 days) if they did **not** choose their PHP and/or PCM. Clients who were enrolled into the PHP 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*.

Important Dental Travel Reimbursement: Travel reimbursement assistance is available for clients who cannot obtain dental care in their local area. For more information about this assistance, clients should call their DCO or if they receive dental services on a fee-for-service (open card) basis the Client Advisory Services Unit (CASU) at 1-800-273-0557.

Mandatory – Multiple PHPs – Enrollment Process

Use this process for clients who:
● Live in a mandatory area, and
● Have more than one PHP available, and
● Either did not choose a PHP or the PHP they chose was not available – *see "Client Notification Requirement" below*

The worker must choose a PHP based on an alphabetical selection. For example, the worker would enroll the client in the first (alphabetically) available PHP. The next enrollment (in the same service area) would go to the next (alphabetically) available PHP 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 a PHP. *See "3. Auto-Enrollment" for more information*

Mandatory – Single PHP – Enrollment Process

Use this process for clients who:
● Live in a mandatory area, and
● Have only one PHP available, and
● Either did not choose a PHP or the PHP they chose was not available – *see "Client Notification Requirement" below*

The worker must enroll the client in the available PHP.

If the worker does not enroll the client and the client does not have an approved exemption, the client will be auto-enrolled into a PHP. *See "3. Auto-Enrollment" for more information*

Mandatory – No PHP Available – Enrollment Process

Use this process for clients who:
● Live in a mandatory area, and
● Have no PHP available, and
● Either did not choose a PHP or the PHP they chose was not available – *see "Client Notification Requirement" below*

The worker must enroll the client in a PCM. When there are no PCMs available, the client will receive services on a fee-for-service basis (open card).

If the client does not have an approved exemption, the client will be auto-enrolled into a PHP when one becomes available. *See "3. Auto-Enrollment" for more information*

Voluntary Enrollment Process

If the client lives in voluntary enrollment area, they are not required to enroll in a PHP or PCM. However, they should be encouraged to enroll in a PHP or PCM because it can increase their access to services.

Clients who are not enrolled in a PHP or PCM receive their services on a fee-for-service basis (open card). These clients are not considered exempt from managed care enrollment. The client will continue to receive services on a fee-for-service basis (open card) until the area changes to mandatory. This is not an allowable exemption. *See "E. Exemptions from Managed Care" for more information*

Client Notification

If the client was enrolled into a managed care plan or PCM other than the one they chose, 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 their enrollment within 30 days.

2. Mandatory/Voluntary Service Area Changes

When a client's service area changes (mandatory/voluntary), during their certification, their managed care enrollment status will change as follows.

- Mandatory to Voluntary – The client will remain enrolled in their PHP and/or PCM until they reapply.
- Voluntary to Mandatory –The client will be enrolled at redetermination or auto-enrolled by OMAP Systems. *See "3. Auto-Enrollment" for more information*

3. Auto Enrollment

This information does not apply to clients who have been coded with an exemption. See section E –Exemptions from Managed Care in this worker guide for detailed information.

OMAP Systems will auto-enroll clients who are receiving services on a fee-for-service basis (open card) in a mandatory enrollment area. Clients who have been auto-enrolled can ask (within 30 days from the enrollment) to change their PHP if there are other PHPs available in their area. However, they cannot go back to fee-for-service (open card). A notice is sent to inform the client that they have been auto-enrolled and that they can request a change.

C. Effective Date of PHP Coverage   *OHP Rule 410-141-0060*

1. Existing Clients

When an existing client has moved out of their PHP and/or PCM's service area, enter their changes as follows:

- Day 1 – Enter the client's address change – existing enrollments will end that night
- Day 2 – Enter the client's new managed care enrollment information – the client will be enrolled at the next weekly enrollment

If both address and managed care enrollment changes are made on the same day, the client's current managed care enrollment will not end until the last day of the month. This will cause their new enrollment to be delayed until the following month.

	Date	Worker enters	Address change effective	Managed Care Enrollment	
				Existing ends	New begins
Correct	8/4/05	Address change	8/4/05	8/4/05	
	8/5/05	New managed care information			8/15/05
Incorrect	8/4/05	Address change **and** new managed care enrollment information	8/4/05	8/31/05	9/1/05

2. New Clients

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

- Before **5:00 p.m. on a Wednesday**, coverage is effective the **following Monday**
- After 5:00 on a Wednesday, coverage is effective a week from the following Monday

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

Newborns are retroactively enrolled back to their date of birth as long as their birth mother was enrolled in a PHP at the time of the baby's birth. This retroactive enrollment pays capitation 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.

MHOs – OMAP Systems auto-enrolls clients into MHOs each month, with the first of the month as an effective date.

D. Disenrollment/Changes in Managed Care   *OHP Rule 410-141-0080*

Clients may change their PHP or PCM:

● When they reapply

● If they move out of the PHP or PCM service area

● Within 30 days of an auto-enrollment in an area with multiple PHPs

● When approved by OMAP

Contact HMU when the client's enrollment needs to be changed or when clients are requesting disenrollment due to access of care or quality of care issues. **Questions about disenrollment/changes can be sent to omap.hmu@state.or.us (HMU, OMAP in Groupwise).** For assistance in deciding whether or not a client is eligible to change plans, contact the OMAP PHP Coordinator.

E. Exemptions from Managed Care   *OHP Rule 410-141-0060*

Exemption Codes

Clients may temporarily or permanently be exempt from enrolling in a PHP if they are coded with one of the codes in the following table. Some codes are restricted and must be entered by HMU. **All** exemptions require a specific date (other than 999999) except "PIH".

Some exemptions must be approved by the OMAP Medical Director or PHP Coordinator. For questions regarding exemptions, contact HMU.

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 very 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 PHP 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 PHP. The worker must have documentation from the client's medical provider before using this code. Documentation must be kept in the client's casefile.
EXL	Use when the client's PHP requested, with good cause, to have client disenrolled and excluded from enrollment
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 – Use when the client is an inpatient in a hospital on the day their managed care enrollment was to begin. Enroll the client 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 Program – the client 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 OMAP Medical Care ID
PRG	Use this code for a pregnant woman when she: 1 – Is in the third trimester of pregnancy, and 2 – Is under the care of a provider who is not contracted with an available PHP, and 3 – Has not enrolled in a PHP during the past three months
MED	Use when a client's medical condition or medical care requires special handling by OMAP, or the client has end stage renal disease (ESRD). Contact HMU to use this exemption. These clients show an end date of 2049.
OTH	**Other reason** – Not to be used in local offices – All requests for this code require authorization by DHS and will include a review of physician notes.
REL	**Religious consideration** - This is used in the rare instance when religious beliefs would prevent the client from accessing a covered service (i.e., a woman needed to see a woman doctor and the PHP did not have female doctors)
RIF	**Rehabilitation/Inpatient/Nursing Facility** – Use for clients in Eastern Oregon Training Center, Eastern Oregon Psychiatric Center, 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 PHP. Documentation must be kept in the casefile.
SUR	Use when the client has surgery scheduled and the current provider is not part of one of the available PHPs

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 a PHP and/or PCM.Client's who are exempt from managed care because of private health insurance are not allowed to be enrolled into managed care. Their private health insurance must remain the private payor.

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.

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
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 Medicare HMO members in medical plans (unless the HMO is also an OHP medical plan), or with PCMs. They may be enrolled in DCOs.

If private health insurance is terminated, the branch worker *must* submit a copy of the 415H with termination date to the Health Insurance Group (HIG) and update the private health insurance (PHI) flag on the PCMS screen.

A case is listed on a discrepancy report if there is a difference between the PHI code and the TPR file, (example: 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 PCMS or submit 415H's to HIG. HIG also researches the discrepancy report and requests additional information from branch workers or requests that PCMS be updated.

Caution: The PHI flag **does not** stop enrollment into managed care, even if that enrollment is inappropriate because of a client's private health insurance. 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 that is not possible, enroll with a PCM. Clients who have end-stage renal disease or are in Medicare hospice cannot be enrolled with plans, but should be enrolled with PCMs 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 are enrolled with PCMs rather than PHPs. If the TPR is specialized, like an accident policy, hospital policy, or school insurance, enroll clients as if they had no TPR. Complete the AFS 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" will be changed to "Medicare Advantage Plan." We have started using this name now.

Before enrolling a dual-eligible client into an OMAP Medical Plan, review the information in this section.

1. Medical Plan Enrollment Requirements

Dual-eligible clients can enroll with any OMAP Medical Plan that is available in their area. However, if the OMAP Medical Plan has a corresponding Medicare Advantage Plan, the client must also enroll in the Medicare Advantage Plan.

If the client lives in a mandatory medical plan enrollment area, they are required to enroll in an OMAP Medical Plan. The client can be exempt from Medical Plan enrollment if the only Medical Plan(s) available has a corresponding Medicare Advantage Plan that the client does not want to enroll in.

OMAP Medical Plan with Corresponding Medicare Advantage Plan

The Medicare Advantage Plan Election form (OHP 7208M) must be completed by the client and sent to the OMAP Medical Plan within 30 days of OMAP Medical Plan enrollment. The client would receive their health care as follows:

● Medicaid services – through their OMAP Medical Plan

● Medicare services – through their Medicare Advantage Plan

Clients are not required to enroll in Medicare Advantage Plans. Clients who live in mandatory medical plan enrollment area must be enrolled into an OMAP Medical Plan. However, the client can be exempt from Medical Plan enrollment if the only Medical Plans available have corresponding Medicare Advantage Plans that the client does not want to enroll in. These clients would receive their Medicaid and Medicare health care 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 developing ESRD.

OMAP Medical Plan without a Corresponding Medicare Advantage Plan

Enroll these clients in their OMAP Medical Plan like all other clients. These clients would receive their health care as follows:

● Medicaid services – through their OMAP Medical Plan

● Medicare services – on a fee-for-service basis

2. Medicare Advantage Plan Election (OHP 7208M) Instructions

Clients who are enrolling in their OMAP Medical Plan's corresponding Medicare Advantage Plan must complete the OHP 7208M. 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 OMAP 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 Request to Terminate Insurance form (OHP 7209) must be completed by the client and sent to the Medicare Advantage Plan they are disenrolling from.

H. Choice Counseling

It is important for clients to choose a PHP and/or PCM that best meets their needs. Most of the time, clients make their own decisions about which PHP and/or PCM they choose. PHP comparison charts are included with all "new" application packets. The comparison chart is a choice counseling tool and is formatted so that all PHPs in an area can be compared to one another.

If the client is unable to choose a PHP and/or PCM, one may be chosen for them by a holder of a power of attorney, guardian, spouse, 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 PHP and/or PCM.

Choice Counseling Checklist
- ❒ Does the client reside in a mandatory or voluntary plan area?
- ❒ Is the client's doctor (PCP) in a PHP or enrolled as a PCM?
- ❒ Do the client's children have a PCP? Is the PCP part of an available PHP?
- ❒ 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? 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 system by doing the following:

- Define truly emergent care – These are services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, bleeding profusely, a tooth that has been knocked out, suspected heart attack and loss of consciousness. Refer to the 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 the appointment.

- Explain that there may be a wait for a routine appointment, especially with a dentist (usually from one to three months).

- Primary care providers (PCPs) are an essential feature of 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 can refer them to one.

- Clients need to bring both their Medical ID and PHP card to all appointments.

- Advise clients that some providers are not taking new patients.

- Explain that clients need to follow the rules of their plan and respect doctors and their staff.

- Tell clients to read the *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, i.e., 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 *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

Who to contact		
For DHS Staff use only		
PHP enrollment and eligibility/billing questions No PHP message or wrong PHP on Medical ID AI/AN exemptions Medical exemptions	Health Management Unit (HMU) – OMAP Fax: 503-947-5221 or Email: omap.hmu@state.or.us or HMU, OMAP in Groupwise	(503) 945-7014 (503) 945-6558 (503) 945-6523
PHP claim problems, available services, physicians, etc.	Contracted PHP	Contact PHP listed on client Medical ID
ELGC/ELGR and/or coding problems	Client Maintenance Unit (CMU) – CAF	(503) 378-4369
Private health insurance or third party resource (TPR)	Health Insurance Group (HIG) – CAF	(503) 378-2220
Unresolved client/PHP problems	Client Advisory Services Unit (CASU) – OMAP	Clients can call: 1-800-273-0557
Requests for continuity of care exemptions Expedited hearing requests	Medical Director's Unit – OMAP	(503) 945-5785
Problems with Mental Health Organizations (MHO)	Office of Mental Health and Addiction Services (OMHAS)	(503) 947-5522
Problems with FCHP/PCO/DCO	Delivery Systems Unit (DSU) – OMAP See DSU assignment list or call	(503) 945-5772

OMAP Worker Guide #6

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 OMAP at 1-800-945-5772 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 $2,016 a month for a family of four (based on 2005 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 portion of the premium only – not vision or dental coverage. 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.

The Insurance Pool Governing Board (IPGB) 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 am to 5 pm. Additional FHIAP information can be found on the IPGB web site at:

www.oregon.gov/IPGB/index.shtml

C. 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 **AFS 415A** application.
- For SPD, document in the case record that EPSDT information was given to the client.

OMAP Worker Guide #7

OMAP Payment of Private Health Insurance Premium

A. OMAP Payment of Private Health Insurance Premiums

OMAP 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 OMAP

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

1. Excluded Groups

OMAP 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 per rule 461-135-0990.

2. Referral to OMAP

A case must be opened (on CMS) before sending a referral to OMAP.

PHI premium payment referrals must be sent to OMAP on the Premium Referral (OMAP 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
OMAP – HFO
500 Summer St NE E44
Salem OR 97301-1079

When completing the OMAP 3073, do not leave any area blank, if an area does not apply, write N/A.

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

- Premium amount
- Type of coverage (major medical, drugs, etc.)
- Name and address of insurance company
- Policy holder'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)

3. Determining Cost-Effectiveness

OMAP 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 OMAP.

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

)(DHS
Oregon Department of Human Services
Office of Medical Assistance Programs

PREMIUM REFERRAL
FOR PRIVATE HEALTH INSURANCE (PHI)

Todays Date:

> **Return Referral Via mail or Shuttle
> to: PHI Premium Coordinator
> OMAP Claims Management, HFO
> Human Services Building
> 500 Summer St NE E44
> Salem OR 97301-1079**

Client Information:

Program: _____ Branch: _____ Case Number: _____

Case Name: _____ Recipient Name: _____

Worker's Name and Phone Number: _____

Insurance Information:

Policy holder's name: _____   When are premiums due?   monthly ☐   quarterly ☐

Policy/Group # _____   Premium Amount $ _____

                                   Date next premium due? _____

Name and address of health insurance company: Name, address, phone number of sponsoring employer:

_____   _____

_____   _____

_____   _____

Medical Condition/Diagnosis (this area <u>must</u> be completed):
Please specify any major medical conditions or other medical information that justifies premium payments.

ATTACH the following:

A copy of the private health insurance ID card.

An original signed/dated "Authorization for Use and Disclosure of Health Information" (DHS 2099), allowing DHS to obtain applicant's information from the employer/health insurance carrier.

A copy of the COBRA approval letter, if premium request is for COBRA coverage.

OMAP 3073 (REV 5/05)

OMAP Worker Guide #8

Administrative Medical 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

The ELGR screen must show that the client has medical eligibility before OMAP 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, open the medical program case, and a new ELGR screen will be created 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 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 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 OMAP 729 series

The OMAP form 729 is a series of seven forms (examples are in this section) used to order medical procedures. Not all DHS agencies use every form in the 729 series.

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

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

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

6. Ordering OMAP 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 92 (billing forms) are sent directly to OMAP by the provider using the addresses at the bottom of the OMAP 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

		Procedure Codes		
Last Updated 7/1/03		**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 96100 96117 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 99080 S9981	99172
	Follow-up	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 and 90889 96100 96117 99080 S9981	99172

D. Guidelines for the OMAP 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.

Revenue Code 229 Amount to be Billed **Usual Charge** Provider Type: **Hospital (HO)**	Description	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 OMAP 729D.
	Guidelines	(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.
	Hints	Use of OMAP 729D is required.
Revenue Code 309 Amount to be Billed: **$22.00** Provider Type: **Hospital (HO)**	Description	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.
	Guidelines	(1) Use for drug screening for Child Welfare and OYA clients and parents.
	Hints	To be used when the chosen provider is an outpatient hospital laboratory.
Revenue Code 309 Amount to be Billed: **$45.00** Provider Type: **Hospital (HO)**	Description	Drug confirmation, each procedure. Only for Child Welfare and OYA clients.
	Guidelines	(1) Used if screen testing is positive.
	Hints	To be used when the chosen provider is an outpatient hospital laboratory.
Revenue Code 309 Amount to be Billed: **$15.00** Provider Type: **Hospital (HO)**	Description	Alcohol and/or other drug testing, collection and handling, only specimen other than blood. Only for Child Welfare and OYA clients.
	Guidelines	(1) Use for drug screening collection for Child Welfare and OYA clients only.
	Hints	To be used when the chosen provider is an outpatient hospital laboratory.

Note: Procedure codes on this page are for **Hospitals only**. Hospitals should use the UB-92 for billing.

Guidelines for the OMAP 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 OMAP 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 OMAP 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 OMAP 729E can be billed at the same time.

Note: Procedure codes on this page are for **Hospitals only**. Hospitals should use the UB-92 for billing.

Guidelines for the OMAP 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-92 for billing.

Guidelines for the OMAP 729 series – continued

Procedure Code: 97750 Amount to be Billed: **$19.98** 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 OMAP 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 (OMAP 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: 96100 Amount to be Billed: **$50.60** 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 OMAP 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 (OMAP 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 OMAP 729F and or Rating of Impairment Severity Report OMAP 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 (OMAP 729E). Use for Mental Residual Function Capacity Report (OMAP 729F). Use for Rating of Impairment Severity Report (OMAP 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 OMAP 729E and/or OMAP 729F and/or OMAP 729G is required

Guidelines for the OMAP 729 series – continued

Procedure Code: S9981 Amount to be Billed: **$18.00** Provider Types: **(PB, MD, CR, CP, SC, PY, MC)**	Description	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.
	Guidelines	(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.
	Hints	Use of OMAP 729D is optional.
Procedure Code: 99455 Amount to be Billed: **$151.02** Provider Types: **Medical Doctors, Osteopaths, Psychologists, Ophthalmologists, Optometrists (MD, PB, IH)**	Description	Work related or medical disability examination by the treating physician. See current CPT for details. May be paid in addition to 99080.
	Guidelines	(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.
	Hints	(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 OMAP 729E can be billed at the same time.
Procedure Code: 99456 Amount to be Billed: **$151.02** Provider Types: **Medical Doctors, Osteopaths, Psychologists, Ophthalmologists, Optometrists (MD, PB, IH)**	Description	Work related or medical disability examination by other than the treating physician. See current CPT for details. May be paid in addition to 99080.
	Guidelines	(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.
	Hints	(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 OMAP 729E can be billed at the same time.

Guidelines for the OMAP 729 series – continued

Procedure Code: 96117 Amount to be Billed: **$50.60** Provider Types: **Psychologists (PY, PB, MC, IH)**	Description	Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour. See current CPT for details. To be used in combination with 90801, 90889 if required. Limited to 3 hours.
	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: **$99.91** 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 OMAP 729 series – continued

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 OMAP 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.

DHS
Oregon Department
of Human Services

**Administrative Medical Examination/
Report Authorization**

⑪

"Caseworker, see instructions on back"

① Patient's Name	② Insured's ID (Prime No)
③ SSN	④ Date of Birth

Agency Use Only

⑤ Program	⑥ Branch	⑦ Case Number	⑧ Wkr ID
⑨ Case Name			Filing Sect **5**

A Release of Information is Enclosed

⑩ **Provider Number** _____

This individual and the Department ask your help in determining his/her medical condition. He/she is seeking assistance because of the following complaints: ⑫ _____

⑬ Procedure Code	⑭ Description of Service	⑮ Amount to be Billed

All medical reports must be written and must contain a diagnosis, prognosis, and supporting objective findings. Functional impairments (changes in physical/mental functioning as a result of illness, injury, medication or surgery) and expected duration should also be included. The reports will only be accepted from Medicaid enrolled licensed medical and osteopathic doctors, optometrists, licensed clinical psychologists, licensed clinical social workers, physical therapists or occupational therapists as requested by the local branch.

⑯ **Attached forms to be completed and returned:**

☐ Comprehensive Psychiatric or Psychological Evaluation — See attached form OMAP 729A
☐ Report on Eye Examination — Complete attached form OMAP 729C
☐ Medical Record Checklist — See attached form OMAP 729D
☐ Mental Residual Function Capacity Report - Complete attached form OMAP 729F
☐ Physical Residual Function Capacity Report - Complete attached form OMAP 729E
☐ Rating of Impairment Severity Report - Complete attached form OMAP 729G

⑰ Branch Name and Address	⑱ Worker's Name	
	⑲ Date Requested	⑳ Telephone

Billing Information: In order to expedite services to this patient and payment to you, please return the report within 15 days to the branch office listed above. Use the ICD-9-CM diagnosis code V68.89. Send the CMS-1500 billing form to OMAP, PO Box 14165, Salem OR 97309. Hospitals send UB 92 to OMAP, PO Box 14956, Salem OR 97309. Copying services send CMS-1500 to OMAP, PO Box 14165, Salem OR 97309. **Relay the V68.89 diagnosis code to the Medicaid enrolled ancillary providers if additional OMAP-covered outpatient diagnostic services (e.g. lab, X-ray, special studies) are needed.**

Distribution: 1 Copy, Provider **TO RETAIN**   1 Copy, Provider **TO RETURN** with report   1 Copy, Case Record

Caseworker Instructions for Completion of OMAP 729
All blanks must be completed

1. Patient's Name .... Name of client to be seen by medical provider

2. Insured's ID/Prime No .... Eight alpha/numeric character field

3. SSN .... Client's Social Security Number

4. Date of Birth .... Patient's Date of Birth

5. Program .... Program (A1, 2, B3, D4, 5, P2, etc)

6. Branch .... Branch number (2401, etc)

7. Case Number .... Case number under which client is identified

8. Worker ID .... Worker Identification code

9. Case Name .... Case name under which client is identified

10. Provider Number .... Medical provider number assigned by OMAP, found on PRV1
    (See Computer Guide for instructions on accessing PRV1)

11. Address Box .... Name and address of medical provider

12. Patient's Complaint Area ...... List stated medical or mental conditions

13. Procedure Code .... Procedure code of selected exam or report

14. Description of Service .... Description for selected examination or report from
    guidelines

15. Amount to be Billed .... Amount to be billed for selected examination or report from
    guidelines

16. Needed Reports Boxes .... If other 729's are used, check the appropriate box

17. Branch Name and Address ... Legible branch name and mailing address

18. Worker's Name .... Legible name of worker requesting examination or report

19. Date Requested .... Date 729 sent to medical provider

20. Telephone .... Legible telephone number of worker requesting report

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

Patient's Name		Insured's ID (Prime No)	
SSN		Date of Birth	

Comprehensive Psychiatric or Psychological Evaluation

Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name			Filing Sect 5

Please use the following outline for the Comprehensive Psychiatric or Psychological Evaluation.

I. Summary history
    A. Social (including family, educational and significant life events)
    B. Mental illness (including development of psychiatric symptoms, hospitalizations and course of illness to date)

II. Mental status examination including
    A. General appearance and interview behaviors
    B. Thought processes
    C. Thought content — delusions, hallucinations
    D. Affects
    E. Judgment
    F. Risk of harm to self or others
    G. Intellectual functioning
    H. Indication of organic impairment, if any
    I. Current social functioning and activities of daily living
    J. Severity of functional limitations
        1. Restriction of activities of daily living
        2. Difficulties in maintaining social functioning
        3. Deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere).
        4. Episodes of deterioration or decompensation in work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration or adaptive behaviors).

III. Substance abuse history and current pattern of use/abuse

IV. Diagnosis (must be substantiated above by history and mental status examination, using American Psychiatric Association nomenclature according to current DSM)

V. Prognosis/expected duration

VI. Treatment recommendations including medications

VII. Physical/health problems and treatment (if any)

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

Report on Eye Examination

Diagnosis _____

_____

Patient's Name		Insured's ID (Prime No)
SSN		Date of Birth
Agency Use Only		
Progr0am	Branch	Case Number	Wkr ID
Case Name			Filing Sect 5

Legal Blindness —To meet the criteria of legal blindness, the answer must be "Yes" to *one* of the following four questions:

1. Is the impairment of central visual acuity in the better eye after best correction to 20/200 or less? ☐ Yes ☐ No

2. Is the contraction of peripheral visual fields in the better eye to 10 degrees or less from the point of fixation; or ☐ Yes ☐ No

3. Is the contraction of peripheral visual fields in the better eye so the widest diameter subtends an angle no greater than 20 degrees; or ☐ Yes ☐ No

4. Is the contraction of peripheral visual fields in the better eye to 20 percent or less visual field efficiency? ☐ Yes ☐ No

What is the prognosis?

_____

_____

Is the condition progressive?   ☐ Yes ☐ No

What is the expected duration of the condition? (circle one)

☐ Less than 60 days   ☐ 60 days or longer

Will the condition deteriorate without treatment?   ☐ Yes ☐ No

Is treatment indicated?   ☐ Yes ☐ No

If "yes," what is the recommended treatment?

_____

_____

_____

Examiner's Name (Please type or print.)	Date of Examination
Address	
Signature	Telephone Number

OMAP 729C (1/95)

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

Patient's Name			Insured's ID (Prime No)	
SSN			Date of Birth	
Agency Use Only				
Program	Branch	Case Number		Wkr ID
Case Name				

Medical Record Checklist

Please send copies of existing records as noted below

Information to request from hospital

- ☐ Hospital Admitting History and Physical Examination
- ☐ Hospital Admission Summary
- ☐ Hospital Discharge Summary
- ☐ Hospital Discharge Instruction Sheet
- ☐ Copies of consultant reports done while in hospital
- ☐ Psychological examination and reports
- ☐ Operative and pathology reports or summaries
- ☐ History and physical examination including height and weight
- ☐ Lab reports
- ☐ X-ray reports

Optional information to request from hospital

- ☐ Progress notes since_____
- ☐ Other _____

Information to request from doctor or clinic

- ☐ Progress notes since_____
- ☐ History and physical examination including height and weight
- ☐ Recent hospital admission and discharge records
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Functional Classification of heart disease according to the New York Heart Association Criteria
- ☐ Angiography interpretations
- ☐ EKG interpretations
- ☐ Treadmill interpretation
- ☐ Pulmonary function tests, pre and post bronchodilators
- ☐ Arterial blood gases
- ☐ Evidence of metastasis
- ☐ Neurological findings
- ☐ EEG interpretation
- ☐ IQ test results, including sub-test scores
- ☐ Psychological examinations or reports
- ☐ Mental status including: evidence of delusions, hallucinations, disorientation, impaired concentration and affect
- ☐ Other _____

Comments: _____

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

Client Name (Last, First, M.I.)		Insured's ID (Prime No)	
SSN		Date of Birth	
Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name		Date Completed	Filing Sec **5**

Physical Residual Function Capacity Report

Exertional Limitations

See patient name above. Please indicate the patient's ability to perform the functions listed below without experiencing severe palpitation, pain, fatigue, nausea with vomiting or difficulty breathing. **Based on an 8-hour day.**

1. Occasionally (2 hours or less) lift and/or carry, maximum:
   ☐ Less than 10 pounds ☐ 10 pounds ☐ 20 pounds ☐ 50 pounds ☐ 100 pounds or more

2. Frequently (6 hours or more) lift and/or carry, maximum:
   ☐ Less than 10 pounds ☐ 10 pounds ☐ 25 pounds ☐ 50 pounds or more

3. Stand and/or walk (with normal breaks) for a total of:
   ☐ less than 2 hours in an 8-hour workday   ☐ medically required hand-held assistive
   ☐ at least 2 hours in an 8-hour workday   device is necessary for ambulation
   ☐ about 6 hours in an 8-hour workday

4. Sit (with normal breaks) for a total of:
   ☐ less than about 6 hours in an 8-hour workday   ☐ must periodically alternate sitting and
   ☐ about 6 hours in an 8-hour workday   standing to relieve pain or discomfort

5. Push and/or pull (including operation of hand and /or foot controls)
   ☐ unlimited, other than as shown for lift and/or carry   ☐ limited in lower extremities
   ☐ limited in upper extremities

Postural Limitations

☐ None established

Limitation	Frequently	Occasionally	Never
1. Climbing (ramp, stairs, ladder, rope, scaffolds)	☐	☐	☐
2. Balancing	☐	☐	☐
3. Stooping	☐	☐	☐
4. Kneeling	☐	☐	☐
5. Crouching	☐	☐	☐
6. Crawling	☐	☐	☐

OMAP 729E (12/96)

Manipulative Limitations

☐ None established

Limitation	Frequently	Occasionally	Never
1. Reaching all directions (including overhead)	☐	☐	☐
2. Handling (gross manipulation)	☐	☐	☐
3. Fingering (fine manipulation)	☐	☐	☐
4. Feeling (skin receptors)	☐	☐	☐

Environmental Limitations

☐ None established

Limitation	No Restriction	Avoid Frequent Exposure	Avoid Occasional Exposure	Avoid All Exposure
1. Extreme cold	☐	☐	☐	☐
2. Extreme heat	☐	☐	☐	☐
3. Wetness	☐	☐	☐	☐
4. Humidity	☐	☐	☐	☐
5. Noise	☐	☐	☐	☐
6. Vibration	☐	☐	☐	☐
7. Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
8. Hazards (machinery, heights, etc.)	☐	☐	☐	☐

Diagnosis	Prognosis

How long do you expect this condition to last?

Date of disability onset	
	Is patient compliant with treatment? ☐ Yes ☐ No

Would you recommend a psychological evaluation?   ☐ Yes   ☐ No

Additional Comments

_____

Physician Name (Please type or print)	Address
Signature	Date

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

Mental Residual Function Capacity Report

Patient's Name	Insured's ID (Prime No)
SSN	Date of Birth

Agency Use Only			
Program	Branch	Case Number	Wkr ID
Case Name		Date Completed	Filing Sec **5**

Mental Residual Function Capacity is evaluated using the following criteria based on the basic mental skills necessary to engage in competitive employment. A marked limitation would impair functioning to a greater extent than a moderate limitation.

In responding to the designated ratings of the following categories of mental functioning, it is essential that your responses and comments be based on your clinical assessment of the individual's current and past mental limitations and not on non-medical factors. For example, your assessment should **not** be based on such non-medical factors as the availability of job openings, the hiring practices of employers, cyclical economic conditions, technological changes in the work industry since the individual last worked, or upon the individual's preference not to do a particular type of work. (*See*, 20 CFR §§ 404.1566(c) and 416.966 (c)).

In responding to the ratings on this form, please <u>do not include</u> any limitations which you believe the individual has as a result of his or her alcoholism or drug addiction, if any. In other words, do not include limitations which would go away if the individual stopped using drugs or alcohol.

The following assessment form reflects the four criteria in Social Security Administration regulations concerning the basic mental demands of work. (*See*, 20 CFR §§ 404.1521 & 416.921). These four criteria, as well as those for other than "basic" mental abilities and aptitudes, are to be documented and evaluated in terms of the individual's maximum remaining ability to perform sustained work on a regular and continuing basis, i.e, 8 hours a day, for 5 days a week, or an equivalent work schedule.

DEFINITIONS OF RATING TERMS

Not Significantly Limited: No significant limitation in this area.

Moderately Limited: A limitation which seriously interferes with the individual's ability to perform the designated activity on a regular and sustained basis, i.e., 8 hours a day, 5 days a week, or an equivalent work schedule.

Markedly Limited: A limitation which precludes the ability to perform the designated activity on a regular and sustained basis, i.e., 8 hours a day, 5 days a week, or an equivalent work schedule.

Unable to Determine: Insufficient evidence to assess.

Using the above-listed DEFINITIONS OF RATING TERMS please assess the degree of limitation the individual experiences in the categories of mental functioning set out below by placing a check mark or X in the corresponding boxes.

Understanding and Memory

Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
1. The ability to remember locations and work-like procedures.	❏	❏	❏	❏
2. The ability to understand and remember very short and simple instructions.	❏	❏	❏	❏
3. The ability to understand and remember detailed instructions.	❏	❏	❏	❏

OMAP 729F (Rev 11/99)

Sustained Concentration and Persistence

Limitation

	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
4. The ability to carry out very short and simple instructions.	❏	❏	❏	❏
5. The ability to carry out detailed instructions.	❏	❏	❏	❏
6. The ability to maintain attention and concentration for extended periods.	❏	❏	❏	❏
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	❏	❏	❏	❏
8. The ability to sustain an ordinary routine without special supervision.	❏	❏	❏	❏
9. The ability to work in coordination with or proximity to others without being distracted by them.	❏	❏	❏	❏
10. The ability to make simple work related decisions.	❏	❏	❏	❏
11. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods	❏	❏	❏	❏

Social Interaction

	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
12. The ability to interact appropriately with the general public.	❏	❏	❏	❏
13. The ability to ask simple questions or request assistance.	❏	❏	❏	❏
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	❏	❏	❏	❏
15. The ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes.	❏	❏	❏	❏
16. The ability to maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness.	❏	❏	❏	❏

Adaptation

	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
17. The ability to respond appropriately to changes in the work setting.	❏	❏	❏	❏
18. The ability to be aware of normal hazards and take appropriate precautions.	❏	❏	❏	❏
19. The ability to travel in unfamiliar places or use public transportation.	❏	❏	❏	❏
20. The ability to set realistic goals or make plans independently of others.	❏	❏	❏	❏

Diagnosis   **Prognosis**

Has or will this person's condition last at least 12 months?   ❏ Yes   ❏ No

If NO, how long do you expect this condition to last?

Date of Disability Onset: **Is patient compliant with treatment?**   ❏ Yes ❏ No

Would you recommend physical evaluation?   ❏ Yes   ❏ No

Additional Comments:

Physician Name   **Address**
(Please print or type)

Signature   **Date**

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

Patient's Name	Insured's ID (Prime No)
SSN	Date of Birth

Rating of Impairment Severity Report

Agency Use Only				
Program	Branch	Case Number		Wkr ID
Case Name			Date Completed	Filing Sec **5**

Rating of Impairment Severity

1. Restriction of Activities of Daily Living (ADLs)

Activities of daily living include adaptive behaviors such as cleaning, shopping, cooking, using public transportation, paying bills, maintaining a residence, attending to grooming and hygiene, using a phone book, or using a post office, etc. Functioning in this area will be evaluated by determining the extent to which these tasks can be performed independently, appropriately, and effectively. A marked limitation is not the number of activities restricted, but the nature and overall degree of interference with function.

❑ None   ❑ Mild   ❑ Moderate   ❑ Marked   ❑ Extreme

Please cite evidence for this assessment rating: _____

_____

_____

2. Social Functioning (SF)

Social functioning refers to the capacity to interact appropriately, independently, and effectively with other individuals on a sustained basis. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Social functioning in work situations may involve interacting with the public, responding appropriately to persons in authority, or cooperating with coworkers. A marked limitation in social functioning is not the total number of areas impaired, but the nature and overall degree of interference with function.

❑ None   ❑ Mild   ❑ Moderate   ❑ Marked   ❑ Extreme

Please cite evidence for this assessment rating: _____

_____

_____

3. Concentration, Persistence, or Pace (CPP)

Concentration, persistence, or pace refer to the ability to sustain focused attention and concentration sufficiently long to permit the timely appropriate completion of tasks commonly found in work and other settings. Major impairment in this area can often be assessed through direct psychiatric and/or psychological testing, although test results should be supplemented with other relevant information when available. A marked limitation in concentration, persistence or pace is not the total number of areas impaired, but the nature and overall degree of interference with function.

❑ None   ❑ Mild   ❑ Moderate   ❑ Marked   ❑ Extreme

Please cite evidence for this assessment rating: _____

_____

_____

4. Episodes of Decompensation (DC)

Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning. An episode is defined as lasting for at least two weeks. The frequency of

episodes is measured over an inclusive 12-month period prior to assessment. More frequent episodes of shorter duration (less than 2 weeks) or less frequent episodes of longer duration (more than 2 weeks) may also be considered in addressing the degree of impairment. Episodes of decompensation may be inferred from medical records or other relevant information concerning the nature and extent of the claimant's impairment related signs and symptoms.

    ❑ Never   ❑ Once or twice   ❑ Three   ❑ Four or more

Please cite evidence for this assessment rating:_____

_____

_____

5. Is the client demonstrating a residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate?

    ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

6. If this person uses drugs or alcohol, would you expect any difference in your ratings of numbers 1-4 above if there were no drug or alcohol use?

    ❑ Yes   ❑ No   ❑ Doesn't apply

If yes, please state what you think each rating would be without the use of drugs or alcohol.

1. ADL	❑ None	❑ Mild	❑ Moderate	❑ Marked	❑ Extreme
2. SC	❑ None	❑ Mild	❑ Moderate	❑ Marked	❑ Extreme
3. CPP	❑ None	❑ Mild	❑ Moderate	❑ Marked	❑ Extreme
4. DC	❑ Never	❑ Once or twice	❑ Three	❑ Four or more	

Diagnosis	Prognosis

Will this person's condition last at least 12 months from the date of assessment?   ❑ Yes ❑ No

Is patient compliant with treatment?   ❑ Yes ❑ No

Would you recommend a physical evaluation?   ❑ Yes ❑ No

Additional Comments _____

_____

_____

Physician Name (Please type or print)	Address
Signature	Date

OMAP Worker Guide 9

Prior Authorization

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

The chart on the next page lists services requiring prior authorization and who can authorize those services. Procedures for processing PAs are the same for all benefit packages, except when a client is in a prepaid health plan which covers the service.

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

NOTE: **If a client belongs to a managed health care plan, the provider should contact the plan directly for prior authorization on health care services covered under the client's benefit package.**

Prior Authorization Authority

Responsible Authority	Client Groups	Services Authorized
Managed Health Care Plan (MHCP)	All clients enrolled in an MHCP when the service is included in the plan's contract	All services for which the plan receives a capitation payment
DHS Branch Staff	DHS Clients for non-emergency medical transportation (for clients enrolled in an FCHP, the plan is responsible for all ambulance, including non-emergency)	Transportation
OMAP Claims Management	Children in subsidized adoption	Medical Transportation Administrative Exams
SPD Branch Staff	SPD clients not enrolled in an MHCP	Medical Transportation
First Health Services 1-800-344-9180	All clients not enrolled in an FCHP Any client receiving a therapeutic class 7 or 11 drug	Drugs related to National Drug Codes (NDCs) Oral nutritional supplements
OMAP Medical Unit	CAF and SPD clients not enrolled in an MHCP except Medically Fragile Children* and Health Integrated** (see below)	Durable Medical Equipment (DME) and Supplies (for specific items, see the DME rules) Physical/Occupational Therapy Private Duty Nursing Home Health Speech and Hearing (for specific items, see the Speech-Language rules) Visual Services Home Enteral/Parenteral IV
OMAP Dental Coordinator 1-800-527-5772 or 503-945-6506 (Salem)	DHS clients not enrolled in a Dental Care Organization or an MCHP which covers dental	Dental services
Transplant/Out-of-state RNs 1-800-527-5772 or 503-945-6488 (Salem)	DHS clients not enrolled in an MCHP	Transplants and out-of-state services
OMPRO 1-800-452-1250 or 503-279-0159 (Portland)	DHS clients not enrolled in an MHCP	Surgeries and services listed in the Med-Surg rules and/or supplements as requiring OMPRO prior authorization
*Medically Fragile Children's Unit (MFCU) 503-731-3088 (Portland)	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, surgeries, dental and visual services
**Health Integrated 1-800-711-5587	DHS fee-for-service High cost/high risk clients	All medical services requiring prior authorization

Prior Authorization Contacts

for Services Not Covered by a Prepaid Health Plan

Dental .... OMAP Dental Coordinator 800-527-5772
or 503-945-6506

DME Equipment/Supplies .... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Drugs/Pharmacy .... First Health 800-344-9180

Managed Access Program (MAP) First Health 800-250-6950

Hearing Aid Services .... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Home Health (nursing only) .... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

**Home Enteral/
   Parenteral** .... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Oral Nutritional Supplements .... First Health 800-344-9180
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Physical/Occupational Therapy ... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Private Duty Nursing .... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Speech/Hearing/Audiology .... OMAP Medical Unit 800-642-8635/503-945-6821
   MFC Clients .... Medically Fragile Children's Unit 503-731-3088
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Surgical Procedures .... OMPRO 800-452-1250/503-279-0159
Outside Oregon 800-325-8933
Oregon Medical Professional Review Organization (OMPRO)
2020 SW Fourth St., Suite 520
Portland, OR 97201-4960
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Prior Authorization Contacts, continued
for Services Not Covered by a Prepaid Health Plan

Transplants ....Medical Directors Unit .. 800-527-5772/503-945-6488
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Transportation ....Local branch office/brokerage

Visual Services ....OMAP Medical Unit 800-642-8635
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

Out-of-State Services ....Medical Directors Unit 800-945-6488
   Fee-for-service high cost/high risk .. Health Integrated 800-711-6687

OMAP Medical Unit ....FAX 503-378-5814

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 OMAP.)

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 guides.

C.   MMIS Screens

The following screens are used in prior authorizing services for clients receiving the Basic Health Care Package. 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 which affects the adjudication of claims.

- ◆ PRVX - To locate a provider by name.

- ◆ PRV1 - Used to identify provider eligibility.

OMAP Worker Guide 10

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.

R01 The client was not eligible for Medical Assistance on this date of service. (General Rules 410-120-1140)

R02 OMAP does not pay for services which are provided outside of the United States, except in those countries operating a Medical Assistance (Title XIX) Program. (General Rules 410-120-1180)

R03 The service for which you billed is not covered by OMAP. (General Rules 410-120-1200; 410-120-1160)

R04 OMAP does not pay for services which are not expected to improve the basic health of the client. (General Rules 410-120-1200)

R05 OMAP does not pay for services that are not considered as reasonable and appropriate for treatment of disability, illness or injury. (General Rules 410-120-1200)

R06 OMAP 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 410-120-1200)

R07 OMAP does not cover examinations for clients older than age 20 for any program or activity not related to the improvement of the client's health and rehabilitation. (General Rules 410-120-1200)

R08 Cosmetic services or surgery to improve appearance are not covered. (General Rules 410-120-1200)

R09 Services or items provided by friends or relatives of a client are not covered. (General Rules 410-120-1200)

R10 OMAP 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 nonmedical public institution. (General Rules 410-120-1200)

R11 Immunizations prescribed for foreign travel are not covered. (General Rules 410-120-1200)

R12 OMAP 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 410-120-1200)

R13 OMAP will not pay for services related directly to a non-covered service. (General Rules 410-120-1200; Durable Medical Equipment 410-122-0080)

R14 OMAP does not cover services related to the establishment or reestablishment of fertility or pregnancy or for the treatment of sexual dysfunction, including impotence. (General Rules 410-120-1200)

R15 Transsexual surgery or any related services are not covered. (General Rules 410-120-1200)

R16 Our records indicate the client has other insurance. When an OMAP client has Medicare or other third party coverage, the provider must bill Medicare or the other insurer before billing OMAP. Please bill the other insurance first. (General Rules 410-120-1280)

R17 If a client accepts financial responsibility for a non-covered service prior to receiving it, payment is a matter between the client and the provider. (General Rules 410-120-1200)

R18 For clients whose medical care is managed by a primary care practitioner, a referral is required before non-emergency care is covered by the health plan or OMAP. (General Rules 410-120-0000)

R19 Drugs from a company which is not participating in the Drug Rebate Program are not covered. (Pharmaceutical Services 410-121-0157)

R20 This service/item is not covered for clients age 21 or older. (General Rules 410-120-1200)

R21 OMAP will not pay for dental services when the client is enrolled in a DCO or a prepaid health plan that includes dental coverage. Please contact the client's plan. (OHP Administrative Rules 410-141-0420)

R22 This diagnosis is not covered by the Oregon Health Plan. (OHP Administrative Rules 410-141-0480, 410-141-0500)

R23 OMAP payment decisions, unless in error, constitute payment in full. This includes zero payments for claims where other resources have paid more than OMAP's maximum allowable. (General Rules 410-120-1340)

R24 OMAP decisions, unless in error, constitute payment in full. This includes denials of payment for failure to submit a claim in a timely manner, obtain prior authorization, or follow other required procedures. (General Rules 410-120-1340)

R25 To be payable, all claims for medical services/items must be submitted for payment within 12 months of the date of service. (General Rules 410-120-1300, OHP Administrative Rules 410-141-0420)

R26 OMAP 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. (OHP Administrative Rules 410-141-0420)

R27 Payment cannot be made because the documentation requested to support claim or request was not submitted. (General Rules 410-120-1320, 410-120-1360)

R28 OMAP does not pay for non-emergency out-of-state medical services unless OMAP authorizes the service in advance. (General Rules 410-120-1180)

R29 Information submitted does not substantiate the medical appropriateness for the service provided/ requested. (General Rules 410-120-0000, 410-120-1200, 410-120-1320)

R30 The request for hearing aid exceeds OMAP's limitation criteria. (Speech-Language Pathology, Audiology and Hearing Aid Services 410-129-0070)

R32 OMAP does not pay for services which deviate markedly from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy. (General Rules 410-120-1200)

R33 It is the responsibility of the provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service and for the service provided. (General Rules 410-120-1140, 410-120-1320)

R34 OMAP will make payment only to the enrolled provider of services or the provider's enrolled billing intermediary (billing provider). (General Rules 410-120-1340, 410-120-1260; OHP Administrative Rules 410-141-0420)

R35 This service/item requires authorization of payment before it can be provided. (General Rules 410-120-1320; Durable Medical Equipment 410-122-0040; Medical-Surgical Services 410-130-0200; Private Duty Nursing 410-132-0100; Transplant Services 410-124-0020)

R36 Items included in the nursing facility all-inclusive per-diem rate are the responsibility of the nursing home facility. (General Rules 410-120-1340; Durable Medical Equipment 410-122-0180; Home Enteral/Parenteral Nutrition and IV Services 410-121-0730; Pharmaceutical Services 410-121-0625; SPD 411-070-0085)

R37 The medical diagnosis and clinical evidence submitted do not meet the criteria for approval. (Dental Services 410-123-1100; Private Duty Nursing 410-132-0080; Durable Medical Equipment 410-122-0080)

R38 The request to authorize payment of non-emergency medical transportation, ordered directly by the client when the branch office was closed, was not submitted to the branch office within 30 calendar days following the provision of the service. Therefore, it is not covered by OMAP. (Medical Transportation Services 410-136-0300)

R39 No payment is made by OMAP when transport was not provided and/or care was not given. (Medical Transportation Services 410-136-0040)

R40 No payment is made by OMAP when death occurs prior to arrival of an ambulance. (Medical Transportation Services 410-136-0100)

R42 Transport or return of an inpatient from the admitting hospital to another hospital for testing or treatment is the responsibility of the admitting hospital. (Hospital Services 410-125-0120; Medical Transportation Services 410-136-0120)

R43 OMPRO has reviewed your request for inpatient hospital services and determined that the service is not medically appropriate or does not contribute to the basic health status of the client. (General Rules 410-120-1200; Hospital Services 410-125-0080, 410-125-0100, 410-125-1080)

R44 Payment for non-emergency medical transportation was not authorized by an existing medical transportation broker or the local branch office. Therefore, it is not covered by OMAP. (Medical Transportation Services 410-136-0300)

R45 Payment for some Durable Medical Equipment and Supplies must be prior authorized. (Durable Medical Equipment 410-122-0040)

R46 OMAP will not pay for services/items that are similar to services/items with the same purpose at a lower cost with the same outcome for the client. (Durable Medical Equipment 410-122-0080; General Rules 410-120-1200; Medical Transportation Services 410-136-0300; Private Duty Nursing 410-132-0080; Home Health Care Services 410-127-0040)

R47 Sleep studies are not required to discontinue an Apnea monitor. (Durable Medical Equipment 410-122-0240)

R48 Written documentation has not been received to justify authorization for medically appropriate service and/or supplies. (General Rules 410-120-0000, 410-120-1200; Home Enteral/ Parenteral Nutrition and IV Services 410-148-0060, 410-148-0260)

R49 This service is not covered by OMAP for clients with only QMB coverage. Coverage is only for those services which are covered by Medicare. (General Rules 410 120-1200)

R50 Maintenance therapy or services are not covered. (Speech-Language Pathology, Audiology and Hearing Aid Services 410-129-0040; Physical and Occupational Therapy Services 410-131-0100; Private Duty Nursing 410-132-0060, 410-132-0080)

R51 The client is in the Medically Needy Program and not eligible for this service. (General Rules 410-120-1200, 410-120-1280)

R52 OMAP pays for stainless steel crowns only on posterior teeth. (Dental Services 410-123-1330)

R53 Information submitted does not meet the criteria for medical appropriateness. (Speech-Language Pathology, Audiology and Hearing Aid Services 410-129-0080)

R54 Replacement of dentures and cast metal partials is limited to once every five years. (Dental Services 410-123-1380)

R55 Permanent bridges are allowed for anterior permanent teeth only. (Dental Services 410-123-1420)

R56 OMAP will not provide another wheelchair if the client has a chair that meets his/her needs regardless of who has obtained it. (Durable Medical Equipment 410-122-0320)

R57 OMAP does not pay for services not performed by a licensed practitioner practicing within his/her scope of practice or licensure. (Private Duty Nursing 410-132-0020; Home Health Care Services 410-127-0020; Physical and Occupational Therapy Services 410-131-0040, 410-131-0060; Speech-Language Pathology, Audiology and Hearing Aid Services 410-129-0065)

R58 This service requires payment authorization. (General Rules 410-120-0000, 410-120-1320; Home Health Care Services 410-127-0080, Physical and Occupational Therapy Services 410-131-0160; Speech-Language Pathology, Audiology and Hearing Aid Services 410-129-0070; Home Enteral/ Parenteral Nutrition and IV Services 410-148-0060)

R59 Payment will not be made for pump rental beyond 15 consecutive months. (Home Enteral/Parenteral Nutrition and IV Services 410-148-0080)

R60 OMAP does not pay for services listed as not covered. (General Rules 410-120-1200; Durable Medical Equipment 410-122-0080)

R61 This service is not covered by OMAP for clients with Citizen/Alien-Waived Emergency Medical (CAWEM) coverage. (General Rules 140-120-0000, 140-120-1200; Durable Medical Equipment 410-122-0080)

R62 Not covered for purchase, rent or repair by OMAP. (Durable Medical Equipment 410-122-0080)

R63 The prescription must be dated, legible and specify the exact medical item or service required, the ICD-9-CM diagnosis codes, number of units and length of time needed. (Durable Medical Equipment 410-122-0020)

R64 Limited to 360 units per month, based on medical appropriateness, of any combination of products (i.e., adult briefs and liners) unless documentation supporting increased medically appropriate usage is sent to OMAP Medical Unit for review and PA. (Durable Medical Equipment 410-122-0190, 410-122-0630)

R65 Exceeds limitations for CPAP and BiPAP accessories. (Durable Medical Equipment 410-122-0202, 410-122-0205)

R66 Procedure codes A7034-A7039 and A7044 are not covered separately with K0533. (Durable Medical Equipment 410-122-0205)

R67 CPAP cannot be converted to purchase without recent documentation of efficacy and compliance from the physician. (Durable Medical Equipment 410-122-0202)

R68 The allowable rental fee for the ventilator includes all equipment, supplies, services and training necessary for the effective use of the ventilator. (Durable Medical Equipment 410-122-0210).

R69 Prior Authorization is not required.

R70 Considered to be paid after 16 consecutive months of rental by the same provider or when purchase price is reached. (Durable Medical Equipment 410-122-0180)

R98 Request denied with manual denial notice sent noting the reason for the denial and the law or rule under which the request was denied.

R99 Request denied; no denial notice was generated; no reason given.

OMAP Worker Guide 11

Client Rights and Responsibilities

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. OMAP 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; 410-120-0420*

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 OMAP 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 OMAP Client Advisory Services Unit at (503) 945-6898 or mail the copies to OMAP, Attention: CASU Billing.

C.   **Health Care Complaint Processes**   *OHP Rules 410-141-0260; 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 OMAP'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 410-141-0264

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 OMAP 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 OMAP.

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 OMAP.

Forward all OMAP hearing requests, with attachments, to:

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

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

OREGON HEALTH PLAN
Complaint Form

If you have a complaint about your Oregon Health Plan services, fill out this form.

☛ If your concern is about services from a Managed Healthcare Plan, send this form to the plan at the address shown on your Medical Care Identification Form.

☛ For other concerns, send this form to Client Advisory Services Unit; OMAP, PPS; 500 Summer St. NE E35; Salem, OR 97301-1077.

Your Name: _____

Your Phone Number: ( )

Client's Name (if you are not the client): _____

Client's Social Security Number or Medicaid ID Number: _____

What happened? When did it happen? Who was involved? (Attach any documents such as notices, denials of service, doctor's bills, etc., which might help us investigate your complaint.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What should be done about it?

_____

_____

_____

_____

_____

Attach additional pages, if needed

NOTICE: This is not an Administrative Hearing request form. To ask for a hearing, obtain form AFS 443 from any office of the Department of Human Services.

OHP 3001 (Rev 4/03)

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Medical Transportation

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. This section of the OMAP Worker Guide includes:

- State requirements and authority
- Covered transports
- Authorizing the transport, including:
    - Branch/agency standards
    - Using a brokerage
    - Eligibility screening
    - Procedures to complete OMAP 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 OMAP 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 HCFA-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.

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

- OMAP 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 OMAP to be cost-effective to OMAP.

- A Branch may not authorize and OMAP will not make payment for non-emergency medical transportation outside of a client's local area when the client has been non-compliant with treatment facility refusing to provide further service or treatment to the client. In the event supporting documentation is submitted to OMAP 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 documen-tation 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 OMAP. 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

OMAP 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 (OMAP 405T) or its equivalent has been forwarded to the transportation provider; AND

- The transportation provider is actively enrolled with OMAP as a provider of Medical Transportation services and the service to be obtained is one of the following covered services:

    - Administrative Medical Exam (An open eligibility segment on ELGR must be present in order for the claim to be paid.)

    - 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

- Special transports to obtain out-of-state services not available in Oregon. Must be authorized by the OMAP Out-of-State Services Coordinator and Medical Transportation Program Manager.

- Speech/hearing/audiology service

- Transplant. Must be authorized by the OMAP Transplant Coordinator or the client's prepaid health plan.

- Vision service (including ophthalmic services)

- Waivered service as follows: OMAP 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:** Most pharmacies now 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 OMAP. Contact Wellpartner at 1-877-935-5797 for more information. Prescription order forms and additional information are available from the DHS website at:

www.dhs.state.or.us/healthplan/clients/mailrx.html

3.   Covered Transports Provided by Volunteers

(These are Title XIX matchable) OMAP 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 Children's Hospital or Doernbecher 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 Children, Doernbechers, 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.

Administrative Rule (410-136-0160), Medical Transportation Services Guide, 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

There are several regions in the state that are within brokerage areas. 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 arerequested.

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.

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 OMAP 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.

- 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. It is also the branch re-sponsibility to coordinate brokerage services outside of the resident location.

⇒ 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 OMAP 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, OMAP'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 OMAP'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 OMAP 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 OMAP 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 OMAP 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 OMAP 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 OMAP 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 OMAP will be reviewed by OMAP 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 OMAP 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 OMAP 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 OMAP.

In order to facilitate a move of this nature OMAP 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 OMAP Medical Transportation Program Manager for final approval. Retain a copy of all information in the branch record.

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

⇒ **Remember:** OMAP 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 OMAP provider may be unwilling to provide a non-emergency transport at OMAP rates. When this happens, the following must occur:

• Determine the reason for the refusal. Is it simply OMAP 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 OMAP 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 OMAP rates. If absolutely no provider can be found who will accept OMAP 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. (OMAP 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 OMAP 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. (OMAP 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 OMAP Out-of-State Coordinator for prior authorization.

If OMAP approves an out-of-state service, a letter of approval will be sent to the branch by the OMAP 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 OMAP 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)

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, OMAP 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 OMAP to the hospital.

8.   Not Covered Transports and Related Services

Following are examples of services/situations where OMAP 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 OMAP 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 OMAP 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". (OMAP 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". (OMAP pays only the Medicare premium for these clients. They do not get a Medical Identification form and OMAP does not pay for any medical services.)

Not Covered Transports and Related Services, continued -

- Transportation to medical services before spend-down is met.

- Non-emergency medical transportation for undocumented non-citizens (CAWEMs).

- 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; i.e., urinalysis for drug testing.

- Transports occurring while client in custody of law enforcement agency, juvenile detention center, or nonmedical 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, 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 OMAP or a provider who refuses to enroll with OMAP or is unwilling to accept OMAP 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, nonmedical 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).

Not Covered Transports and Related Services, continued -

- 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.

- 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 OMAP 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 OMAP. (This equipment becomes a part of the estate of the deceased.)

- Transports to obtain prescriptions from a pharmacy that offers free delivery.

  - See OMAP 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.)

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.)

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.

Exceptions to this reimbursement policy include:

♦ DHS Volunteers - will be reimbursed at the current rate of represented state employees

♦ Client Employed Providers - will be reimbursed at the current rate of their contract

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/intracity 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. OMAP 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 OMAP'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 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 OMAP 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 OMAP 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 pre-pared 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 OMAP 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 OMAP 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 OMAP 409 copy remains in the branch record. The OMAP 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 clients 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.   Appendices

- Revolving Fund Check & Supporting Document Transmittal (AFS 288)
- Example of CMS-1500 (formerly HCFA-1500)
- Medical Transportation Screening/Input Document (OMAP 409)
- Medical Transportation Screening Form (OMAP 410)
- Medical Transportation Eligibility Screening and Medical Transportation Order (OMAP 406)
- Medical Transportation Order (OMAP 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   **Date:** _____
Salem, Oregon   97309

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.

AFS 288 (Rev. 2/2000)
recycle prior versions

PLEASE DO NOT STAPLE IN THIS AREA

Prog: 2
Branch: 2801
Wkr ID: K9

Example

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare#) ☒ (Medicaid#) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)	XX#####X

2. PATIENTS NAME (Last Name, First Name, Middle Initial)

Doe, Jane

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 SEX MM DD YY M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

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. |___.___| 3. |___.___|
2. |___.___| 4. |___.___|

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE		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
FROM MM DD YY	TO MM DD YY										
09 02 00	09 08 00	X	D	A0200 (Attend. Lodging)		280 00	7				
09 02 00	09 08 00	X	D	A0210 (Attend. Meals)		84 00	7				
09 02 00		X	D	A0190 (Client Meals)		12 00	1				
09 02 00		X	D	A0190 (Client Meals)		12 00	1				
09 02 00		X	D	A0140 (Client Airfare)		75 00	1				

PHYSICIAN OR SUPPLIER INFORMATION

MIF/N90-1B

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 $ 463 00

29. AMOUNT PAID $

30. BALANCE DUE $ 463 00

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 **9-11-00**

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 #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Medical Transportation Screening/Input Document
for payments made directly to client/attendant
(see reverse for instructions)
Complete all information applicable

Disposition
☐ Pick-up (enter date) _____
☐ Mail-by (enter date) _____

I Client Info

Pgm _____ Branch _____ Wkr ID _____   Case # _____

Client _____   Prime # _____
         Last   First   M I   SSN # _____

Home Address _____   Phone # _____
      Street   City   State Zip

Mail Address _____   DOB _____
      Street   City   State Zip

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? (circle one) Yes No

III Appointment Info

Destination _____
  (Dr. name, Clinic, etc.)   (Address, City, State)   (Phone #)

Appt. Date _____ (mo, day, yr) Time _____ (am, pm) Verified by _____

Depart _____ (mo, day, yr) Time _____ (am, pm) Return _____ (mo, day, yr) Time _____ (am, pm)

Ongoing Trips: Begin _____ (mo, day, yr) End _____ (mo, day, yr) M Tu W Th F S Su (circle days)

IV Trip Information (see reverse side for criteria)

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

* or less if available

Other: Commercial Airline, Intercity Bus, Train, Bus Pass/Tickets (circle one) $ _____

Procedure Code = 35   TOTAL $ _____

V Data Entry & Authorization

Terminal Entered by _____ Date _____

Revolving Fund Check # _____ (attach tissue copy)

Worker/Requestor _____ Date _____

Branch Authorizing Signature _____ Date _____

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. Circle Y **(yes)** or N **(no)** to indicate what resources are available.
If resource 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. Circle 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 ($) authorized.
Procedure Code – Enter 35.
Other - Circle one, enter reimbursement ($) 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 6:00a.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.

OMAP 409 (Rev 07/18/02)

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)

State of Oregon
Department of Human Services
Office 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

Circle days of week

Begin Date _____   End Date _____   Sun   Mon   Tues   Wed   Thurs   Fri   Sat

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

OMAP 406 (11/99)

State of Oregon
Department of Human Services
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	Trip Info
Taxi WC SC Ambulance Other* SC by Ambulance (Circle One)	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 (11/99)

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Processing Claims

A.   Processing Claims Overview

OMAP'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 are vital to the smooth working of this system.

OMAP 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 OMAP 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 OMAP, it is processed primarily by a computer — the Medicaid Management Information System (MMIS). Unlike most private insurance companies, the OMAP 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 microimaged, 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.
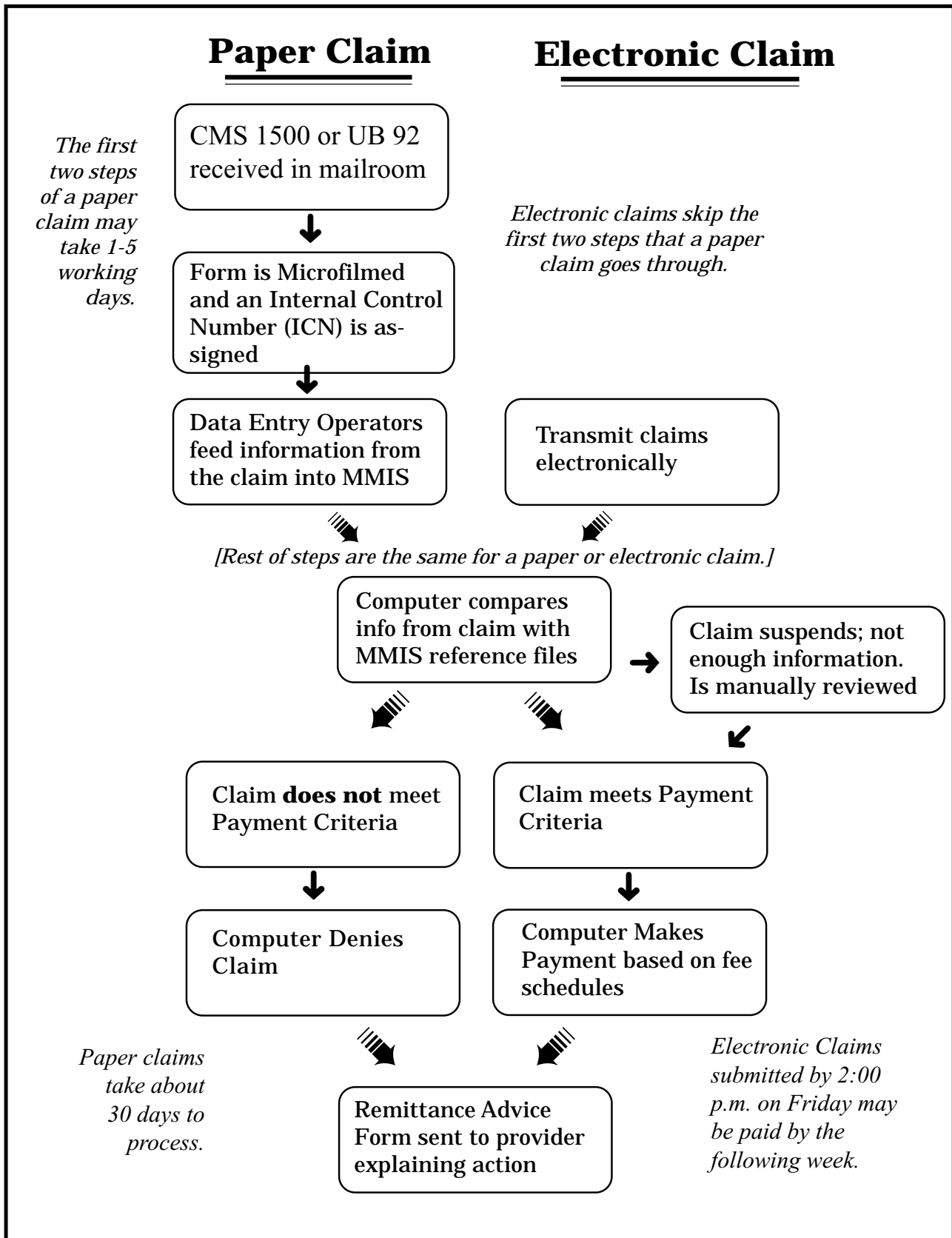
ONLY required fields of information are keyed into MMIS. Data entry operators can process a single claim in 45 seconds. Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms, or take the time to read and annotate notes or written explanations 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 OMAP 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, OMAP 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 OMAP 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

Claim meets Payment Criteria

⬇

Computer Denies Claim

⬇

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.

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Premiums, Copayments

and Special Requirements

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.

B.   Who Pays Premiums?   *General Rules 410-120-1380 and*
                                                                              410-120-1390

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 clients) are exempt from paying premiums:

- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- CAWEM clients

1.   Rate schedule

Premium rates are based on the number of people required to pay premiums and household income. **For actual income amounts, refer to CAF Rule 461-155-0235.**

2.   Premium Billings and Payment

OHP premiums are collected by the Oregon Health Plan Premium Billing Office. The contractor is the William C. Earhart Co., but workers should always refer to it as the OHP Premium Billing Office. That way, the contractor's other phone lines will not be tied up with OHP premium calls.

OMAP 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 3949, Portland, OR 97208-3949. Anyone may pay premiums on behalf of a client (OAR 410-120-1380 and 410-120-1390). Payments should be made by check, money order or cashier's check. ***Payments cannot be made in cash or by credit card.*** Clients who come to a branch office wanting to pay their premiums should be told to send payments to the above address. **Their premium billing includes a return envelope.** The payment coupon should be included with the payment.

C.   Nonpayment of Premiums

1.   Arrearage

Clients are given a one month grace period before losing eligibility. If a required premium payment is not received by the OHP Premium Billing Office on or before the 20th of the month following the due date, all premium paying OHP-OPU clients **on the case** will lose eligibility the first of the next month. For example:

Premium is due July 20th for July coverage
Client(s) **must** make that July payment by August 20th, or
Client(s) will lose coverage September 1st

If **one** premium paying adult in a household does not pay their premium, then **all** premium paying adults in that household will lose eligibility. They will **all** be ineligible for OHP coverage for six months. They must pay premium arrearages before becoming eligible again and can only be determined eligible during open enrollment periods. Any OHP Plus or CAWEM members of the household **will not lose coverage**.

Premiums billed after January 2003 cannot be waived. 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. Refer to the CAF Family Services Manual for specifics. (OAR 461-135-1100, 461-135-1120, and 461-135-1130)

Past arrearage can be adjusted if the Department is notified a member of the filing group filed for bankruptcy and the arrearage is a debt that has been stayed in a bankruptcy proceeding. 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. In order to have such an arrearage removed from the system, the worker should contact a CAF Medical Program Analyst.

2.   **Aid Paid Pending**

- In an OHP-OPU client requests a hearing contesting disqualification for nonpayment of premiums and receives continuation of benefits:

- The worker codes the case with an OAP case descriptor and need/resource item.

- Clients with OAP coding continue to receive premium bills. OAP clients will not be disqualified during the aid paid pending period for nonpayment of premiums.

- If the branch decision to disqualify is upheld, the OAP coding is removed and the medical aid paid pending is ended. The client must serve the six month penalty period and pay past due premiums before their OHP-OPU may be reopened.

- If the branch decision to disqualify is overturned, the OAP coding and disqualification coding is removed. The client must pay all past due premiums billed after February 1, 2003, to avoid disqualification.

D.   **Premium Questions?**

♦ For questions about the billing (whether a payment was received, etc.), call the OHP Premium Billing Office at the number listed on the billing notice, 1-800-922-7592. Workers **only** may call 503-535-1400.

♦ 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 OMAP Medical Care ID.

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

Some OHP clients will be charged 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 ID in fields 7a and 7b.

1.   Exemptions

OHP Plus clients who are enrolled in Fully Capitated Health Plan, Dental Plan, or Mental Health Plan will not be charged 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 will **not** be charged 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 will be charged 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 copayment charged for treatments performed by the provider, such as immunizations, lab, or x-rays.

Services to a client **cannot be denied** 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 will **not** be required 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 will **not** be charged a copayment for the following drugs:

- Prescription drugs for family planning services, like 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)

F.   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 on the OHP Plus Benefit package do not have to make copayments on drugs ordered through this program. Clients can use this program even if they are restricted to one pharmacy through the Pharmacy Management Program.

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

www.dhs.state.or.us/healthplan/clients/mailrx.html

First time prescriptions and completed order forms are to be mailed to Wellpartner, Inc., P.O. Box 5909, Portland, OR 97228-5909. Clients may enroll themselves by calling Wellpartner at 1-877-935-5797. Healthcare providers can fax the prescription to 1-866-624-5797. (This phone number should only be used by the doctor of healthcare provider).

G. 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 retail pharmacy, they can still use the Home Delivery (Mail Order) Pharmacy Program.

2. Selection

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

The designated pharmacy will show 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 will be allowed access to any pharmacy belonging to that chain regardless of geographical location within Oregon and contiguous service areas.

3. Who Will be Enrolled

All clients who are fee-for-service receiving Medicaid benefits, who are not exempt, will be 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 OMAP's Health Management Unit (HMU) with the client's pharmacy choice or the client can call the Client Advisory Services Unit (CASU) directly at 1-800-273-0557. CASU will be responsible for giving the information to HMU to update the client's TPR file. New Medical ID cards will be system generated 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 HMU. Branch Workers can call HMU directly at (503) 945-6523. Mail or fax to:

> HMU
> 500 Summer Street NE
> Salem, OR 97301-1079
> Fax # (503) 945-6873

E.   Americans with Disabilities Act (ADA) Accommodation

Under Title II of the American with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, OAR 461-105-0190 (Discriminatory Actions) DHS is required to make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the modifications would fundamentally alter the nature of the service, program or activity.

If approved, an ADA accommodation for OPU premium payments means the premiums do not have to be paid until the client reapplies at the end of the certification period. When the client reapplies, the worker will pend for the payment of unpaid premiums and any other items needed to determine eligibility. Before the client can establish a new OHP certification period, the premium payments will need to be paid. If the client's OPU medical has already been ended because of a premium disqualification, their medical may be reopened.

If a client or client representative contacts a branch office and wishes to make an ADA request, encourage the client or representative to make the request in writing. (No specific form has been developed but one may be developed in the future.) If that presents a barrier, please gather the information for the client or representative.

The following information is helpful to include with each request:

1. Name of client

2. SSN or prime number

3. Telephone number, if available

4. Disability

5. Description of the disabling conditions and how they affected the client's ability to pay bills on time.

6. Medical documentation of the disability and its affect on the client, if available. Medical documentation is not required to start the process but will be required to make the decision.

7. A release of information if a representative is making a request on the behalf of a client and wants to know the outcome of the request.

Forward the request information by fax or mail to:

Michelle Marks
CAF Medical Program Analyst
Children, Adults and Families
Department of Human Services
500 Summer Street NE
Salem, OR 97301-1066
Fax (503) 373-7032